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Exploring the Cultural Intelligence of Nurse Leaders

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Walden University
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Abstract

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by

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MHA, University of St. Francis, 2013

BSN, Samford University, 1999

BS, Alabama Agricultural and Mechanical University 1986

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Today, nurses represent many cultures and ethnic backgrounds. In their leadership style, nurse leaders must learn to embrace cultural intelligence or cultural quotient (CQ), that is, an extension of emotional intelligence that affords them the ability to manage a culturally diverse workforce. Historically, CQ has been relevant to business, locally and globally. But it is also important to explore the CQ of nurse leaders. Scholarly studies show that leaders with CQ are responsible for developing innovative employee behaviors, forward-thinking ideas, and creativeness in the workplace. CQ has a theoretical foundation in the 2003 research of Early and Ang who focused on CQ and the ability to lead in culturally diverse situations. This theoretical foundation will support the qualitative case study approach used to explore the CQ of nurse leaders. Ten participants were selected to answer semi structured interview questions, which were designed to produce data to answer research questions about the meaning of CQ to nurse leaders, the patient experience, self-awareness of CQ, and leadership practice. Thematic data analysis using the MAXQDA software program was the analysis tool. The results are expected to create positive social change by providing evidence-based results that can enhance the CQ of nurse leaders, their leadership style, and their practice in the United States. This study will add to the existing literature and its results may help the reader to reflect on the importance of CQ in their practice of leadership in the nursing profession.

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Dedication

I dedicate this dissertation to my family. Mom, thank you for inspiring me and supporting me during this process. You saw the desire in my eyes, and you knew that I would be here before I did. You always said, “What God has given to you, you shall have, and no one shall take it away.” I love you, mom. Jalen, you are a beautiful son. Be encouraged and always reach your maximum potential. No matter how hard some things may seem, you can do anything you set your mind and heart to do. Thank you for supporting me during the countless hours that I spent at the kitchen table. You never complained. Thank you, both, and I love you!

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I would like to acknowledge and thank my heavenly Father for allowing me to reach my goals. I would also like to acknowledge my brother, Dr. Mark Campbell, for his support, books, and dissertation advice during this process.

Most of all, I would like to thank my dissertation committee, Dr. Aagard, Dr. LaChapelle, and Dr. Tubman for their guidance and encouragement during the writing and research of this dissertation. A special acknowledgment is extended to my dissertation chair, Dr. Aagard. Dr. Aagard, thank you for allowing me to learn and grow under your leadership. I would like to express the gratitude that I have for you. Your patience and encouragement inspired the drive for quality and excellence in this study. I will always remember what I have learned as a scholar-practitioner under your guidance and leadership.

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Chapter 1: Introduction

Cultural intelligence or cultural quotient (CQ), an extension of emotional intelligence, is at the forefront of social and behavioral research. CQ is the ability of leaders to manage a culturally diverse workforce (Korzilius, Bücker, & Beerlage, 2017). Hence, CQ is relevant to business, globally and locally (Schlägel & Sarstedt, 2016). It is essential to leaders because it supports the ability to identify and demonstrate leadership skills in a diverse workforce. CQ is also responsible for pioneering behaviors in employees, creative work methods, and the development of resilient ideas (Korzilius et al., 2017).

Nurse leaders are entering a culturally diverse profession, and the meaning of CQ to nurse leaders has not been determined. There is some research on CQ, but the construct of of a nurse leader's CQ requires additional focus (Heckemann, Schols, & Halfens, 2015; Mayer, Oosthuizen, & Surtee, 2017; Shatto & Erwin, 2016; Sudha, Shahnawaz, & Farhat, 2016; Thomas et al., 2015). Furthermore, nurse leaders exhibit many facets of leadership in theory and nursing practice, but understanding the meaning of CQ to nurse leaders may enhance self-awareness in a culturally evolving profession.

In 2015, the American Nurses Association developed a workgroup to produce, *Nursing: Scope and Standards of Practice, Standard 8* (Marion et al., 2017). The workgroup created a new standard of culturally congruent practice in the nursing profession (Marion et al., 2017). A study to explore the CQ of nurse leaders may advance the scope of culturally congruent practice in theory and in nursing leadership.

Background

Researchers have studied various aspects and components of CQ that support the CQ of nurse leaders. Although CQ have been used by many researchers in the global leadership, business, and education arenas, CQ may play a part with nurse leaders as well. Engle (2014) pointed out that CQ is vital in multicultural interaction, regardless of the profession. Many researchers have defined CQ as a person's ability to work and efficiently relate across cultures (Caldwell, 2015; Fellows, Goedde, & Schwichtenberg, 2016; Presbitero, 2016). CQ has made an impact cross-culturally and globally. As issues of leadership effectiveness and leadership characteristics evolve, so does the importance of CQ. Ersoy (2014) studied the importance of CQ in leadership and cross-cultural leadership effectiveness. Lorber, Treven, and Mumel, (2016) examined factors relating to the nursing leadership style in hospitals. Lorber et al. (2016) revealed the organizational styles and characteristics that are associated with nursing leadership. One of the features indicated a relationship of a high degree of emotional intelligence in nurse leaders. It is imperative that nurse leaders master the skills necessary to communicate the needs of the organization to their followers. This communication allows for the understanding of directives that must be carried out by the nursing staff and received by the patient, since the product of any nursing leader's communication ultimately affects the patient.

Communication is a fundamental component of culturally sensitive nursing care (Valizadeh, Zamanzadeh, Ghahramanian, & Davis, 2017). The results of Valizadeh, Zamanzadeh, Ghahramanian, and Davis's study suggested that culture is vital as it improves the value of communication from nurses to patients. Nurse leaders should feel

confident in articulating and demonstrating CQ because there is added value in what CQ could bring to nursing leadership. Also, introducing CQ to nurse leaders and focusing on how CQ may change communication within a culturally sensitive setting is significant to this study.

Nurse leaders are exposed to working relationships with staff and culturally diverse patients as a part of their professional practice. Ian, Nakamura-Florez, and Lee (2016) explored the experiences of registered nurses and their interactions with culturally diverse patients and how it influences clinical practice. Nurse leaders lead staff nurses in caring for a culturally diverse population and provide professional guidance to the staff. On the other hand, nurse leaders still need to understand the importance of CQ. The results of a self-assessment of CQ could support and expose the components of leadership that intertwine with professional development. It is essential to know how exploring the CQ of nurse leaders will contribute to the changes needed in leadership style while leading a culturally diverse staff that cares for a culturally diverse population. Nurse leaders should be prepared to develop past the basic culture-based education provided in orientation. Nurse leaders are expected evolve their professional development to a level of growth that encompasses the more recent education and information regarding CQ.

Emotional intelligence (EI) is considered a precursor to CQ (Heckemann et al., 2015). EI is a professional development paradigm intended to enhance the development of interpersonal relationships and the professional management of emotions, which suggests the importance of EI in nursing leadership (Heckemann et al., 2015). Heckmann

et al. implied that EI can be applied in a clinical environment, hence, there could be a valuable application of understanding the relationship of EI versus CQ in nursing leadership for the study of CQ of nurse leaders.

Due to studies that focused on CQ, the global mindset, and the emergence of CQ in general education, there is a need for the exploration of CQ of nurse leaders (Andresen & Bergdolt, 2017; Caldwell, 2015; Watkins & Noble, 2016). Marion et al.'s study (2017) called for more research on culturally congruent practice in nursing. This study of the CQ of nurse leaders answers that call.

Problem Statement

CQ is a necessary leadership characteristic in nurse leaders. In a changing workplace, nurse leaders must learn to integrate CQ strategy, knowledge, motivation, and action into their leadership style. Nurse leaders must learn to lead with CQ in ethnically and culturally diverse situations (Marion et al., 2017). The American Nurses Association produced the *Nursing Scope and Standard of Practice: Standard 8* in 2015 to meet the needs of the culturally diverse patient. Standard 8: Culturally Congruent Practice, emphasizes that registered nurses practice in a manner that is congruent with cultural diversity and inclusion principles (Marion et al., 2017). Therefore, the evolving cross-cultural workforce in nursing expects leaders to understand and demonstrate CQ effectively. Nurse leaders should understand their CQ, thus enabling and demonstrating practices that support cultural congruence in the workplace. There is a need for scholarly research on nurse leaders and CQ. Furthermore, CQ in nurse leaders contributes to leading with innovation, cultural judgment, and EI (Heckemann et al., 2015; Korzilius et

al., 2017). Exploring CQ in nurse leaders may reveal best practices that result in stronger nurse leadership styles, a self-awareness of CQ, and competencies that impact the patient experience in a healthcare setting.

Purpose

This qualitative study aimed to explore the CQ of nurse leaders. The case study inquiry was indicated because it allowed for the holistic interpretation of nurse leaders' CQ. There was an opportunity to gain knowledge that fostered the realization of CQ within nurse leaders. The results of this study could affect nursing leadership in nursing theory and nursing practice.

Theoretical Framework

CQ is defined as an individuals' ability to handle culturally diverse issues (Engle, 2014). Early and Ang developed the theory of CQ in 2003 (Engle, 2014). CQ is comprised of mental, metacognitive and cognitive, motivational, and behavioral components (Engle, 2014). CQ is also connected to leadership outcomes and cultural adaptations. Moreover, cultural judgment and decision-making are related to CQ in a diverse workplace (Engle, 2014).

Based on the background, problem, and purpose of Early and Ang's research, the framework of their study is collaborative and synergistic with this study, exploring the CQ of nurse leaders. Early and Ang's (2003) framework is the foundation for the research questions, which supports the selected method of inquiry and data collection process.

Research Questions

RQ1: What is the meaning of CQ within nursing leadership?

RQ2: How do nurse leaders articulate CQ in their role of facilitating the patient experience?

RQ3: How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?

RQ4: How does self-awareness of CQ change leadership practice?

Nature of the Study

The qualitative approach was selected for this study because the goal was to understand something better (Vass, Rigby, & Payne, 2017). The inductive case study design was chosen to understand processes and outcomes through an in-depth analysis of one or more individuals (Morgan, Pullon, Macdonald, McKinlay, & Gray, 2017). Exploring the CQ of nurse leaders constitutes an extension of the constructivist theory; the case study served as a method to explore and understand the CQ of nurse leaders. Constructivism is consistent with the definition that knowledge occurs at various levels of intelligence and each level relates to specific modes of communication and is considered a natural learning process (Lim, 2015). The constructivist approach highlights the learner's experiences, thus, building on the learner's knowledge, skills, and abilities (Lim, 2015).

Assumptions

The three assumptions of this study were as follows: nurse leaders are capable of articulating CQ and demonstrating CQ in the workplace; (b) nurse leaders can articulate

CQ and incorporate appropriate CQ strategies into their leadership style; (c) nurse leaders will answer openly and honestly in spite of apprehension and fear of enlightenment and self-awareness.

Scope and Delimitations

This study was limited to nurse leaders who were recruited from professional nursing organizations, and social media websites, in the United States. A nurse leader could be a charge nurse, a nurse manager, a nurse educator, a nurse administrator, or a nurse executive. Furthermore, the nurse leader must be titled a nurse leader within her or his work organization. There were no age, race, or educational criteria for participating in this study.

Limitations

The main limitation of this study is there may or may not be access issues to names and contact information for the potential participants. Strategies to abate possible limitations included persistence and quality explanations of study goals when contacting the organizations.

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Definition of Terms

Cultural intelligence: An individual's ability to handle culturally diverse issues (Engle, 2014).

Nursing: The protection, promotion, and optimization of health and abilities, alleviation of pain and suffering through the diagnosis and treatment of the human

response, facilitation of healing, advocacy in the care of individuals, groups, communities, and families ("American Nurses Association," 2016).

Nurse leader: A person responsible for the work performance of one or more individuals and who work together to achieve the goals and objectives of the organization (Lorber et al., 2016).

Nursing leadership: A medium through which health policy and nursing practice are influenced by constant change, where nurse leaders are mandated to advance the profession (Scully, 2015)

Intelligence: The ability to interpret, problem solve and make rational decisions (Engle, 2014).

Significance

A study on the CQ of nurse leaders strive to reveal several methods that nurse leaders use to solve problems, demonstrate leadership effectiveness, and communicate in culturally diverse situations. The American Nurses Association (2015) called for research that would enable the implementation of culturally congruent practice from the nurse leader's perspective. Nursing is a profession where nurses are licensed to provide patient care worldwide. The nursing profession is changing rapidly due to retiring nurses exiting the profession, and post-graduate nurses are transitioning into leadership roles within 1 to 2 years of entering the profession (Shatto, Meyer, & Delicath, 2016). Health care providers are more diverse, and it is important for nurse leaders to understand the impact of CQ on leadership.

Furthermore, a nurse leader who understands the meaning of CQ is able to lead a diverse team through evidence-based practice. Nurse leaders could model CQ in their productive work habits and performance in a culturally diverse environment. A nurse leader with high CQ could influence a team through his or her motivation, and behavioral role modeling. These characteristics impacts the team and can thus improve the quality of the patient experience through staff education, communication, and interaction. The results of this study could improve the leadership style of nurse leaders and possibly change the trajectory of nursing leadership in the future.

Summary

The CQ of leaders has been studied in business and education in the United States as well as globally. However, questions remain about the CQ of nurse leaders. This case study was used to explore the CQ through, self-assessment, self-awareness, and nurse leaders' impact on the patient experience. CQ is a relatively new concept that encompasses the metacognitive, cognitive, motivational, and behavioral aspects of intelligence (Bücker, Furrer, & Lin, 2015). Research has shown the impact of CQ on leader's job performance, leadership style, and communication with staff in global business and academia. As a culturally diverse profession, nursing can benefit from a study on the CQ of nurse leaders There was no research available that explored the CQ of nurse leaders. Hence, it was essential to provide a quality study that can divulge information that impacts the nursing profession locally, cross-culturally, and globally. Chapter 2, the literature review, provides scholarly references to previous studies that

support the purpose and goals of this study. Subsequently, the remaining chapters will provide information on the methods, findings, and results of this study.

Chapter 2: Literature Review

Introduction

The purpose of this study was to explore the CQ of nurse leaders. The aim of this chapter is to provide scholarly research that substantiates the importance of this study.

The literature review begins with a description of the search criteria, the conceptual framework of CQ, and the methodology used to support this qualitative inquiry. Then, the peer-reviewed literature on the relevance of CQ is synthesized. Next, a review of CQ in leadership and CQ in health care is discussed. Finally, the review explores the cross-cultural importance of CQ within organizations.

Literature Search Strategy

A comprehensive search of peer-reviewed journals was conducted; the data were provided by nursing organizations, peer-peer communication, and library databases. The following databases were used: Thoreau, which include, Sage, ProQuest Central, ProQuest Science, Social Science, Health Management Psychology, and ScholarWorks. In addition, Medline was used to research articles on nursing. The following keywords were used: *cultural intelligence*, *nursing*, *nurse leaders*, *intelligence*, *cross-cultural*, and *communication*. Articles for review were selected for their relevance and quality. The data were reviewed in line with the following categories: researcher's approach to the study, purpose, theoretical framework, and methodology.

Theoretical Foundation

CQ was introduced by Early and Ang (2003) in their book, *Cultural Intelligence*, in which they focused on methods to address cross-cultural problems. According to Ng et

al. (2012), CQ is a derivative of a collaborative theoretical framework developed by Sternberg and Detterman (1986). According to Ng et al. (2012), the theoretical framework of a multi-loci of intelligence is a set of capabilities composed of metacognition, cognition, and motivation as capabilities based on mental health, yet, the behavioral component is the overt action. These elements of CQ dealt with resolving cross-cultural issues. CQ is a relatively new concept. However, the theoretical basis of CQ affords stability in consideration of a study that addresses multicultural components within nurse leaders. Early and Ang (2003) emphasized cognitive processes, such as self-awareness, as a significant issue of study within cultural boundaries.

In 2003, Early and Ang conceptualized CQ into four categories. The metacognitive CQ reflects mental capacities that an individual use to interpret cultural knowledge, which includes the ability to express thought processes about culture (Ng et al., 2012). People with high metacognitive CQ possess the potential to plan, monitor, and revise cultural expectations for various cultural groups and geographies (Ng et al., 2012). High metacognitive personalities assume the understanding of cultural preferences throughout communication and adjust to their preconceived thoughts to question cultural ambiguities (Brislin, Worthley, & MacNab, 2006; Ng et al., 2012).

Cognitive CQ represents knowledge of conventions, norms, and traditions of different cultures, obtained through personal interactions and experiences (Brislin et al., 2006). Brislin et al. (2006) argued that those with high cognitive CQ could interpret similarities and differences cross-culturally. Cognitive describes knowledge on a higher level of understanding (Bücker, Farrer, & Lin, 2015). This knowledge includes a legal,

social, and economic understanding of the cross-cultural framework and values system (Brislin et al., 2006; Presbitero, 2016). Moreover, the investment theory of intelligence, Cantrell (1971) supported motivational CQ as a vital component in the growth of metacognitive and cognitive CQ (Ng et al., 2012).

Motivational CQ describes an individual's ability to focus on learning and understanding about situational CQ, and to become engulfed in other cultures (Presbitero, 2016; Solomon & Steyn, 2017a). Those individuals with high motivational CQ address cultural interest naturally with confidence in cross-cultural effectiveness (Jeevan & Kour, 2017). Jeevan and Kour (2017), declared individuals with a higher existence of CQ can encounter difficult situations, critically think about what is happening, and make appropriate decisions about how they understand, discern, and lead in a culturally diverse environment (p. 770). Behavioral CQ represents the ability to demonstrate verbal and nonverbal actions when communicating cross-culturally (Daher, 2015; Engle, 2014; Solomon & Steyn, 2017a). Individuals with high behavioral CQ are verbally and nonverbally adaptive in cultural interaction (Daher, 2015; Solomon & Steyn, 2017a) (Daher, 2015; Solomon & Steyn, 2017). Verbal indicates appropriate words, gestures, inflections, and facial expressions.

Ang, Dyne, and Koh (2006) declared the four dimensions of CQ are qualitatively different regarding the functionality in culturally diverse settings. CQ, a form of intelligence is not based on personality (Ng et al., 2012). CQ refers to an individual's capabilities that are not culture-specific, but CQ is a pliable construct that can be individually developed over time (Ang, Dyne, & Koh, 2006).

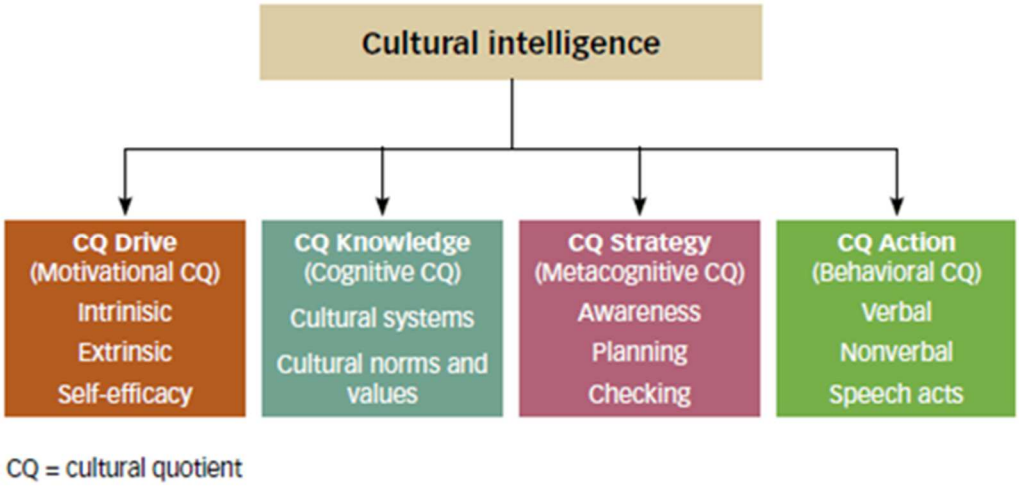

Figure 1. CQ model.

Cultural Intelligence in Leadership

CQ is a facet of nursing leadership that has not been studied from a comprehensive and scholarly approach. Leadership is defined in many ways, yet, it is considered the interaction between the leader, the follower, and the environment in which the interaction occurs (Brancu, Munteanu, & Golet, 2016). Connecting CQ to nurse leaders is an ambiguous process because of the lack of evidence-based scholarly research on CQ and nurse leaders. Information connecting CQ to leadership in nursing is unrevealing and undiscovered as indicative of a comprehensive literature review. CQ can be attached to various areas of leadership other than the nursing profession. For instance,

CQ in leadership can be related to EI as a precursor to CQ in leadership, global leadership, leadership in business, and general education.

Ersoy (2014) discussed EI in nurse leaders. Ersoy (2014) indicated that CQ is an extension of EI. EI is a concept that has changed since it was introduced in the 1990s by Salovey and Mayer. It is defined as "the ability to perceive and express emotion accurately and adaptively, the capacity to understand emotion and emotional knowledge, the ability to use feeling to facilitate thought, and capacity to regulate emotions in oneself and others" (p. 150). Ersoy's (2014) study resulted in the development of requirements for a leader in a cross-cultural context. The three most important requirements are: (a) the ability of leaders to broaden their perspective to a multicultural viewpoint, (b) to possess the ability to balance a multicultural and global perspective, regardless of the incompatibilities, and (c) to maintain flexibility through working with multiple cultures versus one specific culture.

According to Caldwell (2015), five universal factors frame the 35 characteristics of a leader: (a) continuous improvement,(b) openness and action orientation, (c) workforce quality, (d) management quality, and (e) long-term-orientation (p. 56). Caldwell (2015) emphasized that a competent intercultural leader be aware and leads by developing an environment of shared experiences from culturally diverse perspectives. This point of view allows the cultural gaps to close. Caldwell (2015) contributed to the literature with a study of global leadership and the development of culturally intelligent behaviors.

Caldwell (2015) asserted that a culturally intelligent world leader must be aware of how workplace culture, racial identity, and societal culture interconnects and results in their growth and development. Likewise, Forsyth (2015) was also concerned with CQ and global leadership. Forsyth (2015) argued that companies fail in their attempt to succeed in global markets because of their lack of understanding of the countries cross-cultural, social, and political nature. For organizations to be competitive, the leaders must undertake a CQ program (Forsyth, 2015). The CQ position of Forsyth's (2015) argument is supported by (Triandis, 2006, p. 4).

To make a person culturally intelligent requires extensive training. Learning to integrate much information, to look for multiple cues, and to suspend judgments can be helpful in improving interactions in multicultural organizations. Learning to select organizations to avoid countercultural situations is also important. An examination of the positive and negative attributes of ownership and the other culture can prove very helpful in increasing CQ (Triandis, 2006, p. 4).

Gonçalves, Reis, Sousa, Santos, and Orgambidez-Ramos (2015) summarized eight skills for future work. The innate and acquired ability of the intelligence: social intelligence (SI), emotional intelligence (EI), and CQ (CQ) will be imperative as the onset of a multicultural society diverse workforce continue to develop. According to Weng (2015), CQ is a skill that can bring benefits such as creativity and innovation into the workforce.

CQ and the Patient Experience

A key result of cultural diversity in leadership is highlighted by (Lorenz, Ramsey, Tariq, & Morrell, 2017). The study results indicated how service related employees tend to acclimate themselves to meet the expectations of culturally diverse cultures. Similarly, nurse leaders that are culturally intelligent could impact the service excellence expectation surrounding patient care. Scholarly evidence presented by Lorenz et al. (2017) showed that cultural differences influenced a willingness to adopt service-oriented behavior. Furthermore, studies related to changed employee behavior showed CQ is accredited to enhance the desire to change of service providers positively (Lorenz et al., 2017; Wong, 2015).

Nursing is a service-oriented profession. Some duties of the nurse leader include motivating, educating, and supporting the staff by demonstrating CQ. Evidence of CQ of nurse leaders and how it is shown to employees has not been studied comprehensively. However, Wong (2015) connected nursing leadership and patient outcomes. Challenges such as length of stay, electronic medical record implementation, and wait times have impacted the patient experience (Wong, 2015). It is because of the challenges that nursing leadership must focus on a balance of organizational culture, economics, and quality care, because of the challenges. (Wong, 2015).

Interestingly, Wong's (2015) study intertwined relational and task-oriented leadership and higher patient satisfaction in four of their seven studies. The importance of Wong's (2015) study is that it supports the behavioral component of CQ. Wong (2015) maintained the viewpoint that nursing leadership should be acknowledged as a precursor

to the patient experience and outcomes. According to Wong (2015), the application of testing and additional research advancing nursing leadership is urgently needed. It is the description of leader behaviors and methods that will affect patient outcomes and experiences (Lorenz et al., 2017; Wong, 2015).

Translating CQ from nurse leader to staff could improve the overall patient experience. Lorenz et al. (2017) indicated that understanding the cultural diversity impact in the service arena is relevant because the various cultures and norms of the consumer or patient could lead to a misunderstanding. Conversely, Salmela, Koskinen, and Eriksson, (2017) provided evidence-based information that nursing leadership could provide continuous dialogues on the core ethical values. Leadership conversations around cultural competence and moral values improve the staff's ethical and cultural sensitivity. Nurse leaders are the carriers of culture and are appointed the authority to manage and unite the team to a common cause. It is through the self-assessment of CQ that nurse leaders may understand and provide forward-thinking culturally intelligent leadership.

On the other hand, Gonçalves et al. (2015) sought to understand the relationship between CQ, conflict management, and self-monitoring. Gonçalves et al. (2015) researched the concept of CQ along with conflict management. Gonçalves et al. (2015) indicated the presence of a gap in the literature that failed to connect conflict management styles with CQ. The study also mentioned the importance of self-monitoring, as it is a known predictor of CQ and its elements. The results of the survey showed an individual's conflict management style is characteristic of their personality (Gonçalves et al., 2015). Thus, the evidence indicated that CQ and personality trait

monitoring could predict the leaders conflict management style (Gonçalves et al., 2015). Nurse leaders are at the forefront of conflict and crisis management when leading a culturally diverse team. The connection of personality self-monitoring and CQ to conflict management style supports the CQ needs of nurse leaders.

Lorenz et al. (2017) and Marion et al. (2017) argued issues that reinforced intercultural communication. On the other hand, Marion et al. (2017) declared that nursing currently adjusts to meet the consumer's needs and suggested a culturally congruent practice. Culturally congruent practice is defined by Marion et al. (2017) as applying knowledge of how culture influences a patient's health beliefs, health practices, and communication at each phase of the nursing process (p. 6). Marion et al. (2017) focused on cultural congruence in nursing practice and developed a new nursing standard, Standard 8; Culturally Congruent Practice.

Culturally congruent practice is the application of evidence-based nursing that agrees with the preferred cultural values, beliefs, worldview, and practices of the health care consumer and other stakeholders. Cultural competence represents the process by which nurses demonstrate the culturally congruent practice and services for different consumers to improve access, promote positive outcomes, and reduce disparities. (American Nurses Association *Standards of Practice*, 2015, p. 31).

Like Lorenz et al. (2017) and Marion et al. (2017) produced a study that was indicated at the time of the emergence of culturally ethnically diverse consumers. The American Nurses Association (ANA) published a study regarding the development of Standard 8 of the professional nursing standards of practice, as it is the contract holder

between society and the nursing profession (Marion et al., 2017). The ANA owns the nursing scope and standards of practice (Marion et al., 2017). Marion et al. (2017) addressed care that proliferated through the lens of the United States immigration and human rights, policies, and laws. For instance, the United States Supreme Court has supported same-sex marriages, non-gender specific privileges, and related issues that could influence the CQ of nurse leaders ("Same-Sex Marriage Laws," 2015).

Marion et al. (2017) concluded the idea of self-assessment to make one aware of their own conscious and subconscious cultural bias, values, and beliefs. Likewise, nurse leaders that perform a self-assessment could provide substantial information regarding their CQ. Although the results of the self-assessment are revealing, it is essential to conduct such a survey to provide the evidence-based information needed to develop CQ in nurse leaders.

Valizadeh, Zamanzadeh, Ghahramanian, and Davis (2017) studied culturally sensitive nursing care in a pediatric setting, Albeit, the study lacked reference to nursing leadership, the argument regarding cultural sensitivity as being a necessary component in the provision of care provides relevance to the study of exploring CQ of nurse leaders. Valizadeh et al.'s (2017) study revealed three themes: cultural exposure, intercultural communication, and the reconciliation of cultural conflict in families. The results of the study indicated that providing culturally sensitive care can aid in resolving problems of cultural exchanges in a pediatric ward (Valizadeh et al., 2017). This evidence is significant as it is suggestive that culturally intelligent nurses are a product of culturally

intelligent nurse leaders, which in turn are a product of culturally responsible organizations.

CQ in Business

CQ in leadership has a solid foundation in the business arena (Brancu et al., 2016; Daryani, Aali, Amini, & Shareghi, 2017; Engle, 2014; Gabriela Gonçalves, Marta Reis, Cátia Sousa, Joana Santos, & Alejandro Orgambídez-Ramos, 2015). Brancu et al. (2016) took a comparative approach to research CQ in management and non-management students. Brancu et al.'s (2016) study were inspired by the literature-based evidence that showed due to the manifestation of virtual teams and cross-cultural collaboration, and globalization, the prevalence of cross-cultural contact has increased. Brancu et al. (2016) claimed to develop cross-cultural competencies that were intended for current and future managers. The study was not indicated for the nursing profession, yet, there is relevance to managers in any professional arena.

Brancu et al.'s (2016) study contributed to the literature as the goal was to make comparisons between two groups of management students. The study adopted the early development of CQ in managers through adaptation of university curricula and concluded that both the management and non-management group obtained the highest scores in motivation, strategy, behavior, and knowledge (Brancu et al., 2016). Interestingly, there was no evidence of any significant differences between either management group (Brancu et al., 2016). However, observations in the study proved that behavior and knowledge were under-developed in the future professional (Brancu et al., 2016). Also, the study highlights the correlation between knowledge and behavior as future leaders

become more proficient in leading intercultural teams by demonstrating appropriate CQ behaviors (Brancu et al., 2016).

Similarly, Daryani et al. (2017) used a comparative study to understand the role of CQ in bank leaders and to understand how CQ improves employee performance. The study revealed the infused elements of success in bank leaders that introduced the elements of adaptation to the needs of the organization. While the study results revealed ethical, emotional, and CQ, Daryani et al. (2017) argued that CQ is interconnected in the leader's ability to adapt to customs and traditions that were different from their own. In the banking industry, CQ in leadership is mandated due to the need to communicate to the various customers that belong to different racial and ethnic, social and cultural backgrounds (Daryani et al., 2017). Daryani et al. (2017) indicated that leaders who possessed these CQ abilities improved leadership performance and eventually the performance of the organization.

Daher (2015) and Korzilius et al. (2017) asserted that CQ plays an integral part in innovation and multiculturalism in organizations. Korzilius et al. (2017) reasoned that individuals require cultural competencies to balance and incorporate thoughts and ideas from two or more cultures. Due to the evolving culture of health care providers, nurse leaders stand to benefit from the ability to balance innovative ideas cross-culturally. Korzilius et al. (2017) posited that organizations seek to understand and nurture cultural diversity which removes challenges in innovative environments. Also, organizations are using human resource management to recruit leaders that already possess technical knowledge (Korzilius et al., 2017). However, from a forward-thinking perspective,

managers are required to have additional skills such as cultural empathy, tolerance for ambiguity, and awareness of environmental constraints (Daher, 2015). Organizations question the level which employees can leverage their multicultural abilities synergistically (Korzilius et al., 2017). Hence, an understanding of multiculturalism and CQ is expressed through talent management and employee selection (Daher, 2015; Korzilius et al., 2017; Schlägel & Sarstedt, 2016).

The literature review was absent of any information on CQ in nurse leaders. Therefore, the qualitative measurement of the meaning of CQ of nurse leaders has not been determined. Daher (2015) discussed the measurement of CQ as an assessment tool for recruiting, training, and candidate selection. Furthermore, Daher (2015) discussed the CQ scale (CQS) as the most widely used scale for the measurement of CQ. This self-reporting tool was developed in 2007 by Ang et al. (Daher, 2015). The significance of CQ is emphasized, as a person with high CQ can extrapolate those cultural features that would be true in all groups of individuals (p. 170). Therefore, human resources may support the scale to recruit, screen, select, and train potential managers in emotional and CQ (Daher, 2015).

Wang (2016) researched the effects of expatriates CQ on the cross-cultural adjustment and job performance. Because of the changing labor force and evolving technology, Wang (2016) incorporated CQ into the study. Wang (2016) desired to understand a phenomenon that correlated CQ and CQ, and CQ and job performance. Remarkably, Wang (2016) used a definition of CQ from Deasy et al. (2011). The definition stated Deasy thought of CQ as a collection of the behavioral model where an

individual could modify himself to a specific value and attitude in a culturally diverse setting through nature, skills, and abilities (Wang, 2016). An extension of Deasy's definition of CQ included the capacity to conform to various national, occupational, and organizational cultures (Wang, 2016).

The results of Wang's (2016) hypothesis stemmed from a quantitative methodology. The results denoted a significant correlation of CQ with CQ. Oddly enough, this correlation, as performed through factor analysis revealed CQ is correlated with CQ 81.463%. However, there are weaknesses in the result as 18.537% is not accounted for as a variance in the study. Additionally, cross-cultural adjustment reached a covariance 77.913%, and factor analysis of the job performance variable derived an accumulated covariance of 84.579% (Wang, 2016).

Wang's (2016) conclusion of the study discovered that those with high CQ could assimilate to a new cultural environment. Furthermore, CQ could increase a person's ability to modify behaviors and adjust body language when faced with cultural challenges (Wang, 2016). As a result, it is hypothesized that an individual with high CQ would adjust better to overseas work and enhance the overall job performance. Although Wang's (2016) study has some challenges with unexplained variances, there is an inference that this study could represent the literature to support the CQ in nurse leaders. Nurse leaders could leverage CQ to intersect with adjustment and job performance on a global level Subsequently, Wang (2016) suggested organizations use CQ as a condition for selection of expatriates, or to design CQ as a selection tool for training purposes.

CQ in Academia

CQ is taught as a part of global leadership in the undergraduate curriculum in many universities. Whitaker and Greenleaf (2017) acknowledged the challenges that an educator may have when working with younger students that have not been exposed to many of the experiences that some older students have experienced in life. Conversely, students that develop professionally through understanding their CQ assessment tend to be more grounded (Whitaker & Greenleaf, 2017). Whitaker and Greenleaf (2017) cited Black and Gregerson (2000), stating that to emphasize the focus of global leadership training is "Stretching someone's mind past narrow domestic borders and creating a mental cap of the entire world" (p. 175).

Li, Rau, Li, and Maedche (2017), Wang (2016), Whitaker and Greenleaf (2017), agree that CQ is a predictor of success in a cross-cultural leadership setting. Whitaker and Greenleaf's (2017) study informs scholarship of practice in research related to academic performance and learning. The goal of introducing a CQ assessment to students was to build confidence in those students likely to find performing in cross-cultural environments challenging (Whitaker & Greenleaf, 2017). Learner confidence, also known as academic self-efficacy, has a positive correlation to a plethora of performance indicators (Whitaker & Greenleaf, 2017). A study that explores the CQ in nurse leaders could corroborate Whitaker and Greenleaf's quest to inform CQ in students. Nurses could also use the CQ assessment to build their confidence level in challenging situations. Nurses that use that academic environment to become introduced to CQ could potentially elevate their knowledge base before becoming a nurse leader. Self-assessment in CQ benefits students by allowing them to gain insight into their professional growth and

development (Whitaker & Greenleaf, 2017). As stated by Whitaker and Greenleaf (2017) the CQ assessment used in the global leadership course was offered to 25 students. The common denominator of all the students in the class is the lack of exposure to diverse cultures, with limited or no international experience (Whitaker & Greenleaf, 2017). The students were asked to take the test outside of class and to read resource material about CQ as provided by the instructor. There is little known about information in the literature search that addresses nurse leaders and their ability to self-assess and use CQ to demonstrate proficiency in leading in culturally sensitive environments. As the study concluded, feedback from the participating students was positive (Whitaker & Greenleaf, 2017). Many of the comments highlighted opportunities for improvement within themselves. Also, comments included the appreciation for learning of their current position in CQ` and possibilities that could lead to self-improvement (Whittaker & Greenleaf, 2017). Learning about CQ informed the student's readiness to engage in a multicultural environment (Whitaker & Greenleaf, 2017). Through self-assessment, students gained the insight to reflect and respond to the necessary changes that enhanced their leadership ability (Whittaker & Greenleaf, 2017). They concluded that understanding the foundations of leadership theory is useful in debriefing student's assessments. The point that Whitaker and Greenleaf (2017) made was students need to make a clear connection between leadership theory and practice and CQ (Whitaker & Greenleaf, 2017).

The importance of learning CQ in institutions of higher learning has become increasingly prevalent. Engle's (2014) study examines a gap in the literature on the

relationship between the ability of students to use knowledge to analyze a business environment while identifying culturally related issues.

Engle's (2014) results indicated that motivational CQ, along with the behavioral component of CQ, enhances throughout the years of education. Subsequently, cultural adaptation, team performance, and expatriate performance are all impacted positively by CQ (Engle, 2014). Additional relevant findings indicated that metacognitive and cognitive intelligence are not predictors of the study's findings (Engle, 2014). Weaknesses in Engle's (2014) case study is associated with the definition of metacognition. Engle (2014) defined metacognition as the awareness the subject has of issues surrounding CQ, whereas, cognitive is connected to cultural knowledge. Shocking results indicated that 40% of the participants were unaware of the cultural interaction in the study, thus, as stated by Engle (2014), caused significant problems in the study. Another mentionable weakness in Engle's (2014) study involved the 32% of the participants that did not formulate a solution to the cultural issues in the case study presented for assessment. Engle (2014) believed the need for culturally different employees increases, the requirement for university-level lessons on globalization for students that enter a globalized world would also increase. Engle (2014) admitted to unexplained variances and indicated that further research is needed to extend the study to different variables.

A single case study consisting of a module as the research methodology was used in Sutherland, Edgar, and Duncan's (2015) study. Sutherland et al. (2015) aimed to explore the experience of inbound Erasmus exchange students' approach to learning. The

purpose was to determine if student-centered approaches to curriculum delivery were enough in the learning environments (Sutherland et al., 2015). The single case study involved a module that undergraduate students in the management and business area of a United Kingdom University participated (Sutherland et al., 2015). Information derived from interviews of Erasmus students and a focus group of six exchange students was used to compile data that potentially addressed the gaps in the tutor-student interaction, perception, and expectation (Sutherland et al., 2015). The fundamental concept of the study was to transition from cultural awareness to CQ through international infusion in practice (Sutherland et al., 2015).

Sutherland et al. (2015) suggested that evidence supports information that revealed educators and support staff are not sufficiently equipped to handle the multicultural and diverse cohort challenges. There are various degrees of understanding as students differ in educational background, cognitive maps of knowledge, and expectations (Sutherland et al., 2015). In comparison to nursing knowledge in the United States, differences in the backgrounds of the students are consistent with those in Sutherland's, but, the infusion of education that moves the nurse from cultural awareness to CQ does not exist.

It is rare that students develop CQ competency within a higher education setting, yet, it is useful to design a curriculum that facilitates diverse teams that employ a problem-based, reflective learning strategy (Sutherland et al., 2015). Institutions of higher education should help students develop a learning approach that cultivates metacognitive and motivational CQ (Engle, 2014; Fellows et al., 2016; Sutherland et al., 2015).

Moreover, nurse leaders can benefit from a curriculum that advances and enhances the needed leadership skills to include CQ.

Summary

This chapter represented a scholarly literature review that identified a need for further research to explore the CQ of nurse leaders. Early and Ang's (2003) theoretical framework aligns this review with the metacognitive, cognitive, motivation, and behavioral categories that will support the research questions, and qualitative methodology of this study. Several studies have been summarized, yet, there remains an open gap in the literature that leaves the CQ of nurse leaders to question.

A scoping review of the literature disclosed evidence that indicated individuals with high CQ in the metacognitive category have the mental capacity to interpret cultural knowledge, and control thought processes about culture (Ang et al., 2006; Brislin et al., 2006; Thomas et al., 2015). This information is enlightening as the ability to plan, monitor, and alter cultural expectations become forward-thinking expectations in leadership (Ng et al. 2012). High metacognitive individuals understand the various cultural preferences involved in communication (Brislin et al., 2006; Ng et al., 2012).

Cognitive CQ represents the knowledge of conventions norms, and traditions involved in interpersonal interactions (Brislin et al., 2006). Cognitive CQ is obtained through the personal experiences that a person gained through the knowledge of legal, social, and economic understanding (Bücker et al., 2015). High cognitive CQ enables a person to interpret differences cross-culturally (Bücker et al., 2015).

Motivational CQ allows an individual to confidently focus on the cross-cultural situation (Presbitero, 2016; Solomon & Steyn, 2017a). There is an innate ability to critically think and respond to a cross-cultural crisis (Solomon & Steyn, 2017). In turn, individuals with a higher existence of motivational CQ also possess more cross-cultural leadership effectiveness (Solomon & Steyn, 2017). Motivational CQ involves the expectation of success and the value of success (Ng et al., 2012).

The behavioral component of CQ signifies the ability to demonstrate the verbal and nonverbal action of communication cross-culturally (Ng et al., 2012). Metacognitive and cognitive are complemented by the demonstration of the verbal and nonverbal capabilities (Ng et al., 2012). High behavioral CQ is indicated based on the ability to demonstrate the skills in a culturally appropriate manner (Ng et al., 2012). The metacognitive, cognitive, motivational, and behavioral are components of CQ that have yet to be explored in nurse leaders.

Cultural intelligent leadership is significant in the patient experience, business, and academia. Cultural intelligent leadership has been studied by scholar-practitioners to develop an evidence-based foundation for CQ in leadership (Caldwell, 2015; Ersoy, 2014; Forsyth, 2015; Presbitero, 2016). Leader characteristics such as the ability to balance multicultural and global perspectives, an enhanced multicultural viewpoint, and flexibility in the workforce are indicators of CQ in leadership (Caldwell, 2015; Ersoy, 2014; Forsyth, 2015).

Lorenz et al. (2017) provided evidence-based results to indicate how service related employees tend to acclimate themselves to their diverse customers. Also, Lorenz's

et al. (2017) study is an example of how employees change their behaviors to impact service positively, and the changes are accredited to CQ. Lorenz et al. (2017) and Marion et al. (2017) argued the significance of cultural communication. The culturally congruent practice has become a professional standard in the application of nurses to practice on a day to day basis (Marion et al., 2017).

CQ has a firm foundation in business. The necessity for organizations to have culturally intelligent leaders has become imperative (Brancu et al., 2016). Researchers have supported the early development of CQ in managers, and cross-cultural competencies have become a standard for management and non-management groups (Brancu et al., 2016; Daryani et al., 2017). Hence, the correlation between knowledge and leader behavior has become a bridge to the proficiency in the demonstration of CQ. Furthermore, human resource management expects leaders to have additional skills such as cultural empathy, and the ability to leverage multicultural employees (Korzilius et al., 2017). Although the qualitative meaning of CQ in nurse leaders has not been studied extensively, the nurse leader's ability to demonstrate CQ within the health care organization has not been revealed.

CQ has become a part of the global leadership curriculum. Researchers are using academia to prove that CQ is not present in early learning, but comes through additional years of education and exposure (Li et al., 2017; Whitaker & Greenleaf, 2017). CQ assessments are used in the university setting to bring self-awareness and cross-cultural awareness to students (Whitaker & Greenleaf, 2017). This early exposure builds learner confidence and correlates to successful job performance (Whitaker & Greenleaf, 2017).

Chapter 3 explains the methodologies used to explore the CQ in nurse leaders.

Chapter 3: Research Methods

Introduction

The purpose of this study is to explore the meaning of CQ to nurse leaders. Nurse leaders must recognize, demonstrate, and articulate CQ in professional practice in the face of a diverse workforce. Currently, little is known about the connection between CQ and nurse leaders. Nurse leaders must find it necessary to use CQ to lead with innovation, EI, and cultural judgment. This chapter is designed to provide a clear and concise overview of the participants, the recruiting process, data collection tools and analysis. Moreover, the actions taken to protect the participants as well as the role of the primary researcher will be discussed.

Research Design

To explore the CQ of nurse leaders, a qualitative case study was chosen. According to Yin (2014), it is an empirical inquiry that explores a contemporary phenomenon (the case) in detail and depth. According to Rendtorff (2015), a case study is a vital research methodology because it integrates a philosophical and reflective approach.

The case study approach was used to explore, interpret, and to improve understanding. In this study, the case study approach was used to formulate understanding of an in-depth issue. It is also a proven method that justifies knowledge through the study of particular cases, primarily through the interaction between management and organizations (Hollweck, 2015; Rendtorff, 2015). The ontological foundation of this study was represented through the qualitative interview process of the

participants. This inductive case study approach sought to provide a thorough understanding of the meaning of CQ to nurse leaders through an inductive analysis of real-life cases. The research questions served to guide the interview questions, from which data were extrapolated and analyzed.

Research Questions

Research Question 1: What is the meaning of CQ within nursing leadership?

Research Question 2: How do nurse leaders articulate CQ in their role to facilitate the patient experience?

Research Question 3: How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?

Research Question 4: How does self-awareness of CQ change leadership practice?

Role of the Researcher

The role of the researcher in this study was to collect, analyze, and interpret the participants' responses to the interview questions. Furthermore, the role of the researcher was to maintain the integrity and quality of the study through careful alignment of the theory with the conceptual framework used in the development of the research questions.

Bias and Ethical Concerns

There are no professional or personal relationships that will exist with the potential participants. However, research bias could surface because of the shared nursing profession. Bias is an aspect of a researcher's subjective interpretations. Therefore, it is a consideration for management in this study. Roulston and Shelton (2015) defined bias as (a) a particular angle of vision that can obscure the vision of the study, (b) a source of

error that aligns with prejudgments, prejudice, or political persuasion, or (c) a negative aspect of the research design that should be avoided. Threats to the quality of a study to explore the CQ of nurse leaders could be presented (p. 335). However, to keep the quality of the study, I will use strategies such as member checking, peer review, and being aware of my values, assumptions, and beliefs (Roulston & Shelton, 2015) These strategies will allow the ability to recognize and address patterns of potential bias.

It is not the researcher's intent to identify participants by race or ethnic classification unless the information becomes relevant. Race and ethnicity may become relevant if the sample is of one race or ethnicity. In this case, the participants will be identified as one race or ethnicity through the biographical information provided for the study. If this form of bias arises, I will use the most acceptable terms to describe the race or classification to avoid bias.

Conflict of interest could potentially be an ethical concern. I am a member of nursing organizations that could be used to recruit participants. Proactively, I contacted the Walden University Institutional Review Board (IRB) to ask questions regarding the possible conflict of interest. In response, the IRB member was complimentary that I was thinking about ethical issues throughout the research process. Information about locating resources such as the IRB application worksheet was also provided. Moreover, information was given to consider when conducting studies in my professional environment.

Participant Selection

Participants was selected through purposive sampling. Purposive sampling involves the selection of a participant pool to meet the criteria and purpose of the study (Castellanos, 2016). Furthermore, purposive sampling is ideal for expanding the range of data revealed and exposing the various viewpoints from the sample of participants.

A review of the literature disclosed qualitative studies that indicated the number of participants needed to provide enough data to indicate saturation. For instance, Ali and Terry (2017) selected 11 nurses to participate in their peer-reviewed study exploring senior nurse's understanding of compassionate leadership. Valizadeh et al. (2017) selected 25 nurses and nine parents through purposive sampling to participate in a study which explored culturally sensitive nursing care. Also, Waddell and Pio (2015) conducted a recent peer-reviewed study and selected 7 participants to explore the influence of senior leadership on organizational learning. Hence, for this study which explores the CQ of nurse leaders, I will select the number of participants needed to answer the research questions, until no new information is disclosed or data saturation is met. At least 10 participants will be interviewed for the study based on the literature reviewed.

The recruitment process involved the use of a flyer developed primarily for the study. The flyer was used to recruit nurse leaders from professional nursing organizations, social media, and other internet-based websites. The information on the flyer had a brief introduction to the study, and contact information, such as phone number and my Walden University email address. I asked permission to post the flyer on the sites

through the administrative offices of the organization. To date, Sigma Theta Tau Nursing Honor Society has provided the information and process for posting the flyer on their nursing site. Also, I reached out to the ANA research committee and was given a contact person that will assist with providing information regarding the recruiting process through their organization. The flyer was to be posted for 14 days at each location.

The primary criteria for selection are they must be a nurse leader in their place of employment, and they must be a member of professional nursing organizations. A screening form (Appendix A) was provided to the respondents for documenting their nurse leader role and or title. The screening tool was emailed to the respondent at the time of initial contact, with a request for it to be returned be sent back to the email address for review within 48 hours. After the review of the screening tool, the respondent was be notified of acceptance to participate. Upon acceptance, consent to participate (Appendix B) was emailed to the participant. Next, a time was agreed upon for the one-hour interview. A reminder call was given 24 hours before the interview. The interviews were to be scheduled and completed within one should be scheduled and completed within one week of acceptance.

Although participant selection was not initiated until after IRB approval, the necessary consents, agreements, and application required to obtain IRB approval were drafted and submitted to the dissertation chair for review. In turn, the participant recruitment process was initiated after the IRB application submission and approval process. The IRB approval code obtained before participant selection was #02-08-18-0548372.

Site Selection

According to Walden University's research ethics planning worksheet, the location of the organization remains anonymous in the dissertation, unless the organization approves to publicize their name in the resulting process. However, the ANA, GNA, and Sigma Theta Tau International (STTI) are potential sites that may have been used for recruiting participants. These organizations were selected because of their association as reputable professional nursing organizations.

The ANA, established in 1896, is a distinguished nursing organization representing 3.6 million nurses ("About ANA," 2017.). The ANA advances the nursing profession through the promotion of the high standards of nursing practice, promotion of a safe, ethical work environment, advocating for the health and wellness of nurses, and the advocacy of public policy through nursing ("About ANA," 2017).

STTI, founded in 1922 has over 135,000 active members and over 500 chapters, representing over 90 countries ("About STTI," 2017). The mission of STTI is to advance world health and celebrate nursing excellence. Also, STTI provides scholarly leadership and service ("About STTI," 2017). STTI provides resources and opportunities to engage with other nursing leaders to develop professional leadership skills ("About STTI," 2017).

The GNA was founded over 100 years ago for unity in the profession ("Georgia Nurses Association/Foundation," 2017). The GNA is Georgia's largest professional nursing association for registered nurses in all practice settings. The GNA provides support to advance the profession as a whole and nurses as individuals ("GNA's Mission

and Vision - Georgia Nurses Association/Foundation," 2017). Also, other reputable organizations such as the American College of Health Care Executives, and social media websites such as LinkedIn were considered preferred recruitment locations.

Data Collection

Data collection methods for this inquiry involved participant interviews and documentary analysis of "The Entrepreneur's Library" (2015). According to Walden University IRB guidelines, there must be at least three documented attempts to contact the author. To date, I have contacted David Livermore and has permitted to use his documentary or any of his other scholarly literature on CQ. An alternative to David Livermore's YouTube video interview will be my research journal as an if approvals to use the video cannot be approved. The following information justifies the use of the selected qualitative data collection tools.

The interview process is an in-depth, open-ended question and answers session led by the researcher. The in-depth qualitative interview has historically been selected as the type of interview to use when a researcher seeks to explore the viewpoints of others, hence, viewing the problem through a different lens (Dowling, Lloyd, & Suchet-Pearson, 2016). The goal of the interview was to extract information-rich experiences, examples, or stories because of the interview question. A semi structured interview was designed by using previously developed interview questions and following up with additional questions as needed. In comparison, peer-reviewed studies by McVey, Lees, and Nolan (2015), Roulston (2017), and Watson (2015) support and demonstrate the efficient use of qualitative interviewing.

The interviews were conducted via an online video conference service, Free ConferenceCall.com. FreeConferenceCall.com was selected because of the expertise and professionalism that I have experienced in past assignments. Because of the sensitivity of the study, a confidentiality agreement was signed by the transcription service Rev.com (Appendix C). This service also provides transcription service with proven accuracy and quick turnaround time. Participants were screened and given an interview time that will allow them to have an engaging and rich interaction through an online video or telephone interview. Each interview was scheduled to be at last one hour in duration. This amount of time was sufficient to allow for follow-up questions. The interview was then be transcribed and prepared for data analysis. Post-transcription, the document was emailed to the participant for verification.

Because case studies require additional types of data collection, a documentary analysis of the Entrepreneurs Library 2015 YouTube video with the leading CQ author, David Livermore was being examined. The technique of documentary analysis involved an examination of speeches, newspapers, meetings, Internet posts, and blogs, or any form of visual recordings or pictures (Watson, 2015). Recent peer-reviewed studies by Bondebjerg (2014) and Viswambharan and Priya (2016) successfully used the documentary analysis method in their research. Moreover, the document analysis was treated similarly to the qualitative interview process, where the information is transcribed, and data is extracted. Livermore has committed his interest in the study of CQ. He is a social scientist well versed in CQ and global leadership. Livermore is the president of the Cultural Intelligence Center in East Lansing, Michigan and is also a

visiting research fellow in Singapore ("David Livermore | Global Thinker and Author," 2017). Livermore has authored several books including Leading with Cultural Intelligence, Driven by Difference, and Serving with Eyes wide open ("The Entrepreneurs Library," 2017).

The use of the interview protocol (Appendix D) and the documentary analysis provided enough data required to reach data saturation. Sufficiency and appropriateness of data relating to the amount of qualitative data collected were determined through saturation. According to Alfsen, Miller, Egerod, and Lippert (2015) and Anderson (2017), the peak of data saturation occurs when there is adequate information to replicate the study when the ability to obtain new information has been attained, and additional coding is no longer feasible. The Livermore interview and nurse leaders as participants provided the information-rich data needed to explore the CQ of nurse leaders.

Data Analysis Plan

Data analysis for this case study, exploring the CQ of nurse leaders, was derived from the qualitative tradition of research. The research questions lead the participant interviews, thus, keeping in alignment with the theory and the purpose of the study. The type of data collection tool is an indicator of the kind of data analysis that will be used. For instance, qualitative interviews and document analysis both required coding as the selected form of analysis. The interviews remained confidential, transcribed verbatim, and audio recorded. Transcription accuracy was checked against the original recordings. The interviews were stored on the researcher's computer and a USB drive as a backup and will be kept for five years. Both the computer and the USB drive are password

protected for enhanced privacy. The interpretive thematic analysis was employed to examine data. The interpretive thematic analysis describes analyses and identifies specific data patterns (Alfsen, Miller, Egerod, & Lippert, 2015). This method is not restricted by theory and does not place demands on the data collection method (Alfsen et al., 2015). This widely used method is appropriate for this study because of its exploratory focus. Moreover, interpretive analysis became popular within the social and health sciences after the publication of Clarke and Braun's (2006) publication: Using thematic analysis in psychology (Alfsen et al., 2015). The interpretive thematic analysis consisted of six phases that I followed during the analysis process: (a) familiarization with data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report.

In conclusion, I used the raw data derived from the interviews to initiate a thematic analysis approach which leads to the development of codes and themes. Coding is a form of interpretation that leads to new ideas (Sheridan & McArdle, 2016). For example, the data collected from each participant ensured an iterative analysis until a theme that correlated to the research question was established. Subsequently, verification strategies were used to verify that the analysis was trustworthy and credible.

Software

The software package that I used was MAXQDA, a qualitative data analysis software that has an interface that is like Windows based software (Oliveira, Bitencourt, Zanardo dos Santos, & Teixeira, 2016). The software was comprised of four windows: one that houses the codes and categories; an editing and document browser; a data

window from each group of text and a window for providing searches and checks (Oliveira et al., 2016). The MAXQDA program is a color-coded, user-friendly, a software program. There are recent peer-reviewed studies that support the use of MAXQDA above the Nvivo software program. I had the opportunity to take a tutorial and use the program before and decided that this program would be the one selected for the study.

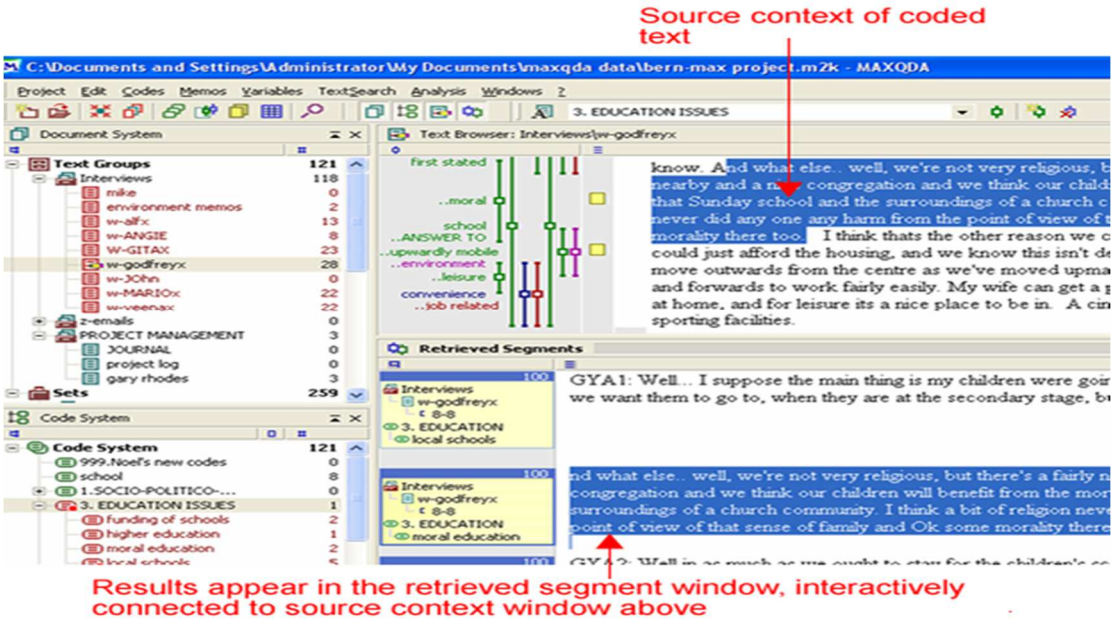

Figure 2. MAXQDA.

Issues of Trustworthiness

Trustworthiness, also known as rigor in qualitative studies is used to ensure the worthiness and the quality of the survey (Morse, 2015), but, there are issues related to trustworthiness in qualitative research. A significant problem for qualitative researchers is striving for the highest quality possible when conducting and reporting research (Cope, 2014). Qualitative research is considered subjective, subject to research bias, and lacks

generalizability (Connelly, 2016; Cope, 2014). Qualitative research places emphasis on exploring individual experiences, describing the phenomenon, and theory development (Cope, 2014). Lincoln and Guba (1986) developed criteria for establishing trustworthiness. These criteria are credibility, confirmability, transferability, and dependability (Connelly, 2016; Cope, 2014). As I addressed the criteria trustworthiness for this study, I have indicated examples of how used the criteria for trustworthiness to support the quality of the research.

Credibility

Credibility is established through persistent observation, triangulation, peer debriefing and member checks (Morse, 2015). Triangulation refers to the use of two or more data sets or methods to respond to one question (Morse, 2015). Another definition of triangulation is; it is a process used to conclude or an attempt to comprehend a broad view of the phenomenon (Connelly, 2016; Cope, 2014; Morse, 2015) Member checking was used to determine credibility. I asked the participants to provide their viewpoint on the credibility of the findings. According to Lincoln and Guba (1986), member checking is the most critical method of determining credibility (Cope, 2014). I asked the participants to examine the results and provide observations from the information provided. A copy of the results was emailed to all participants for review and asked to return the document with their observations within 72 hours of receiving them. I also used peer review as a method to support the credibility of this study. The second technique will be persistent observation. Persistent observation will be represented by the ongoing observation of the research notes that I will make in my research journal

(Connelly, 2016; Cope, 2014; Morse, 2015). This information was used to dive deeper into meanings that may be deemed superficial observations.

Transferability

Transferability is required for an interested party to transfer original findings to another context or individual (Morse, 2015). Another scholarly definition of transferability refers to whether the study or conclusions can lead to lessons learned. This information may be pertinent to other populations or different settings (Connelly, 2016; Cope, 2014). The technique that I used to determine transferability was to include thick, rich, detailed description so that the readers of the study can assess for transferability and appropriateness in their environment.

Dependability

Connelly (2016) defines dependability as the stability of data over time and the conditions of the study. In this study, I show dependability using process logs to document all activities that happen during the study. Furthermore, the process logs will indicate who was selected to interview and what to observe. More importantly, it is imperative to demonstrate that methods are systematic, well designed and well documented.

Confirmability

In qualitative research, it is necessary to prevent bias from only one person's perspective on the research (Connelly, 2016; Cope, 2014). Hence, I used the process of member checking with the participants in the study. Member checking was initiated by providing the participants a copy of the report for review and observations. The feedback

and observation were reviewed, compared, and documented in the final report. Also, I identified any areas of uncertainty and documented them in the findings of the final report.

Ethical Concerns

The American Psychological Association (APA, 2016) defined general principles and ethical guidelines for research with human participants (Ponterotto & Reynolds, 2017). The APA has provided three goals that the research must be compliant with, (a) to ensure the accuracy of scientific knowledge, (b) to protect the rights and welfare of research participants, and (c) to protect the intellectual property rights (Ponterotto & Reynolds, 2017). Before conducting any research, the institutional review board at Walden University approved this study.

Ethical concerns are relevant to qualitative research. It is essential to provide the highest level of agreements necessary to protect participants. The documents that I used for the agreement between the researcher and the participant is the consent form. The informed consent is included in this proposal for review by the committee chair.

During the recruitment phase, I took heed of the five C's of research ethics (Ponterotto & Reynolds, 2017). First, confidentiality is crucial as it is vital to keep the participant's names and identities confidential. I used numbers as codes to identify the participants. Second, coercion is an ethical concern in research. Coercion is diminished as the process of contacting the potential participants via flyer is not a form of coercion. Also, there will not be a personal relationship between myself and the participants. I indicated at the time that the participant signed the consent that they could withdraw from

the study or withdraw the data they provided at any time. Third, the consent process was comprehensive and explained so that the expectations were clear and concise. The participants were provided with information about the study and informed of the time commitment. Fourth, special care was taken during the survey to give a fair explanation of the risks and benefits to the participants. There are no foreseen risks that occurred, nor was there be any personal benefit to the participants. Subsequently, I made myself available to answer any questions that the participant may have. Additionally, I provided a copy of the consent to the participant.

Likewise, there was an ethical concern regarding data collection. If a participant refuses to provide information, the participant will be allowed to have early withdrawal from the study. In the event of adverse situations or occurrences, a phone number and email address were being provided to the Walden University ethics committee.

Treatment of Data

Data collected from this study is confidential and private. Proper handling of the data is critical as it is crucial to maintaining the integrity of the information. During the study, the information was saved on the computer iCloud, and I backed up data to an encrypted USB. This information can be stored for five years. Subsequently, professional nursing organizations such as the ANA provide databases to download research and archive research relevant to the nursing profession.

Summary

The qualitative method used in this study was aligned with the theoretical framework which guided the purpose of this case study approach, data collection, and

analysis. The recruitment process for study participants included the posting of a flyer on professional nursing organizations websites, LinkedIn, or other internet sources (Appendix E). Participant interviews and document analysis was the selected data collection methods for this study. Furthermore, scholarly data support the decision to use 10 participants for this study. Chapter 3 also provided details of the participant selection, data collection method, and the use of MAXQDA as an analysis tool. Also, the issues of trustworthiness; credibility, transferability, dependability, and confirmability were used to strengthen the quality of the study.

Moreover, ethical concerns were addressed in this chapter. The APA ethical guidelines served to support the use of the highest level of agreement necessary to protect the participants in the study. Finally, the treatment and storage of the data were addressed. This section was important because it is critical to maintaining the integrity of the data collected in this study.

Chapter 4 discusses the results and analysis derived from the collected data.

Chapter 4: Findings

Introduction

Chapter 4 reveals findings from an interview guide. The guide was developed to generate information-rich responses, which were needed to answer the research questions. This study sought explore the CQ of nurse leaders, who are faced with working in an environment where the staff nurses may be from various cultural backgrounds. Nurse leaders must look within to discover the importance and self-awareness of CQ and to understand how it relates to nursing practice and leadership. Although EI was a precursor to enhancing leadership skills, the EI capacity of leadership is elevated to a higher level with CQ. A detailed investigation showed insufficient scholarly literature surrounding CQ of nurse leaders.

The following research questions were developed as the foundation for the study:

RQ1: What is the meaning of CQ within nursing leadership?

RQ2: How do nurse leaders articulate CQ in their role in facilitating the patient experience?

RQ3: How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?

RQ4: How does self-awareness of CQ change leadership practice?

The interview guide functioned to reveal the information-rich data from each of the interviews (Appendix D). Each question in the interview guide correlated with a specific research question which is detailed in the data collection section.

Chapter 4 details the setting of the study, demographic information, data collection and analysis, and trustworthiness. Lastly, there is a robust report of the research findings.

Participant Selection

Participants were selected using the purposive sampling technique described in Chapter 3. Purposive sampling was chosen because the participant pool had to meet the purpose and criteria of this study. The number of participants was determined through a review of the literature. Peer-reviewed studies by Waddell and Pio (2015), Castellanos (2016), and Terry (2017) are examples of case studies that used purposeful sampling techniques to recruit participants.

Participants were recruited from the Sigma Theta Tau International Honor Society (STTI) global member forum and from the LinkedIn social media website. I selected STTI because of the organization's large membership and because I am a member of the organization. I was approved to post the recruitment flyer on STTI's global forum website after contacting the administration and receiving an email approval. The flyer was posted for four weeks. Unfortunately, I had no respondents from STTI's global forum.

On the other hand, LinkedIn proved to be successful. I selected LinkedIn because nurse leaders connected to the site would potentially read the recruitment flyer and be willing to participate. LinkedIn was a feasible option for nurse leader recruitment because of the number of connections that I had at the beginning of the study. Around the time the flyer was posted, I had over 500 LinkedIn connections. I used a technique where I

reposted the flyer on Monday of each week for four weeks. I documented the number of views that I received each week. Week 1 views = 49, week 2 views = 67, week 3 views = 98, week 4 views = 22. The total number of views to the flyer was N = 236. Subsequently, for each view, I was able to narrow down the nurse leaders and submit the flyer to them via LinkedIn messenger. Although the process was tedious, taking the time to recruit the nurse leaders from the views, yielded a total of N = 25 respondents. Of the 25 respondents, only 10 met the inclusion criteria for the study. The remaining 15 respondents did not qualify for the study.

There were two criteria for inclusion in the study, other than being a U.S. citizen. First, the participant had to be a nurse leader in their place of employment. Second, the nurse leader must be a member of a professional nursing organization. Reasons for not meeting the criteria for the study included lack of membership in a professional nursing organization, individual decision to decline, and not returning the required screening tools and consent forms. Other reasons included the inability to participate due to a natural disaster and work obligations.

Also, there are no known organizational or personal conditions that may have influenced the respondent's decision to participate in the study. The interpretation of the findings of the study was based on the data retrieved from the participant interviews.

Setting and Demographics

This research took place in the United States in the homes of nurse leaders. Participants lived in the following states: Washington State, California, Texas, Tennessee, and Georgia. The participant's leadership role and education levels were

documented as a part of the participant screening tool. The education level and title of each participant is listed as verification of the nurse leader role in their organization (Table 1). One participant had a Bachelor of Nursing degree (BSN), there were four participants with a Master of Nursing degree (MSN), and five nurse leaders with a Doctor of Nursing Practice degree (DNP; Table 1).

Table 1

Participant Identification Code, Title, and Education Level

Nurse leader code	Title	Education level
Nurse leader 1	Nurse Educator	MSN
Nurse leader 2	Director of Quality	MSN
Nurse leader 3	Organization President	BSN
Nurse leader 4	Nurse Executive	DNP
Nurse leader 5	Chief Nursing Officer	DNP
Nurse leader 6	Director of Nursing	MSN
Nurse leader 7	Assistant Chief Nursing	DNP
Nurse leader 8	Dean of Nursing	DNP
Nurse leader 9	Director of Nursing	MSN
Nurse leader 10	Chief Nursing Officer	DNP

Data Collection

Individual interviews were the selected method of data collection in this case study. Evidence supports that case studies offer a reflective, ethical, and philosophical lens used to understand inductive and deductive approaches to research (Rendtorff, 2015). Individual interviews served to gain knowledge, based on the participant's awareness of CQ (Roulston, 2017). An interview protocol form (Appendix D) was developed and used to guide the research responses. The number of participants interviewed was (N = 10). The interview process involved asking semi structured, open-ended questions from a protocol interview form. The protocol interview form was developed for me to ask probing questions that would provide data to answer the research questions. The semi structured interview was selected to explore the viewpoints of the participants (Dowling, Lloyd, & Suchet-Pearson, 2016). Each participant provided rich, in-depth information via audio recorded telephonic interviews that were transcribed and used for data. Each participant was assigned a nurse leader number so the identification of the participant would remain confidential.

The interviews were continued until data saturation was achieved. The height of data saturation occurs when there is enough information available to replicate the study, and the coding process has been exhausted (Alfsen et al., 2015; Anderson, 2017). Participants interested in the study were emailed a consent form (Appendix B) and the participant screening tool (Appendix A). The consent form provided contact information to Walden University's IRB, to be used if concerns or issues arose in the study. After receiving the screening tool from the participants, the form was reviewed to ensure that

the inclusion criteria were met. Next, the participant was notified via email and scheduled for an interview at a time convenient for them.

Scheduling became complicated due to participant's responsibilities and time zone issues, but rescheduling was successful in those instances. The interviewee was given a number to call on FreeConferenceCall.com for the interview. Although the goal was to complete the interview within 48 hours of verification, the frequency of the interviews was scheduled as far out as a week. Each participant was allowed 1 hour to answer the 15 questions in the interview protocol. The average time spent for interviewing was approximately 20 minutes. Occasionally, prompts such as *please clarify* were used to delve into the granular aspects of the participant responses. I took notes on the interview protocol form, and in my research journal as the participants answered the protocol questions. Some of the responses to the interview questions required additional attention to detail. Hence, I decided to document impactful statements that were used during the development of the themes. Immediately following the interview, each recording was sent electronically to REV.com for transcription. REV.com was the transcription service selected for transcribing the interviews. Before the participant selection, REV.com was required to sign and submit a confidentiality agreement (Appendix C). Likewise, a YouTube interview with David Livermore and Entrepreneur's Library correspondent was transcribed by Rev.com as a data collection source (Entrepreneur's Library, 2015).

Data Analysis

Data analysis for this case study followed the qualitative tradition. Interviews and document analysis were used to gather the enlivening data used to frame the results of this study, exploring the CQ of nurse leaders.

I used interpretive thematic analysis to examine the data in each interview. Interpretive thematic analysis involves a meticulous approach to divulging data patterns and themes from the interviews (Alfsen et al., 2015). I used the following six steps to initiate the data analysis (Alfsen et al., 2015) :

1. Familiarization with the data
2. Generalizing initial codes
3. Searching for themes
4. Reviewing the themes
5. Defining and naming themes
6. Producing the report

Refining the themes was an iterative process requiring intense reflection and a deep dive into the codes and categories needed to produce the themes. After identifying the first level codes, I would frequently re-read the transcripts. Re-reading the transcripts provided another opportunity to look for emerging themes. Next, using a color-coded system, I developed sub codes and placed them in the selected categories. Subsequently, the categories became the foundation for the themes.

Table 2

Research Questions, Categories, and Themes

Research Questions	Interview Protocol Questions	Categories	Themes
RQ1: What is the meaning of CQ within nursing leadership?	Q1, Q6, 6a,6b, Q12	How do nurse leaders define CQ? L1 codes: Cultural awareness *(n* = 49) Cultural differences (*n* = 108)	1. CQ versus Cultural Diversity: What is the difference? 2. Culturally aware nurse leaders. 3. Intrinsic and Extrinsic motivational strategies of nurse leaders. 4. Culturally intelligent nurse leaders within healthcare organizations.
RQ2: How do nurse leaders articulate CQ in their role in facilitating the patient experience?	Q4, Q5, Q14, Q15	References about nurse leaders, CQ, and patients L1 Codes: Patients (*n* = 84) Patient experience *(n* = 17) Outcomes (*n* = 27)	5. The culturally intelligent nurse leader drives the patient experience. 6. The CQ nurse leader's actions surrounding the patient experience. 7. The CQ nurse leader's importance to the patient.
RQ3 How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?	Q3, Q7, Q8, Q9, Q10, Q13	What nurse leader's think and understand about the CQ L1 Codes: Understanding (*n* = 54) Communication (*n* = 30) Openness *(n* = 21)	8. Nurse leaders understanding and demonstration of CQ in the workplace.

RQ4 How does self-awareness of CQ change leadership practice?	Q11	Ways CQ impact nursing leadership practice L1 Codes: Self-awareness (*n* = 49) Teams (*n* = 48) Coaching (*n* = 11) Modeling Behaviors (*n* = 15) Barriers *(n* = 17)	9. Changing team dynamics through nurse leader's self-awareness of CQ 10. Obstacles to leading with CQ within the organization

Findings

As I developed themes, I reflected on my values, assumptions, beliefs, and expectations. I wanted to be aware of my values and beliefs so that the development of the themes was not affected by my personal views. Each interview was thoroughly analyzed according to the data collected from the responses to the interview protocol questions. In this section, I reveal the findings of the study and report the themes derived from the data analysis. The 10 themes that emerged from the data analysis was:

1. CQ versus cultural diversity: What is the difference?
2. Culturally aware nurse leaders.
3. Intrinsic and extrinsic motivational strategies of nurse leaders.
4. Culturally intelligent nurse leaders within healthcare organizations.
5. The CQ nurse leader drives the patient experience.
6. The CQ nurse leader's actions surrounding the patient experience.
7. The CQ nurse leader's impact on patient care.
8. Nurse leaders CQ knowledge, CQ drive, CQ strategy, and CQ action.
9. Changing team dynamics through the nurse leader's self-awareness of CQ.

10. Obstacles to leading with CQ within the healthcare organization.

Discrepant Case

The only discrepant interview was nurse leader1. Nurse leader1 asked for a copy of the questions before the interview. I reached out to my dissertation chair and was authorized to give the participant a copy of the questions. Therefore, Nurse leader1 was the only participant with prior knowledge of the interview questions. Providing the interview questions did not alter the analysis, but, the responses may or may not have changed due to nurse leader1 reviewing the information before the interview.

Results

RQ1: What is the Meaning of CQ within Nursing Leadership?

Theme 1: CQ versus cultural diversity: What is the difference? Cultural diversity and CQ are closely related, yet, there are differences between them. Cultural diversity is defined as the presence of a variety of ethnic groups within a society (Valizadeh et al., 2017). On the other hand, CQ is the ability to work and relate effectively to diverse situations (Stevenson, 2015). Nurse leaders have been exposed to cultural diversity through education and professional development. However, CQ is a relatively new concept to the nursing leadership profession. As the meaning of CQ to nurse leaders evolved from the analysis, there were similarities in how CQ was defined. For instance, there were frequent references to understanding diverse cultures and cultural diversity. Seemingly, the nurse leaders have had some exposure to CQ in the workplace, yet, understanding the difference between CQ and cultural diversity, to the point of correctly defining CQ, was a challenge,

Nurse leader 1: Being aware, accepting, appreciative of the diversity around you, and enhancing the growth of the group and have overall success.

Nurse leader 2: Having knowledge of the different cultures that you encounter in the workplace.

Nurse leader 5: Diversity that we have where we are, in our workplace and neighborhoods… understanding that we are all different.

Nurse leader10: CQ means to me having the awareness, understanding, and ability to formulate actions to ensure a culturally diverse team.

It is also evident that nurse leaders have not been exposed to the term CQ. For instance, nurse leaders compared CQ to cultural competence and admitted that the term was unknown to them. Furthermore, establishing the core meaning and definition of CQ from nurse leaders established a foundation of understanding and meaning of CQ from the nurse leader participants in this study.

Theme 2: Culturally aware nurse leaders. The data analysis revealed that it takes a conscious effort by nurse leaders to be culturally self-aware. All participants, (N = 10), gave several examples of being a culturally aware nurse leader. Being culturally aware emerged as a skill that is required for nurse leaders. Cultural awareness is relevant because nurse leaders understand that being culturally self- aware is necessary to lead and relate in a culturally diverse setting. Moreover, a culturally aware nurse leader also understands the meaning of CQ and how it relates to their leadership practice.

The findings showed that 80% of the nurse leaders felt that they were culturally aware. Several of the nurse leaders (n = 4), stated that they are self-aware based on their

education, exposure to various cultures, and the level of exposure to diverse cultures during their professional career.

> Nurse leader 6: I feel that I have been a nurse for over 20 years, and I have encountered many different types of people from all over the world through nursing.
>
> Nurse leader 7: Yes, I do, because I have had the good fortune of working in organizations that embrace cultural diversity, education, and awareness.
>
> Nurse leader 9: I do feel that I am culturally self-aware… more aware of my personal culture as well as getting to know the other cultures and being able to respectfully interact with those cultures.
>
> Hence, the research question is answered through the evidence of being a culturally aware nurse leader.

Theme 3: Intrinsic and extrinsic motivational strategies of nurse leaders. Also, the participants discussed intrinsic and extrinsic strategies that give meaning to the CQ in nursing leadership. Interview data analysis revealed that only 60% of the participants could clearly articulate the intrinsic and extrinsic motivational strategies used in their leadership practice. Intrinsic strategies were categorized according to the individual nurse leader, the team, and the organization. The extrinsic motivational strategies discussed were categorized in terms of rewards and staff opportunities.

> Nurse leader 1: Intrinsic for me is connecting with that person, empowering them, inspiring them, recognizing the value that they bring to the organization or the team.

Nurse leader 1: I have used a variety of things. It depends on the need. I have used an employee of the month recognition, I have used common goal setting, I have done 1:1 sit down meetings.

Nurse leader 2: Being aware of the different needs of various cultures from an extrinsic perspective. If you're educating you may need to provide rewards because that may help reinforce what you are educating. Some individuals like to be celebrated and praised, so being mindful of those needs and what those expectations are from each culture helps me to adjust.

Nurse leader 10: I think intrinsically it's just my passion for nursing and my passion for team building to deliver results. I, myself, as a person of a minority in the gay/lesbian population, understand and have a lot of empathy and that drives my passion, diversity and looking through the differences and celebrating the similarities… I provide opportunities to get to know each other, to formulate interpersonal relationships that lead to a great professional relationship. I do that through outings with my team once a quarter, coffee time,… I have them do what we call partner walks, and we talk about the problems at hand and problem solve together. And I purposefully pair people up by their differences, whether it is culturally or by specialty.

The data analysis shows that intrinsic and extrinsic motivational strategies are used by nurse leaders to inspire and lead their teams. The evidence indicated creative and individualized ways used by the nurse leaders to motivate their teams. In turn, some nurse leaders have transformed stagnant leadership motivational styles into strategies that

motivate and engage their culturally diverse teams.

Theme 4: Culturally intelligent nurse leaders within healthcare organizations. A more in-depth probe of the data analysis and the meaning of CQ within nursing leadership was revealed in the role of nurse leader within healthcare organizations. The analysis showed the importance of the CQ nurse leaders' role through their organizational leadership and examples of collaboration in administrative decision making.

> Nurse leader 1: The healthcare field is changing, … It gives nurse leaders the opportunity to drive and empower the vision of nursing, which impacts the overall care of the patients whether you are in the emergency room and you're just coming in or whether you're a chief nursing officer and sitting in the boardroom.
>
> Nurse leader 4: I think it is critically important that culturally competent or culturally intelligent nurse leaders have that because our demographics are changing. The country, the nation, the world, the demographics are changing. Therefore, we must meet the needs of people that we are charged with the responsibility of caring for. So, if we don't have nurse leaders who are culturally intelligent, then they can't drive the initiatives or the requirements of the frontline team.
>
> Nurse leader 9: Because we are such a diverse group of professionals, we come from all different backgrounds in the world. It takes CQ to form a cohesive team, to work together to build a stronger profession.

This theme answers the research question with findings that show the meaning of

CQ nurse leadership within a healthcare organization. There was 108 level one codes related to cultural differences. The data analysis indicated that nurse leaders leading with CQ within a healthcare organization empowers and gives them the ability to understand and relate in a culturally changing profession. Nurse leaders must lead with CQ because they are on the front line, leading and making decisions that affect their followers. Subsequently, the impact of leading with CQ also filters down to the patient. Nurse leaders are cognizant of their role as a CQ leader in healthcare organizations and how it relates back to the meaning of CQ within the nursing leadership.

> Nurse leader 2: Number one, because healthcare is culturally diverse. So, there's various cultures that nurse leaders have to interact with. So, nurse leaders who are culturally intelligent, culturally competent, it's very critical to those leaders being successful in their role as a leader.NL10: I think to be able to provide seamless, quality, safe care. If we're putting our differences in front of us, we're keeping ourselves as a patient advocate and patient-focused. We can't have barriers. We can't have distractions.

Finally, nurse leaders discover their importance within the healthcare organization because of an understanding of their role and impact on the changing dynamics within the organization. Also, the nurse leaders relate CQ to their role in understanding the connection between leading the team caring for the patients within an organization.

RQ2: How Do Nurse Leaders Articulate CQ in their Role to Facilitate the Patient Experience?

Theme 5: The CQ nurse leader drives the patient experience. The research findings indicated that facilitating the patient experience has become the foremost goal in healthcare organizations today. The following four interview questions were used to that navigated the responses of the 10 participants. Data analysis showed how nurse leaders articulated CQ in their role to facilitate the patient experience. Thus, nurse leaders used CQ to drive the patient experience through their actions surrounding patient experience initiatives, understanding the culture of the staff and patients, and communicating leadership expectations to the staff.

> Nurse leader 8: When it comes to work settings or with patients, I want to know what they would want that might be different from the things that I might want, and then figuring out how to make it a yes, because I don't want to make the assumption always to be that something has to be a no, even if it's a patient care thing that is nontraditional. I want to figure how we can say yes.
>
> Nurse leader 9: If the nurse is not providing that or meeting that need or isn't respectful to the patient's diversity, that there are cultural differences, it's a hinderance to the care. Patients are left feeling neglected and misunderstood. So, it's important for CQ to be integrated throughout the nurse's interaction with the patient.

Data analysis show that nurse leaders understand the patient care initiatives and can articulate the leadership expectations to the team. It is now through understanding

CQ, that nurse leaders want to push beyond the satisfaction score and impact the team through openness and communication surrounding CQ and the patient experience.

Theme 6: The CQ nurse leader's actions surrounding the patient experience. A review of the data revealed information which focused on the culturally intelligent nurse leaders' actions which influenced the patient experience. Data analysis from the interviews showed 50% of the nurse leaders had a clear understanding of how their CQ impacted the patient experience.

> Nurse leader 1: I think for us, we have to really invest in ourselves, believe and push ourselves for ongoing education. Through that education, we can protect the patient experience, help them to have a good outcome by educating our staff, having those conversations, building the team so that they can grow, and they can erase all those boundaries.
>
> Nurse leader 6: I think that the old saying is what you project is sort of what you get. So, if you're projecting bias, then your nurses will be biased at the bedside about care. However, if you're not projecting that yourself and you have that sense of being open about cultures.… they will follow their leader's example most of the time. I think it's very important to set a certain cultural expectation as a leader, and you know what's acceptable and how patients should be cared for.
>
> Nurse leader 9: So, nurse leaders and patient experience and cultural intelligence. I have taken care of such a diverse group of cultures and different backgrounds… making sure that resources are in place. Understanding the importance of healing,

> that their culture is a part of their healing process is something that I would definitely communicate to my nurses, and hopefully, they would understand that.
>
> Nurse leader 10: I think when we talk about the patient experience, and we talk about the big initiatives right now with the patient experience, we look at the initiatives like bedside shift report, hourly rounding, those initiatives that give us the opportunity to engage. I don't think that we can fully engage unless we are asking the spiritual and cultural questions that we need to.
>
> Nurse leader 8: It's my responsibility to drive that culture, so if I'm culturally naïve or ignorant… it may be very difficult for me to ensure the best possible encounter.

Culturally intelligent nurse leaders must be transparent in their understanding of CQ to demonstrate CQ. Subsequently, understanding CQ leads to actions that empower staff which cares for the culturally diverse patient.

Theme 7: The CQ nurse leader's importance to patient care. Nurse leaders understand that CQ begins from an internal perspective and carries over into the directives to the staff. Therefore, translating CQ directives to the staff becomes vital to the patient as it allows for the development of mutual understanding and trust. Patients can relate to and understand nursing staff that is sensitive to their cultural needs. Data analysis revealed that patients are the recipients of the CQ care or bias given at the bedside. Furthermore, when nurse leaders lack understanding of CQ, leading a culturally diverse team that cares for the patient becomes ineffective.

> Nurse leader 1: Basically, verbatim relevance, if there's no acknowledgment or attempt to understand cultural intelligence, the whole system fails. You're gonna have staff taking care of patients that are not going to be trained to understand what their need is, if they want pain medicine or if they don't want pain medicine. It could really be a snowball effect and it could lead to poor outcomes, longer length of stays, higher turnover rates for staff and less reimbursement from Medicaid and Medicare.
>
> Nurse leader 4: If you have a nurse leader who is culturally competent, who is charged with leading a team and having a particular outcome, then that's why it's important. So, I think at the end of the day, that's why it's important, because nurse leaders are the people who are responsible for driving performance for the teams who provide the care.
>
> Nurse leader 9: If the nurse is not providing that or meeting that need or isn't respectful of the patient's diversity, that there are cultural differences, it's a hindrance to the patient care outcome. It impedes on communication. It impedes on the processes. Patients are left feeling neglected and misunderstood. So, it's important for CQ to be integrated throughout the nurse's interactions with the patient.

Understanding the connection between nurse leaders and the influence that leading with CQ can have on the patient is imperative. Nurse leaders are providing the CQ guidance from an administrative aspect of leadership. Thus, the patient and patient outcomes are impacted by the actions of the CQ nurse leader.

RQ3: How Do Nurse Leaders Describe Their Own Cognitive, Behavioral, and Motivational Abilities?

Theme 8: Nurse leaders' understanding of CQ and demonstration of CQ in the workplace. Data analysis implied that CQ in nursing leadership can be obtained through the exposure to CQ education and demonstrated practices of nurse leaders. It is through CQ knowledge that nurse leaders can learn to demonstrate the behavioral and motivational strategies needed to lead and relate to a culturally diverse team. The findings confirmed CQ obtained through professional development, yet, most of the nurse leaders have not gained the training and exposure needed to be proficient in leading CQ.

The overall perception of CQ from the nurse leaders was obtained through aspects of formal education and exposure to CQ in various professional settings. The results show that 20% of the nurse leaders have had formal CQ education, while the remaining 80% demonstrated CQ, yet, were unaware of the concept of CQ as a skill in nursing leadership.

> Nurse leader 1: Well, personally and professionally I have been involved in hearing speakers, local and international, who specifically speak on this topic with interactive sessions, talking directly about leadership.
>
> Nurse leader 5: Well, I am also in school right now, going for my doctorate in executive nursing and so I've had a few classes that incorporated it, CQ, and I think that's really helped me keep my mind open.

The remainder of the participants associated their perceived knowledge of cultural intelligence to other forms of learning.

Nurse leader 4: I think it's about networking, ensuring that I don't surround myself with a homogenous group.

Nurse leader 6: I've been open to opportunities where I can mingle with other nurses and other colleagues. I've also traveled quite a bit and have worked in many areas of the country. I have looked for opportunities in diverse cultural settings, mostly inner city.

Nurse leader 8: I've had some formal classes. It was an elective course that I took when I was in grad school that had to do with understanding ethnicities through different food practices.

Data analysis also revealed how nurse leaders lead by demonstrating CQ behavior in culturally diverse situations.

All the nurse leaders had stories demonstrating how they lead through behavioral and motivational CQ, but only four are included for this part of the study. These stories answer the research question as they provided the information-rich data needed for this study. The analysis of the data revealed behavioral aspects of verbal and nonverbal cues used in the nurse leaders' professional lives and how they adapted to cultural situations. Furthermore, the findings indicated that nurse leaders demonstrated the verbal and non-verbal aspects of CQ in the workplace through behaviors that were similar for all 10 participants. Some of the verbal and non-verbal findings included altering personal posture, mirroring, and professional tone.

Nurse leader 6: I am very self-aware of my posture. Typically, if I am not aware of the culture.… I am very aware of my body posture. And mostly keeping my

hands to my waist or at my sides or behind my back and being open with my frontal body posture. I try to mimic body gestures and language.

Nurse leader 8: You can use mirroring… not ever making fun of somebody or mimicking somebody because you have to make sure that it doesn't seem ingenuous. Slowing down my pace of speech, soft voice versus louder voice.

Nurse leader 9: Body language is very important, and so having an open stance… and making sure that I am inviting. Mirroring somebody's verbal cues is important… the language is equal, and the language meets the language given.

The findings also show that using verbal cues in the form of questioning and clarifying is demonstrated in their workplace.

Nurse leader 1: Always professional tone, being respectful, knowing the audience. Clarifying questions versus demanding things.

Nurse leader 3: I try to look at cues like if they're making good eye contact or if they feel intimidated and try to ask more questions to make sure they are comfortable and understands what the process is.

Nurse leader 4: If you're asking whether or not I modify my behavior or my interactions or my verbiage, I don't believe I do at all.

Nurse leader 10: I use all-inclusive language regardless of ethnicity, age, gender, anything.

The *motivational* abilities of nurse leaders were essential findings. The following stories indicate several motivational strategies for the nurse leaders. The following stories demonstrated how nurse leaders used understanding and trust to motivate and engage a

culturally diverse staff. Other motivational strategies include acceptance of cultural differences and providing transparent leadership to the staff. The findings indicated that some staff could trust and depend on their nurse leaders during a crisis.

On the other hand, nurse leaders are still responsible for fair and equitable leadership. Culturally intelligent nurse leaders must motivate the staff while taking the diversity and cultural needs of the staff into consideration. Some of the motivational strategies will work with some, but not with others. These stories are indicative of the nurse leader's engagement with their team. It is through the engagement and leadership provided that the staff become motivated and responsive to CQ nurse leadership.

> Nurse leader 1: For me, one-word kind of sums it up. It's value. The value that you place in the individual that they bring to the table. One of the examples that I have is, I used to work with a pretty much majority Filipino staff, and one of the nurses wanted to take a leave for four months. Well, this was not allowed by hospital policy and procedure if it did not relate to FMLA… so I checked out how we could accommodate the need, cover staff… I knew if she left, that would probably impact staffing, decrease trust, and have a snowball effect. So, I worked with the upper administration to approve that. We had to deal with some challenges, but everything turned out to be a win-win.… It helped them realize… I'm from a totally different culture, but I recognize this need is real and I honored that request, I followed that chain of command, and you're willing to go to bat for them.

Nurse leader 5: I do leadership rounding, and we've had cases where a specific religion, we might not be familiar with… they wanted to have specific things in the room that went against our policy. The nurses brought it to my attention, and we didn't know too much about it. The nurses did some research and brought it to the C-suite, we looked things over and we approved it. But that was something because they were all saying, 'no, you can't have this, it's a fire hazard'. After speaking to them and finding out the importance of it, we educated all staff after learning about it and shared the outcome. There was an acceptance. I was very proud of everybody coming together and putting their differences or their beliefs aside and be able to take care of this family and respect their beliefs.

Nurse leader 8: I think we really try to be crystal clear and set our expectations. Clarity is one of the expectations that I have on my team, and another one is assuming innocence, that idea of giving the other person the benefit of the doubt. Respect for others, that's very important. I think I've shifted it to more of ownership of a process versus reality. I think it's more about ownership to me, because if I own the things that come out of my mouth, it owns the behaviors that I have, and act as though I am co-owner of this group, which we are all a part of our team. This is everybody, this isn't just me, we work on norms as a group and we may come back to them periodically because the team dynamics might change, or we might have new members of the team. We go through, and we do

norms both as my smaller leadership team as well as our broader unit or team. We really set the stage for what's this going to look like to be a member of this team.

Nurse leader 9: I think it's important to me because I want the same consideration. I want to the example of one who expresses, I guess, expresses that cultural intelligence that isn't closed minded, that isn't afraid to interact of either opinion, or cultures, or beliefs. I believe that setting an example of that leading nurse, into those interactions with each other, is just important. It brings a better cohesiveness among the team, among the nursing staff. It gives better care at the bedside.

The data analysis revealed that nurse leaders are validating their CQ through understanding their cognitive, motivational, and behavioral abilities by providing ways to engage and support the staff.

RQ 4: How Does Self-Awareness of CQ Change Leadership Practice?

Theme 9: Changing team dynamics through nurse leaders' self-awareness of CQ. Changing team dynamics through nurse leader's self-awareness was an unexpected finding. As I reviewed the data from each participant's interview, a trend indicating a transformation of the team due to the nurse leader's self-awareness of CQ emerged. Each interview produced data that disclosed changes in the team due to the cultural awareness of the leader. Hence, the changes of the team are a direct result of leadership practice changes revealed in the analysis.

Nurse leader 1: Through education.… educating our staff, having those conversations, building the team, so that they can grow and erase all those boundaries.

Nurse leader 4: I model the behaviors that I want to see. I have to set the climate, and I have to set the expectation. If we have nurse leaders that are not culturally intelligent, then they can't drive the requirements for the frontline team.

Nurse leader 6: I think to work together as a team and being sensitive to their belief system and to realize you can't force a nurse to do something that they are not comfortable with, against their own set of values.

Nurse leader 7: I have a diverse nursing leadership team… I've got Filipino, Hispanic, Indian, Nigerian. I have to be very careful when I am presenting particular topics. I have to communicate differently because of cultural differences, communication, style differences and then their leadership experience differences.

Nurse leader 10: I set the expectation of working together as a team to a common goal and learning what strengths and weaknesses that we all have, regardless of the differences that we bring to the table.

As the interview data was further analyzed, information emerged that that indicated how self- awareness of CQ changed their leadership practice. Nurse leaders' leadership practice is changed through the awareness of CQ, understanding the individual and altering the approach to work situations and keeping an open mind.

Nurse leader 1: I try to individualize the situation, understand that person's point of view… value who they are, their background to connect with them personally.

Nurse leader 2: I'm aware that there are different cultural needs of the workplace and the individuals with those needs. I adjust my approach and communication with those individuals.

Nurse leader 5: Just keeping an open mind that not one question or not one answer is the is the same for all, that we are all different.

Nurse leader 8: I really focus on trying to challenge the assumptions and always giving the benefit of the doubt… trying to figure out how we get to a place where we can both kind of coexist in a productive way.

Nurse leader 9: Learning how to communicate within the cultural awareness is just so important in nursing… you to have to know what your differences are. It's not a one size fit all approach.

Furthermore, data analysis revealed that self-awareness of CQ is key to the interaction and connection with others. Culturally intelligent nurse leaders are the role models for the teams that they lead. The data shows that CQ nurse leaders can lead a team, and engage a team, thus, signifying professional competence in the workplace.

Nurse leader 4: I believe my self-awareness makes up the way in which I interact… I model the behaviors that I want to see in other people. If I have my directors or my managers or even students... I make sure that I model that behavior that I would like for them to see and emulate.

Nurse leader 7: It's about having that self-awareness to look at the audience that you are presenting to and making sure that you're connecting with

them on a personal level, and that you're communicating in a style that you feel comfortable with.

> Nurse leader 10: I think self-awareness is one of the most important leadership characteristics, traits, competencies, that we have to obtain, 'because I think it drives everything… if you are aware of yourself, you can then become aware of others and their actions, their behaviors. I think that though my self-awareness, I am able to acknowledge the differences amongst our team then and create a safe environment.

Culturally aware nurse leaders have demonstrated ways to change the team dynamics by incorporating CQ in the leader-follower relationship. Culturally intelligent nurse leaders are changing from the overall team- based mentality to more of an individual, culturally aware, interpersonal relationship with diverse team members. Hence, these quotes are indicative of how awareness of CQ changes nursing leadership practice.

Theme 10: Obstacles to leading with CQ within the organization. Data analysis also revealed how self- awareness of CQ might change nursing leadership through the obstacles that are encountered in the workplace. The findings showed of the 10 participants, 80% of nurse leaders had barriers that they encountered when leading with CQ. The other 20% revealed barriers that occurred when trying to educate the staff. Together, a theme was developed to answer the research question, and quotes show evidence of how self- awareness of CQ may change leadership practice.

Nurse leader 1: I think when you're talking about barriers, it's pretty much across the board. Sometimes people are biased and not willing to accept differences, not willing to come to the table and discuss or talk. Sometimes it is very political. Sometimes there's language barriers; sometimes there are even ethical and racial barriers or disparities that people just can't get past.

Nurse leader 2: I can only say that when there are decisions from a leadership level that have to be made, it has to be made across the board regardless, and not taking into consideration the cultural needs of each group within the organization, that can be a barrier because as a leader you're not able to make the adjustments in how you interact with those individuals.

Nurse leader 4: I have as a transitional leader for the last seven years. I travel throughout the country helping organizations thrive in the C-suite. That's where I serve, in the C-suite. Now, with that said, I have found that there has been a lack of diversity in many places that I've served and trying to make that leap from a lack of diversity, then helping people understand cultural differences has been a challenge… the lack of diversity, lack of cultural differences… There appears to be a lot of like-mindedness.

The findings also revealed information related to barriers to the education of the staff.

Nurse leader 6: Financial restrictions or budgets. Trying to educate and lead and train nurses on a dime. A lot of times, budgets don't allow for excessive

education, and it's hard to prioritize all things… there is not time spent on cultural intelligence.

Nurse leader 7: I think education at the staff level is huge. If you don't take the opportunity and the time to educate your staff, you are doing the staff a disservice, and you're doing the patients a disservice.

Barriers can be a catalyst or hindrance to change when leading with CQ. The findings revealed various challenges as barriers to the nurse leaders. However, the findings show that CQ nurse leaders are committed to leading with CQ regardless of the barriers. Barriers can prevent nurse leaders from leading and practicing with CQ. Alternately, the same barriers become the motivation to overcome the obstacles that impede professional development and enhance leadership practices.

The next section will provide a transition to understanding the indicators of quality for this study.

Trustworthiness

Trustworthiness, an indicator of quality, is used to confirm the value of this study. The scholarly indicators of quality in qualitative research are credibility, confirmability, transferability, and dependability. These collective processes were used to enhance the quality of the study and provide a contribution to the current literature. It was through data collection, data analysis, and the reporting of the findings that trustworthiness was obtained.

Credibility

Credibility was determined through reflection and observation. A continuous

review of the raw interview data was done to look for meaning beyond the superficial level. Triangulation was determined by using a transcribed interview from a documentary of Livermore, an expert on CQ and leadership ("The Entrepreneurs Library," 2015). According to Lincoln and Guba (1986), member checking is the most critical method of determining credibility (Cope, 2014). I asked the participants to examine the results and provide observations from the information provided. A copy of the results was emailed to all participants for review and asked to return the document with their observations within 72 hours of receiving them. All comments and feedback were posted in the discussion section of Chapter 5.

Transferability

Transferability relates to what lessons can be learned and applied to different settings or populations (Connelly, 2016). The findings from this study provided information that can transfer to nurse leaders in all aspects of the nursing profession. The method used to determine transferability was to provide information-rich data with detailed descriptions so that the reader could determine if the information would transfer into their environment (Connelly, 2016).

Dependability

Connelly (2016) defined dependability as the stability of the data over time. Dependability of this study was determined using the data management tool MAXQDA, Excel spreadsheets, FreeConferenceCall.com recordings and documentation from my research journal. Each data management tool served to provide elements of stability in the study. FreeConferenceCall.com provided recordings that I saved as electronic

documents which I could access at any time.

Confirmability

Member checking was used to prevent study bias. Member checking occurred when each participant was provided a copy of the findings for review and feedback (Connelly, 2016). All issues, concerns, and uncertainties presented by the participants are documented in the final report.

Summary

The purpose of this study was to explore the CQ of nurse leaders. Interviews with ten nurse leaders provided the data for this study. A review of the methods used to analyze the data from the semi structured interview process was discussed. The nurse leaders were selected based on purposeful sampling. Also, during the process of selection, the nurse leaders were provided informed consent, participant rights and an explanation of what the study entailed.

An analysis of the data provided from the responses to an interview protocol tool provided the themes that answered the four research questions in this study. This summary is a review of the findings supported through the data analysis process.

RQ1: What is the meaning of CQ within nursing leadership?

Data analysis produced four themes that answered the research question. (a) CQ versus Cultural Diversity: What is the difference? (b) Culturally aware nurse leaders (c) intrinsic and extrinsic motivational strategies of nurse leaders, and (d) culturally intelligent nurse leaders within healthcare organizations. Answers to the research questions was provided through an analysis of the data used to develop the themes. This

the findings revealed that nurse leaders interpret the meaning of CQ similarly to the meaning of cultural diversity. Although the nurse leaders had similar responses, providing the correct definition of CQ was a challenge, Yet, given the purpose of this study, understanding the definitions of CQ and cultural diversity is the foundation for understanding the meaning of CQ within the nursing leadership.

Also, cultural awareness emerged as a skill required for CQ nurse leaders to engage and interact in culturally diverse situations. Data analysis indicated that culturally aware nurse leaders could comprehend CQ and relate it back to leadership practice. The findings showed 80% of the nurse leaders felt that they were culturally aware.

Intrinsic and extrinsic motivational strategies of nurse leaders relate back to understanding the meaning of CQ within the nursing leadership. The findings indicated that 60% of the nurse leaders comprehended how their CQ was associated with the team and the healthcare organization. The analysis revealed that staff opportunity and rewards are strategies specific to understanding the meaning of CQ within healthcare organizations.

Furthermore, the relevance of CQ nurse leaders to healthcare organizations was revealed. Culturally intelligent nurse leader's importance to healthcare organizations was a significant finding because analysis revealed the nurse leader's ability to be empowered and relate in a culturally changing profession. Hence, healthcare organizations are impacted by the meaning of CQ within nursing leadership as nurse leaders guide and influence their peers and of the healthcare organization.

RQ 2: How do nurse leaders articulate their CQ in their role in facilitating the patient experience?

Three themes emerged from the data analysis. (a) The CQ nurse leaders drive the patient experience, (b) the culturally intelligent nurse leader's actions surrounding the patient experience, and (c) the nurse leaders' importance to patient care. The findings revealed the importance of the CQ nurse leader's role in the facilitation of the patient care. First, it is necessary for a nurse leader to understand the culture of the staff and patients. Second, communicating the leadership expectation to a diverse staff is a vital element in articulating CQ in their role to facilitate the patient experience. The nurse leader's ability to drive the patient experience and communicating the leadership expectation is the interconnecting elements needed to influence the patient experience. Although the patient experience initiatives exist as guidelines, evidence shows that the nurse leader is the initiator of the communication that impacts the frontline team caring for the patient.

Nevertheless, as evidence points towards nurse leaders being the driver of the patient experience, data analysis revealed a surprising result. Only 50% of the nurse leaders understood how being engaged and working with a diverse team impacted the patient experience. The patient experience is predisposed to the nurse leader's actions and transparency provided to the team. The patient care team is liked with the nurse leader's CQ communication and directives. In turn, the nurse leader articulates CQ to facilitate the patient experience.

The CQ nurse leader plays a role in patient care. Data analysis showed the role in patient care comes in the leadership communication of directives to the staff. It is through clear and concise communication with the staff that is imperative to the development of mutual understanding and trust. Patients are the recipients of the care provided by the team that the nurse leader oversee. Therefore, there is a 360-degree effect on the CQ nurse leader, diverse care team, patient relationship.

RQ 3: How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?

Understanding the nurse leaders cognitive (intellectual capacity), behavioral, and motivational abilities as demonstrated in the workplace was the primary theme developed during data analysis. Working with a team in culturally diverse situations requires the nurse leader the possess the ability to skillfully and competently describe their CQ. Admittedly, 20% of the nurse leader participants had any formal CQ education. On the other hand, 80% demonstrated CQ in leadership, but could not verbally associate their CQ as a skill used in their leadership practice.

More importantly, data analysis revealed how the nurse leader participants described their actions in culturally diverse situations. A compilation of four stories told by the nurse leaders during their interviews was used to extract data revealing their behavioral and motivational abilities. Because of the analysis, the findings disclosed the *behavioral* abilities of nurse leaders to be verbal and non-verbal indicators. Examples of verbal indicators were questioning, clarifying, and speech tone. The non-verbal indicators were mirroring posture and body language.

The *motivational* abilities of nurse leaders were significant findings. The findings indicated that nurse leaders use trust, openness, and understanding to engage a culturally diverse team. The examples that nurse leaders used to describe their motivational abilities include acceptance of cultural differences, being present during the time of crisis, and engagement on an individual and team level. Hence, the research question is validated through the evidence of the nurse leader's exposure to CQ, and the emergence of behavioral and motivational abilities which materialized through storytelling.

RQ 4: How Does Self-Awareness of CQ Change Leadership Practice?

As a result of data analysis, the following themes were developed: (a) self-awareness of CQ changes team dynamics and (b) obstacles to leading with CQ within the organization. Data analysis revealed a transformation of leader and team interactions when leading with CQ. All the nurse leaders provided data which indicated how team dynamics changed because of leading with CQ. Team dynamics are changed by erasing cultural boundaries and modeling CQ behavior. The findings revealed that nurse leaders are seeking to understand diverse individuals within the team and altering the one size fits all approach to leading the team. It is through the nurse leader's awareness of CQ in their leadership practice that the approach to leading a diverse team changes the team dynamics. Some team member's mimic their leadership style and the leader-follower relationship of the team is changed. The data reveals that the leader-follower relationship is changed through an individual nurse leader cultural awareness and interpersonal relationships with a culturally diverse team.

The final theme addressed the obstacles nurse leaders experienced in healthcare organizations. The findings show 80% of the nurse leaders experienced barriers in their organization when leading a culturally diverse team. Some of the barriers are due to organizational leadership, and other barriers emerged as financial. Despite the barriers, evidence indicated that nurse leaders are committed to using the barriers as a catalyst to continue to make changes in their leadership practice.

The final section in this chapter supports trustworthiness. I previously discussed examples of how I determined trustworthiness through confirmability, transferability, credibility, and dependability. The aim was to provide evidence that supported the quality of this study.

In conclusion, Chapter 5 will offer discussions related to the study findings, limitations, and future recommendations. Furthermore, a discussion of the impact of the social change will be presented before submitting any final reflections related to this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to explore the CQ of nurse leaders. CQ is a leadership characteristic that nurse leaders should incorporate into leadership practice. Culturally intelligent nurse leaders are required to work and relate to a culturally diverse workforce, and to lead with innovation (Korzilius et al., 2017). A review of the literature revealed that CQ had not been studied extensively. Nurse leaders must learn to adapt and lead with CQ. However, there is little scholarly information that addresses CQ in the nursing profession. CQ is essential to integrate into nursing leadership, just as it is currently relevant in global business and academia (Forsyth, 2015; Gonçalves et al., 2015). Nurse leaders must understand and demonstrate CQ because it will enhance their leadership practice as they engage with diverse staff, in culturally diverse environments. Understanding the impact of CQ on nursing leadership is significant because of the potential to change nursing leadership practice locally, nationally, and globally.

The research method for this study included the analysis of semi structured interviews with 10 nurse leaders, who were selected by purposeful sampling. Next, nurse leader interviews were audio-recorded and transcribed for analysis using MAXQDA. Chapter 4 described the quality indicators for this study.

As a result of the analysis, ten themes emerged that answered the following four research questions**:**

RQ:1 What is the meaning of CQ within nursing leadership?

Theme 1: Cultural Intelligence versus Cultural Diversity: What is the difference?

Theme 2: Culturally aware nurse leaders

Theme 3: Intrinsic and Extrinsic leadership strategies

Theme 4: CQ nurse leaders' importance to healthcare organizations

RQ 2: How do nurse leaders articulate CQ in their role in facilitating the patient experience?

Theme 5: CQ nurse leaders drive the patient experience.

Theme 6: CQ nurse leaders actions influence patient care.

Theme 7: The CQ nurse leaders' importance to patient care.

RQ 3: How do nurse leaders describe their own cognitive, motivation, and behavioral abilities?

Theme 8: CQ nurse leaders' knowledge, drive, strategy, and action.

RQ 4: How does self-awareness of CQ change nursing leadership practice?

Theme 9: Changing team dynamics through nurse leader awareness of CQ.

Theme 10: Obstacles to leading with CQ within the organization.

Interpretation of Findings

Cultural Intelligence versus Cultural Diversity: What Is the Difference?

CQ and cultural diversity are different concepts. According to Anthony, Solomon, Reiner & Steyn (2017), CQ is defined as the ability to reason, understand, and function effectively in situations described as culturally diverse. On the other hand, cultural diversity is defined as the differences between the cultural aspects of life, values, norms,

and languages between and within groups of individuals (Valizadeh et al., 2017). In this study, nurse leaders interpreted the meaning of CQ comparable to the meaning of cultural diversity. Because this study explored the CQ of nurse leaders, it was important to establish a baseline or understanding of their definition of CQ.

Nurse leaders have been exposed to the concept of cultural diversity in various aspects of professional development (Weber, Sulstarova, & Singy, 2016). In this study, CQ was discovered to be a concept that nurse leaders struggled to define. The participants used the term as a synonym for cultural competency and cultural diversity, which was noted throughout the findings. The following quotes by the nurse leaders indicated that there is an understanding of cultural differences, but the confusion is articulating the actual definition of CQ. Nurse leader 2 and nurse leader 5 gave quotes that were examples of what they thought the definition of CQ was. Nurse leader 2 stated the definition of CQ was "Having knowledge of the different cultures that you encounter in the workplace." Another example of the definition of CQ was stated by nurse leader 5 as "Diversity that we have where we are, in our workplace and neighborhoods… understanding that we are all different."

The previously mentioned definitions of CQ were closer to the definition of cultural diversity. The nurse leaders' challenge defining CQ was evident. Therefore, it is recommended that nurse leaders be introduced to the construct of CQ during professional development and education. Understanding the definition of CQ will increase awareness of CQ and enhance the nurse leader's ability to demonstrate CQ in the workforce.

Culturally Aware Nurse Leaders

Cultural awareness emerged as a skill required for nurse leaders to engage professionally in culturally diverse situations. The data analysis indicated that cultural awareness is a characteristic necessary to understand the meaning of cultural diversity in nursing leadership. Interestingly, 80% of the nurse leaders in this study felt that they were culturally aware. Cultural self-awareness is defined as an individual's metacognitive understanding of the relationship between self and the cultural experiences, that shape the individual (Lu & Wan, 2018). Moreover, meta-cognition, a dimension of CQ, is also known as CQ strategy (Whitaker & Greenleaf, 2017). CQ strategy allows for the nurse leaders to understand and experience the cultural encounters surrounding their leadership practice. In turn, the analysis revealed evidence of high cultural self-awareness of the nurse leaders. High cultural self- awareness is determined by the ability of the individual to make a connection between themselves and cultural experiences (Fellows et al., 2016). Also, Brancu et al.'s (2016) study indicated that people with high CQ are perceptive and understand the social, legal, and economic context of various cultures. While Fellowes (2016) and Brancu et al. (2016) clearly defined cultural self-awareness and high CQ, evidence of high CQ of the nurse leaders emerged in this study (Figure 3). For example, some of the nurse leaders provided quotes that coincided with evidence of high CQ. Nurse leader 1 stated, "Being aware, accepting, appreciative of the diversity around you, and enhancing the growth of the group and have overall success." Another quote was provided by nurse leader 5, "Diversity that we have where we are, in our workplace and neighborhoods… understanding that we are all different". Nurse leaders in this study

made can make the connection between their cultural awareness and their connection with their cultural experiences. This awareness elevates the level of CQ that they have developed. Again, the connection between understanding cultural differences and how the connection within, is supported by a quote from nurse leader 9, "I do feel that I am culturally self-aware… more aware of my culture as well as getting to know the other cultures and being able to respectfully interact on those cultures".

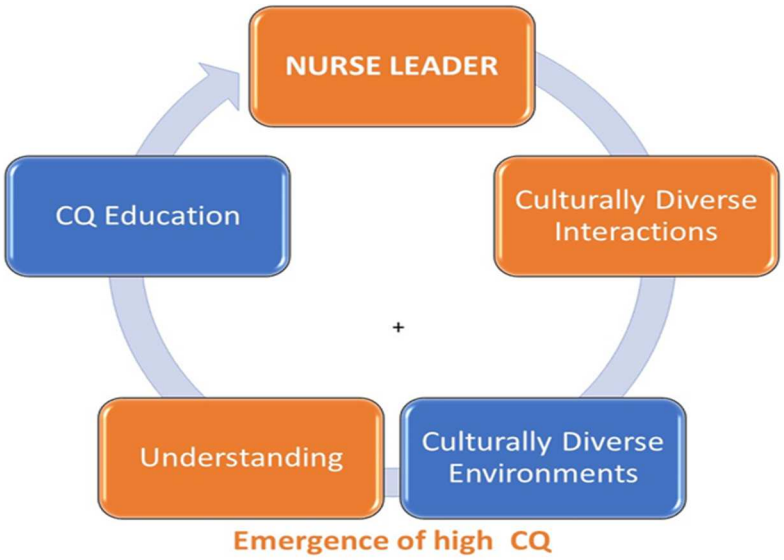

Figure 3. High CQ model for nurse leaders.

The results of the data analysis coincided with nurse leaders gave examples of their cultural self-awareness and were able to recognize what it meant to have CQ in nursing leadership. The data analysis revealed how a connection between the nurse leader's professional and interpersonal relationships with a culturally diverse team has influenced their cultural self-awareness and enhanced their leadership abilities (Figure 3).

Although data analysis shows that 80% of the nurse leaders felt that they were culturally self-aware, the evidence showed that 60% of the nurse leaders comprehended

the connection between their CQ and how it is associated with the team and the organization. For instance, intrinsic and extrinsic motivational strategies were shown to be responsible for CQ nurse leaders connecting with and leading a culturally diverse team.

Intrinsic and Extrinsic Motivational Strategies of CQ Nurse Leaders

Intrinsic strategies emerged in the form of staff opportunities that the nurse leader would facilitate. Some examples of intrinsic strategies included partner walks, 1:1 time, and open appreciation. Intrinsic motivation is the indicator for deriving satisfaction from culturally diverse interactions (Stevenson, 2015). Conversely, the findings showed that *extrinsic* strategies are the physical benefits or the motivation achieved from an activity (Stevenson, 2015; Woolley & Fischbach, 2018).

Regarding the extrinsic strategies, examples were related to physical rewards such as meals and non-monetary items. The findings of this study revealed ways to motivate that are breaking barriers and challenging the norms in nursing leadership. One nurse leader gave examples of how she motivates her leadership team. Nurse leader 10 stated the following:

> I think intrinsically it's just my passion for nursing and my passion for team building to deliver results. I, myself, as a person of a minority in the gay/lesbian population, understand and have a lot of empathy and that drives my passion, diversity and looking through the differences and celebrating the similarities…. I provide opportunities to get to know each other, to formulate interpersonal relationships that lead to a great professional relationship. I do that through

> outings with my team once a quarter, coffee time, … I have them do what we call partner walks, and we talk about the problems at hand and problem solve together. And I purposefully pair people up by their differences, whether it is culturally or by specialty.

Nurse leaders are using CQ to challenge the norm and break the structured motivational strategies that are now antiquated and inefficient in a culturally diverse work environment. Not only are intrinsic and extrinsic strategies changing the way leadership teams are motivated, but these innovative strategies are responsible for building successful leadership teams.

The findings indicated that the nurse leaders have a sense of how intrinsic and extrinsic strategies impact a culturally diverse team, yet, there are some areas of opportunities that exist. The analysis disclosed that nurse leaders understand the conventional ways to motivate a team. However, applying intrinsic and extrinsic motivational strategies in a culturally diverse situation requires an additional level of consideration and creativity. Culturally intelligent nurse leaders must challenge themselves to lead with innovation and creativity.

Culturally Intelligent Nurse Leaders within a Healthcare Organization

While little is known about CQ and nursing leadership in healthcare, scholarly evidence revealed leaders that posses CQ abilities were proficient in leadership performance within the organization (Korzilius, 2017). Korzilius (2017) reported that organizations seek to understand and embrace ways to remove diversity challenges

within the organization. Daryani et al. (2017) suggested that CQ is the catalyst for leaders to conform and lead in a culturally diverse environment.

In health care organizations, diverse groups of individuals are unified and steered towards accomplishing goals and directives. It is the nurse leaders who demonstrate CQ that will be responsible for leading the charge that impacts and influences the care of patients within the healthcare organization.

Healthcare organizations are using new approaches that affect system thinking (Fellows et al., 2016). Data analysis indicated that nurse leaders use effective communication within a diverse workforce and they are the administrator of policies and procedures that impact outcomes within the healthcare organization. Furthermore, organizations find meaning in nurse leaders as they are required to use their ability to lead and understand a culturally diverse team within the organization. One nurse leader expressed her opinion in a quote from her interview: Nurse leader 4 stated the following:

> I think it is critically important that culturally competent or culturally intelligent nurse leaders have that because our demographics are changing. The country, the nation, the world, the demographics are changing. Therefore, we must meet the needs of people that we are charged with the responsibility of caring for. So, if we don't have nurse leaders who are culturally intelligent, then they can't drive the initiatives or the requirements of the frontline team.

Forsyth (2015) and Korzilius et al. (2017) discussed the complexities of CQ within an organization. Scholarly evidence indicated that organizations failed to assimilate into global markets due to misunderstanding and poor communication of the

social, cultural, and political environments (Forsyth, 2015). Similarities exist within healthcare organizations on a local and national level. Local and national health care organizations do not extend into global markets, but the global market extends to local and national healthcare organizations. This extension in healthcare organizations is represented by internal and external stakeholders such as medical supply companies, research and development, pharmaceuticals, and most of all, through the employment of culturally diverse employees.

Culturally intelligent nurse leaders add value to healthcare organizations, just as culturally intelligent business leaders add value to businesses. An in-depth probe of the data analysis showed the relevance of CQ nurse leaders within the organization. Another nurse leader stated, “Because we are such a diverse group of professionals, we come from all different backgrounds in the world. It takes CQ to form a cohesive team, to work together to build a stronger profession”. Culturally intelligent nurse leaders are forging the path to culturally intelligent leadership in healthcare organizations as they demonstrate CQ in executive leadership.

In some business arenas, research shows that organizations can be oblivious to the way employees leverage multicultural capabilities (Korzilius, 2017). In health care, research is not available, and the importance of cultural intelligent nurse leaders to health care organizations remained ambiguous until the findings of this study were reported. A peer-reviewed study by Daher (2015) discussed the measurement of CQ as a tool for recruiting, training, and candidate selection, Daher (2015) asserted that managers are required to have tolerance for uncertainty, awareness of environmental constraints, and

cultural empathy. The words of one nurse leader expressed sentiments regarding her thoughts about CQ nurse leaders within healthcare organizations, “Nurse leader 2 stated, “Number one because healthcare is culturally diverse. So, there are various cultures that nurse leaders must interact with. So, nurse leaders who are culturally intelligent, culturally competent, it’s very critical to those leaders being successful in their role as a leader”.

The findings of this study indicate that nurse leaders are aware of CQ, and the impact it has on their ability to demonstrate CQ in nursing leadership within the health care organization. Furthermore, the results of this study present evidence that nurse leaders are interested in engaging in professional development focused towards CQ and diversity.

CQ Nurse Leaders Drive the Patient Experience

The research findings indicated that nurse leaders feel that facilitating the patient experience has become a leading goal of healthcare organizations today. An analysis of the data indicated how nurse leaders articulated CQ in their role to facilitate the patient experience. A nurse leader used a quote to stress that the importance of using CQ to drive the patient experience.

Nurse leader 8 stated the following:

> When it comes to work settings or with patients, I want to know what they would want that might be different from the things that I might want, and then figuring out how to make it a yes, because I don’t want to make the assumption always to

be that something has to be a no, even if it's a patient care thing that is nontraditional. I want to figure out how we can say yes.

The goal of the nurse leader is to evaluate the needs of the team caring for the patient and meet them at that point of need.

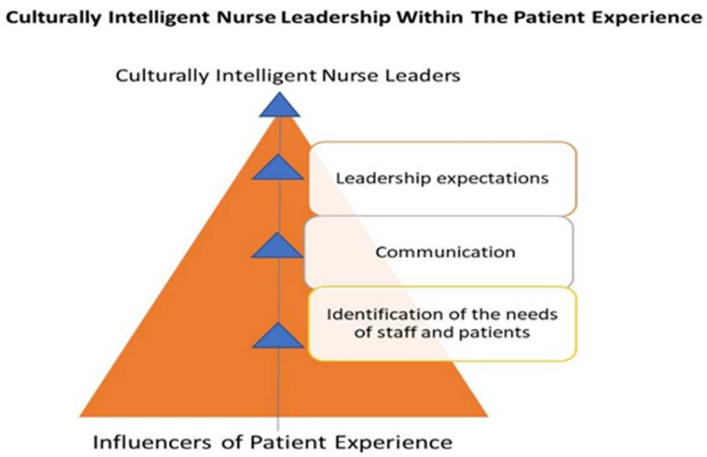

Figure 4. Culturally intelligent nurse leaders and the patient experience.

Furthermore, the findings also showed that the nurse leaders feel that CQ should be integrated into the nurse's interaction with the patient, thus, avoiding what would be a hindrance to adverse outcomes and patient experiences. For instance, one nurse stated the following:

> If the nurse is not providing that or meeting that need or isn't respectful to the patient's diversity, that there are cultural differences, it's a hinderance to the care. Patients are left feeling neglected and misunderstood. So, it's important for cultural intelligence to be integrated throughout the nurse's interaction with the patient.

Nurse leaders that articulate CQ in their role to facilitate the patient experience find that CQ is vital to optimizing the total patient experience A recent peer-reviewed

study by McNicholas et al., (2017) showed that effective communication with the team facilitates the overall patient experience. Likewise, nurse leaders articulate CQ in their role to facilitate the patient experience through meeting the needs of the patient care team and through effective communication (Figure 4).

Niederhauser and Wolf (2018), described the importance of the role of nurse leaders in efforts to improve the patient experience. Hence, a call to action for nurse leaders to assess the need to reframe the patient experience as the focus of the organizational strategy was recommended (Niederhauser & Wolf, 2018). Ultimately, this study reveals evidence of nurse leaders impacting the patient experience. Nurse leaders drive the patient experience through their commitment to meeting the needs of the staff caring for the patients and communicating the directives that facilitate care of the patient in a culturally diverse setting.

Nurse Leader's Action Surrounding the Patient Experience

Nurse leaders understand and act on the specific requirements necessary to impact the patient experience. Interestingly, only 50% of the nurse leaders were clear and concise when it came to an understanding of how their actions impacted the patient experience. Nurse leaders felt that the actions that influenced the patient experience started with personal experiences that developed and enhanced their ability to care for culturally diverse patients. For instance, nurse leader 9 stated the following:

> So, nurse leaders and patient experience and cultural intelligence. I have taken care of such a diverse group of cultures and different backgrounds… making sure that resources are in place. Understanding the importance of healing, that their

culture is a part of their healing process is something that I would communicate with my nurses, and hopefully, they would understand that.

In turn, professional development, staff development, and setting cultural expectations as a leader emerged as actions that nurse leaders took to influence the overall patient experience. Moreover, nurse leaders understood and demonstrated the actions and responsibilities surrounding the patient care initiatives such as leader rounding. It is through the nurse leaders' actions that inspiration and motivation were provided to the team. Subsequently, it is the actions of the nurse leaders that lead to impacting outcomes related to bedside rounding, hourly rounding, and the overall patient experience.

Nurse Leaders' Understanding of CQ and Demonstration of CQ in the Workplace

Early and Ang (2003) are the theorists that introduced CQ to conceptualize an individual's skills and abilities required to interact and perform in culturally diverse environments. The findings of this study implied that CQ can be obtained by the exposure to CQ education and demonstrated practices of nurse leaders. Findings from this study indicate that CQ knowledge is the precursor to the nurse leader's ability to understand and demonstrate motivational and behavioral strategies. These strategies are needed to lead and relate to a culturally diverse team. Data from the nurse leader interviews showed that 80% of the nurse leaders believed that they had not received enough training and exposure to be proficient in leading with CQ. However, the evidence revealed that the participants were unknowingly able to demonstrate some facets of the CQ concepts.

Şahin and Gürbüz, (2014) emphasized the importance of CQ as a predictor of an individual's adaptive performance. The work environment is rapidly changing, and organizations require more from their leaders. As a result of Şahin and Gürbüz's (2014) study, the evidence shows that organizations will require flexible, adaptive, and creative leaders, with the ability to learn new skills and adapt in culturally diverse environments. There is an essential connection between adaptive performance and the nurse leader's ability to understand and demonstrate CQ in the workplace. Nurse leaders must educate themselves and become proficient in the four collaborative components of CQ. As a result, nurse leaders will become adept at understanding and demonstrate CQ in the workplace.

CQ is composed of (a) meta-cognitive (CQ Strategy), (b) cognitive (CQ Knowledge), (c) motivation (CQ Drive), and (d) behavioral (CQ Action) (Daher, 2015; Fellows et al., 2016; Whitaker & Greenleaf, 2017). CQ strategy and CQ knowledge represent the knowledge component, and CQ action and CQ drive are components of an individual's attitudinal characteristics (Fellows et al., 2016).

Fellows et al. (2016) characterized the *CQ strategy* according to Chu, Veasna, and Wu (2013)'s three-factor approach: awareness, planning, and checking. This study exploring the CQ of nurse leaders describes CQ strategy as self-awareness, mutual understanding, and demonstration of CQ in the workplace. In the context of this study, self-awareness is the ability to connect to and understand the cultural differences a nurse leader may have. In turn, mutual understanding and respect are communicated by the

leader in culturally diverse situations. Lastly, the nurse leader's ability to demonstrate CQ effectively in their role is imperative when influencing the team and patient experience.

CQ knowledge is associated with the confirmed knowledge of various cultures an individual may possess (Fellows et al., 2016). Fellows et al. (2016) argued that CQ knowledge might be categorized by business, interpersonal and socio-linguistic (verbal and non-verbal) communication. The findings of this study concur with Fellows et al.'s (2016) description of CQ knowledge. One nurse leader stated, "Well, I am also in school right now, going for my doctorate in executive nursing and so I've had a few classes that incorporated it, CQ, and I think that's really helped me keep my mind open".

Nurse leaders are challenged with all dimensions of CQ knowledge as it relates to understanding and demonstrating CQ in the workplace. A quote from another nurse leader supported Fellowes (2016) business and interpersonal aspects of CQ knowledge, "Well, personally and professionally I have been involved in hearing speakers, local and international, who specifically speak on this topic with interactive sessions, talking directly about leadership." The findings of this study revealed that nurse leaders have had exposure to CQ, but not all nurse leaders could provide information surrounding their CQ knowledge.

CQ drive is associated with the individual's motivational ability to understand, engage, and become educated through culturally diverse experiences (Fellows et al., 2016). Moreover, additional scholars have provided similar examples of motivational CQ (Ali & Terry, 2017; Lorenz et al., 2017; Solomon & Steyn, 2017b). Fellows et al. (2016) associates CQ drive three subcategories: intrinsic interest (enjoying the culturally diverse

experience) extrinsic interest (gaining benefits from involvement in culturally diverse experiences and self-efficacy (dealing with culturally diverse experiences with confidence). The findings of this study showed that nurse leaders demonstrate and exhibit the same qualities in the workplace. Nurse leaders can demonstrate CQ drive through the ability to learn from culturally diverse experiences and to motivate in culturally diverse environments.

CQ action is described as the individual's ability to demonstrate culturally appropriate behavior (Fellows et al., 2016). Examples of culturally appropriate behavior include verbal and nonverbal actions, modifying language, and tone. Evidence of CQ action in this study is reflective of examples of the quotes from the nurse leaders. One nurse leader stated, "I try to look at cues, like if they are making good eye contact or if they feel intimidated and I try to ask more questions to make sure they are comfortable and understand what the process is". Another nurse leader stated, "Body language is very important, and so having an open stance… and making sure that I am inviting. Mirroring somebody's verbal cues is important… the language is equal, and the language meets the language given". The evidence overwhelmingly shows that the nurse leaders who participated in this study demonstrated CQ in action.

Changing Team Dynamics Through Nurse Leader's Self-Awareness of CQ

An unexpected finding indicated a trend indicative of a transformation of the nursing team due to the nurse leader's self-awareness of CQ. Also, as the nurse leaders became self-aware of CQ, their leadership practice also changed. According to Lu and Wan (2018), cultural self-awareness is linked to the influence of culture on oneself.

A recent peer-reviewed study by Salmela et al. (2017**)** revealed evidence that declared nurse leaders are responsible for transcending ethically sustainable cultures and formulating the foundation for the growth and development of the staff. Sonko, (2018) described the characteristics of a transformational leader as one capable of inspiring positive change. However, in this study, transformational teams can be described as *the team that changes to meet the expectations of the nurse leader exhibiting CQ*. One nurse leader provided a relevant quote, "I model the behaviors that I want to see. I have to set the climate, and I have to set the expectation. If we have nurse leaders that are not culturally intelligent, then they can't drive the requirements for the frontline". CQ begins with the ability to work and relate in a culturally diverse environment. According to the results if this study, the dynamics of the team is changing from a leader-follower team dynamic, to a more interpersonal leader-team member dynamic (Figure 5). A quote from the interview of one nurse leader describes how she has changed to interact with her team,

> Nurse leader 7: I have a diverse nursing leadership team… I've got Filipino, Hispanic, Indian, Nigerian. I have to be very careful when I am presenting particular topics. I have to communicate differently because of cultural differences, communication style differences and then their leadership experience differences.

All the nurse leaders indicated how they have changed to more of an interpersonal, individual relationship with their culturally diverse team members.

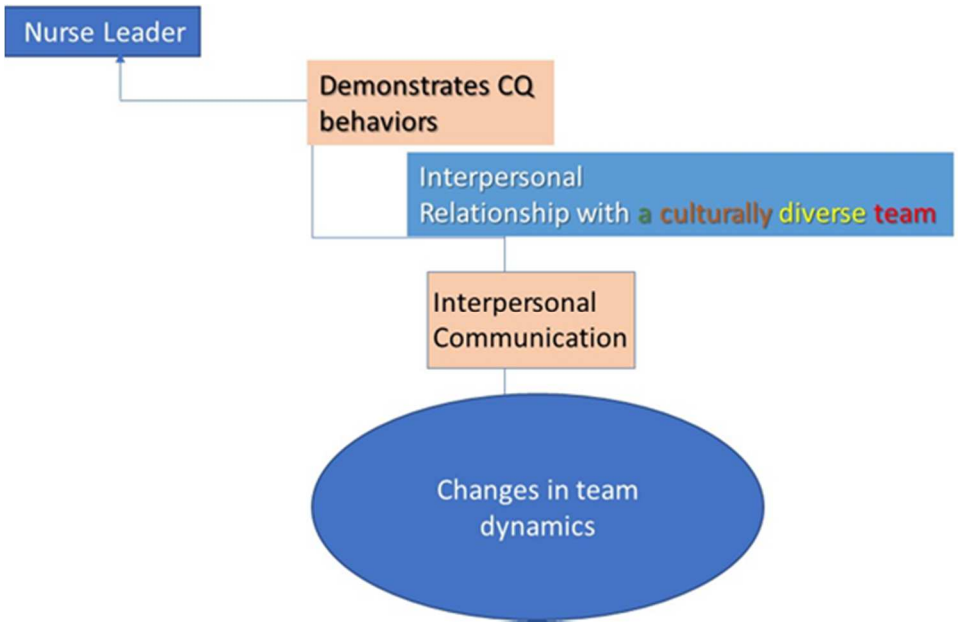

Figure 5. Nurse leaders and the CQ steps that change team dynamics.

Obstacles to Leading with CQ within the Organization

Barriers and obstacles are inevitable with change. The nurse leaders in this study indicated barriers that they have experienced in the workplace when trying to lead with CQ. A barrier can sometimes be a hindrance, on the other hand, barriers can be a catalyst for positive change. However, the nurse leader using CQ is committed to leading in the face of diversity within organizations. The findings indicate that nurse leader using CQ encounter organizational barriers in various ways. The following are quotes that will provide insight into what nurse leaders feel are obstacles to leading with CQ.

Nurse leader 4: I have as a transitional leader for the last seven years. I travel throughout the country helping organizations thrive in the C-suite. That's where I

> serve, in the C-suite. Now, with that said, I have found that there has been a lack of diversity in many places that I've served and trying to make that leap from a lack of diversity, then helping people understand cultural differences has been a challenge… the lack of diversity, lack of cultural differences… There appears to be a lot of like-mindedness.

Likewise, nurse leader 10 stated "Questions. A lot of questions. I get challenged on what my thought process was, what am I thinking? I'm told that I challenge the norm".

Although there are notable challenges that emerge when leading with CQ, nurse leaders are dedicated to overcoming the obstacles and continue to push through the obstacles. According to the nurse leaders, leading with CQ is not an option, it is a professional responsibility.

Limitations

This study was limited to nurse leaders who live in the United States and were recruited from professional nursing organizations, and social media websites. Also, the nurse leaders needed to be considered a leader in their workplace and an active member of a professional organization. The CQ of the frontline nursing staff was not considered in this study as it is an opportunity for future research. The researcher was the primary investigator in this study and is a registered nurse by profession.

The study proposed to recruit nurses through professional nursing organizations; however, no responses were received from any professional nursing organizations. This is considered a limitation in the recruitment of the study.

Recommendations

Exploring the CQ of nurse leaders focused on nurse leaders within the United States. Additional research related to frontline nursing staff and the influence on the patient experience is an opportunity for future study. Furthermore, exploring the CQ of nurse leaders outside of the United States should be considered as it would provide a global approach to understanding and validating the CQ of nurse leaders worldwide. This is a call to action, as a study that approaches CQ of nurse leaders globally would validate the need for CQ strategy, CQ knowledge, CQ drive, and CQ action of all nurse leaders and add to the existing literature.

Implications for Positive Social Change

This study was necessary because of a lack of scholarly information related to the CQ of nurse leaders. Although nurse leaders possess and demonstrate many characteristics of a proficient leader, CQ is now an essential skill necessary to lead with innovation and effectiveness. All the nurse leaders involved in this study are active members of a professional nursing organization. Hopefully, the nurse leaders will initiate conversations regarding CQ within their workplace and professional organizations. Nurse leaders must use CQ to work and relate effectively in culturally diverse settings.

Moreover, CQ, an extension of EI, has become an emerging skill required for all nurse leaders. As the faces of the healthcare workforce change into a web of various cultures, nurse leaders must use their CQ to lead the team and organizations effectively. Nursing is a profession recognized worldwide, and CQ nurse leaders will impact the positive changes that will occur in nursing practice across the globe.

Conclusion

In conclusion, based on the results of the study, CQ is a skill necessary for nurse leaders to impact leadership practice, frontline nursing staff, the patient experience, and their organization. The results of this study revealed the importance of some of the nurse leader's ability to interconnect CQ into all aspects of nursing leadership. Although scholarly information regarding CQ of nurse leaders is scarce, this study is indicative of the importance of nurse leaders who understand and exhibit CQ and how they can influence nursing leadership practice, team dynamics, and the patient experience. More importantly, the results of this study can be used to enhance the professional development of nurse leaders, positively promote social change within the nursing profession, and add to the existing literature regarding CQ.

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Appendix A: Screening Form

Participant Screening Tool for the Study: Exploring the Cultural Intelligence of Nurse Leaders

The purpose of this study is to explore the cultural intelligence of nurse leaders. The respondents will be screened to determine if they qualify for the study. If selected, the participant will be required to participate in a one-hour video conference or telephone interview. An additional request to review the documents included in the study will be made during the data collection phase. The following questions are actual research questions that will be asked during the interview process:

1. **How do culturally intelligent nurse leaders benefit health care organizations?**
2. **How do nurse leaders integrate cultural intelligence into the patient experience?**

After I review the completed screening tool, you will be notified whether or not you qualify within one week of returning this screening tool.

This screening tool will be kept in a confidential and secure web-based program during the study. After the study, all participant information will be held for five years and subsequently archived in a national research database.

Email any questions regarding the completion of this form to:

Participant Screening Tool for the Study: Exploring the Cultural Intelligence of Nurse Leaders

Directions

Please complete the information below and return this form to:

Valerie.campbell3@waldenu.edu within 48 hours of receiving this document.

Last		First	
Home phone number	Cell phone number	Email Address	
Permission to call ___Y or___ N	Permission to call or text ___ Y or ___ N		
Available times	Available times		

Age_____ Race_____ Gender_ _____M_____ F

Registered Nurse ___ Y _____ N Number of years licensed? _____

Are you a member of a professional nursing organization? _____ Y _____ N

If so, which one? _____

Are you a nurse leader? _____ Y _____ N

What is your nurse leader title in your place of employment? Example: Charge Nurse, Nurse Manager, Nurse Supervisor, Nurse Administrator

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Signature_____ Date_____

Appendix B: Confidentiality Agreement

Confidentiality Agreement

Name of Signer: REV.com (Transcription Service)

During my activity in transcribing interviews for this research: "Exploring the cultural intelligence of nurse leaders, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I am officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Appendix C: Interview Protocol

Interview Protocol Form

Project: Exploring the cultural intelligence of nurse leaders

Date _____

Time _____

Location _____

Interviewer _____

Interviewee _____

Consent form signed? ____

Notes to the interviewee

Thank you for your participation. I believe your input will be valuable to this research and in helping grow all our professional practice.

Confidentiality of responses is guaranteed.

Approximate length of interview: 30 minutes- 1- hour, four major questions

Purpose of Research

To explore the cultural intelligence of nurse leaders by answering the following research questions:

i. What is the meaning of cultural intelligence within nursing leadership?
ii. How do nurse leader's articulate CQ in their role to facilitate the patient experience?
iii. How do nurse leaders describe their own cognitive, behavioral, and motivational abilities?

iv. How does self-awareness of cultural intelligence change leadership practice?

1. What does cultural intelligence mean to you?
2. Do you feel that you are culturally self-aware? Why or Why not?
3. What actions have you taken to develop your CQ knowledge skill set?
4. What verbal cues, speech, or language do you use to demonstrate cultural intelligence in your workplace?
5. What nonverbal cues do you use to demonstrate cultural intelligence in your workplace?
6. How does self -awareness of cultural intelligence change your leadership practice?
7. What actions do you use to demonstrate cultural intelligence in your workplace?
8. What cultural norms and values do you use to understand and lead a diverse team?
9. Motivation is a component of CQ. Describe strategies that you use to motivate a culturally diverse team.

a. 6a. What intrinsic motivational strategies do you use?
b. 6b. What extrinsic motivational strategies do you use?

10. What are some barriers that you may have encountered in an organization when leading with CQ?
11. Why are culturally intelligent nurse leaders important to healthcare organizations?

12. Can you tell me about a time when you lead with cultural intelligence? What was the situation?

a. 8a. What was the outcome?

b. 8b. Why is this example important to you?

13. Explain how nurse leaders incorporate CQ into the patient experience.

14. What makes the CQ of the nurse leader relevant to the patient?

1.Observations	2. Observations
3. Observations	4. Observations
5. Observations	6. Observations
7. Observations	8. Observations

9. Observations	10. Observations
11. Observations	12. Observations
13. Observations	14. Observations
15. Observations	

Reflection by Interviewer

Reflection by Interviewer

- Closure
    - Thank you to the interviewee
    - Reassure confidentiality

ask permission to follow-up _____

Appendix D: Recruitment Flyer

Attention Nurse Leaders

This is an opportunity to make a difference in your profession!

Charge Nurses, Nurse Managers, Nurse Administrators, and Nurse Executives wanted to participate in a study exploring the cultural intelligence of nurse leaders.

Volunteer participation is needed for a short-term study exploring the cultural intelligence of nurse leaders.

Study criteria:

(1) The nurse leader must be a member of a professional nursing organization. The nurse leader must have the title of nurse leader in their work environment.
(2) The nurse leader must be willing to participate in an interview process.

Please email me.
This opportunity expires on_____