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Nurse Executives' Lived Experience of Incorporating Caring Leadership

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Abstract

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MS, Texas Woman's University, 1996

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Proposal Submitted in Partial Fulfillment

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Abstract

The link between compassion and caring at all levels of nursing practice and the enhancement of the patient experience is well-documented. However, the techniques nurse executives use to incorporate caring into their daily practice while coping with competing organizational priorities is poorly understood. The purpose of this qualitative phenomenological study, guided by Watson's theory of human caring, was to examine detailed accounts of the experiences of nurse executives incorporating compassion and caring into their daily practice, including techniques they use to build and sustain compassion and caring while balancing competing priorities. A purposive sample of 10 nurse executives participated in the study. Audio recordings of each participant's face-to-face interview were transcribed and coded using NVivo 12 software while the demographic surveys were analyzed using SurveyMonkey. The data analysis was performed using the interpretive phenomenological analysis (IPA) process. Four themes emerged from the analysis: (a) preparation for executive role, (b) execution of responsibilities, (c) demonstration of caring, and (d) balancing influences. The key findings revealed that caring permeates the nurse executive's practice and nurse executives require mentorship to effectively execute their function. Based on these results, nurse executives should focus on welcoming guidance from other experienced mentors and nurse leaders. Nursing administrators, educators, and researchers can use these findings to design further research exploring the experience of nurse executives from additional settings, cultures, and ethnicities. Positive social change may result from this work by providing direction to nurse executives seeking to successfully navigate corporate culture while improving the staff work environment, quality of care, staff retention, and patient outcomes through compassion and caring.

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Dedication

This dissertation is dedicated to my mother, Pearl Stepp. Thank you, mom for your continuous love, support, and shining Christian example.

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The completion of this dissertation was made possible by the kind support of numerous individuals. Firstly, I would like to express my thanks to my Lord, Jesus Christ, for the strength and peace of mind to complete this journey and for His boundless mercy and compassion. I would also like to thank my dissertation committee chair, Dr. Cynthia Fletcher, for her patient guidance, encouragement, and immense knowledge. I appreciate all her contributions of time and ideas to make my Ph.D. experience productive and stimulating. Besides my chair, I would like to thank the rest of my dissertation committee: Dr. Leslie Hussey and Dr. Elaine Fowles, for their insightful comments and encouragement. Each of the members of my Dissertation Committee has provided me extensive professional guidance and taught me a great deal about scientific research. Additionally, my sincere thanks go to all those who participated in the study and shared their experiences related to the demonstration of compassion and caring in their practice. Last but not least, I would like to thank my family for providing unending inspiration and supporting me spiritually and emotionally throughout the writing of this dissertation.

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Chapter 1: Introduction to the Study

Changes in the healthcare system continue to drive transformations in the role of nursing. Today, nurses are required to accept more administrative and leadership responsibilities while continuing to promote health and positive patient outcomes. Nurse executives in particular must ensure that the staff work environment is conducive to the delivery of quality patient care in addition to managing financial and human resources in a strategic manner (American Organization of Nurse Executives [AONE], 2017a). Despite the addition of these critical functions, compassion and caring, which are the essence of nursing practice, remain an integral part of all nursing roles including those of nurse executives.

The values of compassion and caring are of concern to practicing nurses for numerous reasons. Most importantly, the Nursing Code of Ethics in the Professional Standards of Practice regard the demonstration of compassion and caring as compulsory for nurses in all roles of nursing (American Nurses Association, 2015). Inclusion of compassion as fundamental to nursing practice is supported by the improvement in care experiences reported when direct care nurses make a compassionate connection with patients (Dempsey, Wojciechowski, McConville, & Drain, 2014). Likewise, nurse managers who demonstrate compassion through caring behaviors toward staff positively impact the work experience for staff, leading to better professional and personal outcomes (Feather, Ebright, & Bakas, 2015; Schlagel & Jenko, 2015). Nurse executives, by modeling compassion through caring behaviors, can optimize outcomes for patients, families, staff, and the organization. However, corporate objectives often challenge and suppress the compassionate approach to interpersonal interactions with staff (Worline & Dutton, 2017). To date, there is limited evidence reflecting the lived experiences of nurse executives

who struggle to manifest compassion, as demonstrated by caring behaviors while balancing competing priorities.

This phenomenological study focuses on the lived experience of nurse executives balancing competing priorities while modeling compassion and caring behaviors. The findings of this study may impact nursing by providing a deeper understanding of the phenomena of nurse executives seeking to build, manifest, and sustain compassion and caring toward staff and provide a voice for nurse executives to relate their experience and methods and techniques they find effective for building and maintaining compassion and caring. In Chapter 1, I outline the background of compassion, caring behaviors, responsibilities, and challenges that nurse executives face. I also discuss the purpose of the qualitative study, the conceptual framework of caring, assumptions, scope of delimitations, limitations, and the significance of the study in relation to the impact of social change.

Background

The healthcare system in the United States continues to experience increasing pressure to evolve to optimize performance and outcomes despite the efforts of numerous groups to improve healthcare delivery. Currently, healthcare spending is projected to account for 20% of the gross domestic product by the year 2020 with the government-sponsored share of healthcare expenditures to reach 50% by 2022 (Centers for Medicare and Medicaid Services [CMS], 2012). These statistics are, in part, attributable to an aging population, increased longevity, and significant science and technological advances resulting in society's need for a multidisciplinary approach to affect change. Healthcare policy makers, payers, and clinicians have joined forces through organizations, such as the Healthcare Transformation Task Force, to initiate

modifications focused on improving quality of care, patient satisfaction, the health of populations, and reducing healthcare costs. Overall, healthcare improvement groups seek to minimize profits from high volume services and replace physician-centric care with a patient-centric approach. Unfortunately, efforts to promote healthcare reform and optimize performance, have yet to result in large-scale transformation and rhetoric regarding patient-centered care fails to deliver sustained improvement in terms of the patient experience (Bodenheimer & Sinsky, 2014).

Additional groups have emerged over the last 25 years to facilitate the use of a systems approach to redesign healthcare in the US. The Healthcare Transformation Institute, a nonprofit organization, seeks to improve the connection between scientific discovery, health service delivery, and reimbursement. This group identifies, along with public, private, and governmental agencies, that a shift from a volume to value-based system is necessary, but progress toward this goal has been limited.

Healthcare strategists, in response to the call for alternative service delivery systems, designed mechanisms for coordinating primary care through patient-centered medical homes (PCMH) and new payment models that tie payments to quality outcome metrics, such as accountable care organizations (ACO), to avoid duplication of services and implement shared cost savings (Jackson et al., 2013; McWilliams et al., 2016). Emerging data that measured the impact of these alternative healthcare delivery and payment systems, demonstrate that the outcomes related to cost savings have been less than impressive. Rosenthal et al. (2013) evaluated a pilot PCMH program that included 5 independent primary care practices and 3 private insurers. The researchers reported no improvement in quality scores and no statistically

significant alteration in emergency department visits or in-patient admissions for chronically ill patients (Rosenthal et al., 2013). In a separate study, Friedberg et al. (2014) examined the success of the Southeastern Pennsylvania Chronic Care Initiative, another PCMH program, based on quality, utilization, and cost of care. Results from the study demonstrated no change from baseline in services utilization or cost savings (Friedberg et al., 2014).

The success of the accountable care organizations in containing costs remains unclear. Medicare officials continue to report savings; however, the ACOs in 2014 recorded a net loss of $2.6 million (CMS, 2015). McWilliams et al. (2016) evaluated the 32 healthcare organizations who entered the Pioneer Accountable Care Organization group and compared the spending for beneficiaries within the program with others outside the group in other traditional healthcare plans. The researchers reported only a modest reduction in costs resulting a 1.2% saving for organizations within the Pioneer group compared to the control group (McWilliams et al, 2016). These initiatives and programs focused on systems and quality improvement, but the wholesale transformation to value-based care and improvement of the patient experience requires the development of a culture of compassion and caring.

Nurses continue to play an important role in the advancement of healthcare reform. Providing care in numerous settings and diverse roles, nurses remain the largest group of healthcare practitioners and are capable of providing the leadership needed at all levels to enhance the patient experience (Salmond & Echevarria, 2017). Nurse executives are positioned to develop and initiate innovative strategies that contain utilization costs while appreciating the importance of demonstrating compassion and caring toward others to foster strong professional partnerships (Wilson, Whitaker, & Whitford, 2012). A unique perspective that balances

innovation and compassion could effectively drive the needed shift from systems and processes to a culture conducive to value-based, positive, patient experiences that result in positive outcomes.

The rapid transformation of the United States healthcare system since 2007 has focused on the three dimensions, improvement of the patient health, improvement of patient healthcare experience, and reducing cost, delineated by the Triple Aim initiative proposed by the Institute for Healthcare Improvement (Institute for Healthcare Improvement [IHI], 2017). However, the addition of a fourth dimension, identified as improving the work environment of clinicians and staff, may prove to be the necessary to reach the goals of the Triple Aim initiative (Bodenheimer & Sinsky, 2014). Gaining a better understanding of how nurse executives build, manifest, and maintain compassion as demonstrated through caring behaviors may positively impact the nursing discipline and facilitate healthcare reform, leading to enhanced patient-centric and value-based systems.

Statement of the Problem

The concept of caring, while not unique to the field of nursing, provides nurses with the foundation necessary to generate interpersonal connections that promote health, facilitate healing, and mediate growth and development (Watson, 2012a). Caring denotes benevolent encounters with others and supports a humanistic stance in terms of patient care and leadership (Watson, 2017). This humanistic approach promotes the recognition of compassion as the cornerstone of caring behaviors, which are fundamental to positive nurse-patient and nurse-nurse relationships and improved patient outcomes (Watson, 2012a). Caring behaviors demonstrated by nurse leaders toward staff are also essential for providing an environment conducive to the

provision of quality nursing care (Feather, Ebright, & Bakas, 2015; Schlagel & Jenko, 2015). However, technological advances and limited resources threaten to marginalize the practice of compassion and caring among nurses in executive roles (Watson, 2012b).

Research about the means through which nurse executives can cultivate, sustain, and manifest compassion as demonstrated by caring behaviors while balancing competing priorities remains sparse. Raab (2014), stated that cultivating the capacity to demonstrate respect and caring behaviors toward self leads to the demonstration of respect and sensitivity toward others. Additionally, Raab (2014), encouraged healthcare professionals to use mindfulness, focusing on the present moment, as a mechanism to decrease stress, increase self-compassion, and generate compassion toward others. Whittington, Nolan, Lewis, and Torres (2015), while not directly referencing compassion, described how healthcare leaders use the caring behavior of focusing on patient needs to manage population health and per capita costs. Independently, Raab (2014) and Whittington et al. (2015) provided a glimpse into the importance of compassion and caring to the nurse executive's role in patient care. As a result, additional studies that identify factors which promote the integration of compassion, scientific knowledge, and business acumen may assist nurse executives in incorporating key caring behaviors.

The use of spiritual practices by nurse executives continues to garner interest from numerous researchers. Specifically, nurse researchers seek to understand the potential for spiritual practices to nurture humanistic values through increased self-awareness. A majority of the available research focused on the implementation of mindfulness exercises as a spiritual practice designed to improve attention, resulting in improved compassion and caring behaviors. None the less, little research, thus far, has explored the applicability of other traditional spiritual

practices, such as centering, meditation, breath work, yoga, prayer, reflection, Reiki, or healing energy touch therapy, and the reading of sacred, religious texts, such as the Bible, Qur'an, or Torah. Watson (2017) recommended that nurses, in order to move from the technical aspects of caring to the art of being caring and establish a sustainable pattern of caring behavior, use self-reflection and spiritual practices that enhance self-awareness; yet, there exists a gap in the literature regarding how spiritual practices relate to the compassion energy and caring behaviors of nurse executives. The nature of this presumed relationship between spiritual practices of nurse executives and the demonstration of caring behaviors remains an enigma that requires further research.

Purpose of the Study

The purpose of this qualitative study was to examine the lived experiences of nurse executives who seek to manifest compassion toward their staff while experiencing and balancing competing priorities. The phenomenological approach supported this investigation. Individual interviews with nurse executives provided insights and led to the development of a deeper understanding regarding the experiences and strategies used by nurse executives to integrate compassion and caring into their practice.

Research Question

The research question for this proposal was:

RQ: What are the lived experiences of nurse executives who seek to manifest compassion for their staff while experiencing and balancing competing priorities?

Conceptual Framework

For over 40 years, starting in 1975, Watson has explored the phenomenon of caring within the context of delivering quality nursing care. As a result of her extensive research, focusing on the identification, description, and measurement of caring, Watson developed the theory of human caring (THC) (Smith, 2004). The THC provided the framework for this proposed study. Watson's THC addresses the nature of caring, incorporation of caring behaviors in all areas and levels of nursing practice, and the relationship between spiritual self-care and compassion and authenticity. THC also supports the creation of a caring environment free of authoritarian principles and the development of caring relationships between nurses and patients. Watson's theory previously supported numerous nursing research projects that explored the caring behaviors of nurses providing direct patient care as well as nurse leaders, though on a limited basis. This proposed qualitative phenomenological study, therefore, draws upon nurses' understanding of caring relationships inherent in the THC and applies this to the practice of nursing leadership within the context of the nurse executive role. More detail on Watson's theory is presented in Chapter 2.

Nature of the Study

The nature of the proposed study was qualitative with a phenomenological approach. Qualitative research is a descriptive and holistic approach to research that takes a subjective and human-oriented approach (Merriam & Tisdell, 2015). Issues of compassion, caring, and spirituality are deeply subjective, and their place in nursing leadership is not yet well-established and conceptualized. Cullen (2016) reported, following an analysis of 47 peer reviewed research regarding nursing management, spirituality, and religion, that spirituality is beneficial in nursing

management, training, and care and that additional research in the area of nursing management and spiritual initiatives was needed. Additionally, Watson (2017), stated that continuous research exploring caring practices assists nursing leaders to understand the scholarship of caring science. Thus, a qualitative approach for this study was relevant for two reasons. First, qualitative research serves to support the development of hypotheses designed to explore an ill-defined area of research, allowing future researchers to potentially conduct more large-scale investigations. Moreover, the qualitative approach allows researchers to investigate deeply personal and subjective phenomena holistically and descriptively. Both of these reasons made a qualitative approach more appropriate than a quantitative one. Focusing on the lived experiences of nurse executives attempting to manifest compassion and caring is supported by Watson's human caring theory regarding the potential role of caring in leadership. Semi structured interviews conducted with each nurse executive participant provided data for transcription and thematic analysis.

Definition of Terms

Caring: The exhibition of nurturing concern, empathy, and compassion toward others, and is demonstrated through intentionality to be present and attentive (Swanson, 1991; Watson, 2002).

Caring behaviors: Actions characteristic of concern for the well-being of others which including attentive listening, honesty, patience, responsibility, sensitivity, respect, and transparency (Wolf, Gianrdino, Osborne, & Ambrose, 1994).

Caring leadership: Combining care and leadership theoretical concepts to develop a positive work environment by fostering autonomy, respect, and shared governance (Horton-Deutsch, 2017).

Caritas: Loving consciousness that encompasses charity and compassion in service to mankind (Watson, 2017).

Compassion: A positive emotion focused on the alleviation of suffering in others (Ozawa-de Silva et al., 2012).

Nurse Executive: Master's or Doctorate level licensed nurses who practice within a hospital, healthcare system, or school of nursing as part of the senior leadership team and focus on optimizing nursing services provided across the healthcare continuum (AONE, 2017b).

Spiritual practices: Both religious and nonreligious exercises performed to cultivate compassionate curiosity and spiritual well-being through connection with the divine, self, and others (Sitzman & Watson, 2013).

Spiritual well-being: The ability to identify meaning and purpose in life through interpersonal connectedness (Haugan, 2015)

Assumptions

Researchers are responsible for decisions regarding every aspect of study development and execution. These decisions are based on assumptions that often lack validation or proof. There were several such assumptions that influenced the design of this project. First, each participating nurse executive will provide accurate and truthful statements in response to questions during data collection. Second, participants will openly share and describe positive and negative experiences related to the manifestation of compassion and their role as nurse

executives. Third, noted similarities in the collected data will allow for the emergence of themes relevant to the research question. Lastly, nurse executives desire to be compassionate in their role.

Scope and Delimitations

Nurse executives and managers function in numerous settings with often overlapping responsibilities. According to the AONE (2017b), nurse executive leaders are registered nurses responsible for administration and management of patient services within healthcare settings, health-related businesses, and academia. Therefore, nurse executives are a part of the senior management team and provide strategic direction to achieve the organization's mission. Nurse managers, however, are tasked with operationalizing set organizational goals and objectives. Both groups function as leaders and are responsible for directing the activities of others.

The diversity of roles, responsibilities, and settings of nurse executives' practice necessitate the delineation of the scope of this project. The purpose of this study was to explore the lived experiences of nurse executives and managers who are balancing competing priorities while working to manifest compassion. This research project focused on nurse leaders responsible for strategic and tactical planning within healthcare facilities and academia. Therefore, including nurse executives who do not have direct responsibilities for staff was not directly relevant. Additionally, consultants do not traditionally possess a significant level of accountability for corporate performance and the information they might share could be problematic during analysis. As a result, nurse leaders functioning as public health strategists or consultants, or lacked direct management responsibilities were excluded. Limiting the setting to

US hospitals, hospital systems, and academic universities, for participant recruitment was also crucial for the study to be feasible and the results to be accurately analyzed and reported.

Collecting subjective data can be challenging but is supported by the qualitative methodology. According to Creswell and Poth (2018), the five main approaches associated with qualitative research are ethnography, ground theory, case study, and phenomenology. For this study, the qualitative method with a phenomenological approach was used to facilitate the exploration of feelings, values, and behaviors related to professional and personal experiences of the study participants concerning caring. Other approaches such as narrative and case study were evaluated but did not adequately meet the criteria necessary to address the research question for this study.

Numerous theorists in the nursing disciple have explored the phenomenon of compassion and caring behaviors. Most of these nurse philosophers focused extensively on the caring that occurs between nurses and patients. Leininger (1988), in the culture care theory, argues that nursing care must align with patients' cultural values and beliefs in a caring manner but fails to address the caring behaviors of nurse executives toward staff. The theory of bureaucratic caring by Ray (1988), provides a framework to understand the connection between organizational structure, management, and spiritual-ethical caring and how these factors permeate all nursing care. Yet, Ray (1988) omits the role of the nurse executive in the development of a caring organizational culture. Eriksson (2007), in the theory of caritative caring, similar to Leininger, connects deep communication and cultural to the concept of caring but does not directly address caring and the role of the nurse executive. Martinsen's (Alvsvåg, 2018), in the philosophy of caring, who posited that compassion is a basic, fundamental, value of nursing, nevertheless,

omitted addressing compassion of the nurse executive. These theories were considered alternatives to Watson's human caring theory as the theoretical support to this study. Compared to the grand theory of human caring developed by Watson, these other midrange theories, though related to the area of study, do not significantly address the manifestation of compassion and caring in the nursing leadership role. As such, Watson's theory of human caring was used for this study.

These research study design decisions, such as method and approach, provide scope to this research project and allow for the identification of aspects of the caring behaviors of nurse executives that will need to be covered in other research projects. Specifically, future research may be designed to include larger groups and more diverse healthcare settings. The potential transferability of the results of this study will depend on the ability of individuals interested in the phenomenon of compassion and caring manifested by nurse executives to make associations between findings and their own experiences while considering their own situation and circumstances.

Limitations

Research projects are inherently at risk for issues that may impact the analysis and interpretation of study results. These problems usually arise from the study design and methodology (Creswell & Poth, 2017). For this study, the limitations are associated with the use of the phenomenological approach focusing on the lived experiences of individual nurse executives.

Qualitative research using the phenomenological approach can limit the generalizability of the results. The greatest concern is the subjectivity of the data collected. The lived

experiences of participants can be highly complex and multilayered (Creswell & Poth, 2017). Therefore, researchers must be alert during the collection and analysis of qualitative data of subtle messages communicated by participants and clarify any ambiguous statements. I was the sole researcher collecting the data through in-depth interviews using open-ended questions. I limited my personal researcher bias by using reflexivity and suspending my assumptions regarding challenges experienced by nurse executives in healthcare facilities and academia and techniques to build and maintain compassion. I asked participants probing question to clarify any responses that were unclear and had them review my transcribed notes to check for accuracy.

Another limitation of this study related to the sample size and selection. The sample size was small, which is consistent with a qualitative study using the phenomenological design. A nonrandomized convenience sample of nurse executives who work within a US based hospital, hospital system, or university was recruited. The interpretation of the results was conducted with caution due to the limited sample selection. As part of the interpretation of results, lived experiences from this population may not be the same for nurse executives working in industry, advocacy groups, or other health-related organizations. Additionally, federal, state, and local laws and regulations differ between practice settings for nurse executives and are addressed in the results analysis and interpretation process. The measures of clarifying ambiguous statements, asking open ended questions and reflexivity were implemented to maximize the trustworthiness and dependability of the data.

Significance of the Study

The need for nurses to engage in compassion, as demonstrated by caring behaviors, permeates all levels of nursing practice; however, nurse executives, due to conflicting priorities,

may omit caring behaviors from their daily routine (Jazaieri et al., 2016). According to Watson (2017), spiritual practices, augment compassion, foster the caring behaviors of nurses and nurse managers, and may assist nurse executives implement caring leadership performance as well. Nurse researchers and educators have explored the potential for cognitive compassion and ethics education as a method to enhance caring practices in health-related disciplines but have not included nurse executives in the study population. Therefore, educators need to understand if and how nurse executives enrich their capacity for compassion and integrate caring behaviors toward staff. According to the research results reported by Feather, Ebright, and Bakas (2015) nurses identify caring from nursing leadership as essential for a positive work environment, but more critical research on how this is accomplished by nurse executives is needed.

Acknowledging and engaging with spirituality represents an important part of compassion and caring as this leads to acceptance of patients as spiritual beings (Watson, 2017). Specifically, the use of spiritual practices by nurses holds potential for contributing to the caring process and improving patient care (Watson, 2017), but little research has examined the influence of spiritual practices from the nurse executive's perspective. Additionally, research regarding other methods beyond spiritual practices is warranted. In the context of this study, spiritual practices included focusing exercises such as centering, meditation, mindfulness, and reflection. Energy-based therapies that are used for self-therapy, namely Reiki, were incorporated as well. Additionally, faith-based spiritual practices, e.g. yoga, prayer, and sacred text reading were recognized. Also included, cognitive compassion education programs designed to improve the participants' ethical sensibility and unbiased compassion toward others. The findings of this study add to nurses and educators understanding of the interrelationship between

spiritual practices, compassion, and caring behaviors as well as other techniques, such as mindfulness, that assist nurse executives in manifesting compassion.

This project sought to address a gap in understanding of nurse researchers, executives, and educators regarding the lived experience of nurse executives and factors that influence nurse executives' ability to manifest compassion through caring behaviors toward staff while managing competing priorities. This project is unique because it addresses an unexplored area of caring science regarding the caring practices of nurse executives within the evolving and complex landscape of healthcare. The concept of compassion and caring between nurse executives and staff has received limited attention. Joseph and Huber (2015) argued that, with the transformation occurring in healthcare, the role of the nurse and nurse leader is expanding to encompass new responsibilities. As such, the applicability of the findings of this study is broad and includes the optimization of nurses' contributions in today's healthcare system. Nurses and nurse leaders continue to champion social change through the promotion of positive health outcomes and are consistently searching for new research to support their efforts. The results may affect positive social change for the nursing profession and the care they provide to patients by providing a deeper and more comprehensive understanding of compassion and caring as manifested at the nurse executive level useful for those seeking direction for improving the staff work environment, quality of care, staff retention, and patient outcomes.

Summary

Overall, there is a significant amount of evidence that describes the importance of compassion and caring to the practice of nursing in all roles and settings. However, information that centers on the nurse executives' experiences manifesting compassion and caring behaviors

while balancing competing priorities remains notably limited. This study sought to provide a deeper understanding of the human experience of striving to translate compassion and caring to the executive leadership role of nurses.

Chapter 2 provides evidence regarding the impact of caring behaviors on nurse executive and staff relationships and patient outcomes in healthcare. Further, the concepts of compassion, caring, caring behaviors, caritas, and caring leadership are examined. The evidence presented in Chapter 2 also delineates the logical connection between compassion and caring behaviors of nurse executives and organizational and health outcomes.

Chapter 2: Literature Review

Introduction

Nurse executives significantly contribute to the operational excellence of health organizations. However, the challenges associated with leading cross-functional and multi-disciplinary teams while maintaining regulatory compliance can be daunting. Experienced and successful nurse executives employ numerous, extensively-researched methods to achieve corporate and operational goals. A deeper understanding by nurse leaders, researchers, and educators regarding techniques used to strengthen nurse executives' resolve to build and maintain compassion and caring behaviors toward staff remains elusive.

Bedside nurses and nurse managers transitioning from other leadership roles struggle to translate their knowledge regarding compassion and caring to an executive level position. As they acquire new skills related to business acumen and strategic agility, novice nurse executives begin to adapt to the demands of their new position but may fail to integrate compassion and caring behaviors effectively (Beglinger, 2015). Experienced nurse executives recognize that a blending of fundamental nursing traits with executive level competencies is necessary to successfully execute their functional responsibilities; however, they continue to struggle to adequately merge these skill sets. The rapid pace at which healthcare continues to evolve requires nurse executives to prepare a strategic plan that supports the outward facing function of the organization while inwardly ensuring interprofessional alignment within a positive work environment (Beglinger, 2015). A continued focus on compassion and caring by novice and experienced nurse executives could maximize their influence throughout the organization.

Numerous pressures continue to impact the nurse executive's ability to maintain and demonstrate compassion and caring behaviors despite their best efforts. Thompson (2008) queried 20 US nurse leaders from urban, academic centers and small, rural, community settings, to discover the key issues they faced in their daily practice. As the focus of healthcare shifts from processes to patient and organizational outcomes, the prominent nurse leaders interviewed by Thompson (2008) reported safety and quality, finance, and workforce as significant areas of stress. (Thompson, 2008). Jones-Berry (2016) reported that with 61 (46%) out of the 132 senior nurse leaders interviewed had been in the leadership role less than three years. Jones-Berry (2016) argued the short tenure of these chief nursing executives in the United Kingdom was attributable to the lack of board level support regarding frontline needs of staff, such as technology, supplies, compensation, and autonomy. Jones, Havens, and Thompson (2008), after interviewing 622 Chief Nursing Officers from hospitals and health care organizations across the US, reported that 62% of the respondents planned to change jobs within five years. Kelly, Lankshear, and Jones (2016), conducted interviews with 40 executive nurses, including executive, chief nurses, and directors, working in hospital and healthcare settings in the UK. The researchers reported chronic stressors such as expanding workloads and perceived personal vulnerability as factors impeding personal resilience and job satisfaction (Kelly, Lankshear, & Jones, 2016). Clancy and Reed (2016) related that technological advances in data capture, storage, and analysis add another layer of complexity and stress to the role of nursing executives. Leach and McFarland (2014) analyzed questionnaire responses from 155 nurse executives who are members of the Association of California Nurse Leaders, and identified that they faced additional demands to influence nurses' work environment and health care policy and to expand

their ability to innovate and optimize organizational productivity while guiding transformational change and redesign of the US healthcare system. Lack of board level support, perceived personal vulnerability, and competing priorities may exert the greatest negative impact on the nurse executives' compassion and caring behaviors.

The purpose of this study was to develop an in-depth understanding of the lived experiences of nurses functioning in an executive role, including chief nurse officers, directors of nursing, chief nurse executives, and nursing school academic officers, within the US who seek to manifest compassion through caring behaviors toward staff while balancing competing priorities. Chapter 2 explores current literature related to caring in nursing and nursing leadership, the consequences of caring, and current theoretical concepts related to caring and compassion. Caring remains the cornerstone of nursing and permeates all areas and roles within which nurses' practice. Ostensibly, nurse executives experience impediments to their continued demonstration of compassion and caring. Therefore, the identification of factors that can enhance compassion and lead to more caring behaviors for nurse executives, despite adversity, will have a positive social impact that is vital to improved nursing practice and quality patient care outcomes.

Literature Research Strategy

The purpose of this literature review was to explore currently available information pertaining to Watson's THC, caring leadership, and compassion. I collected literature related to these topics through a systematic subject-based approach between 1979, when data regarding the THC first appeared, and 2017. Numerous terms were used to access the literature. The words employed were caring, *caritas*, *compassion*, *nursing*, *nursing leadership*, *emotional intelligence*, *spiritual intelligence*, and *spiritual practices*. The database sources used were Medline,

CINAHL (Nursing and Allied Health), PubMed, EBSCOHost, Academic Research Premier, PsycInfo, Cochrane Library, ProQuest, and Google Scholar. I obtained primary digital versions of pertinent articles and books or physical copies when electronic versions were unavailable. Relevant studies were identified as those where the author discussed concepts of caring, compassion, and leadership within the context of nursing, regardless of publication status. The literature revealed hundreds of peer-reviewed and academic related works with a cross section of studies based on international research.

The first section of this literature review provides insight regarding the THC developed by Jean Watson. The THC will provide the necessary focus and structure to facilitate a deeper understanding of the phenomena in this study. The second section focuses on the traditional role and impact of caring and compassion in nursing. The third section illustrates current research regarding the application of caring and compassion in nursing leadership. The last section provides insights regarding the positive and negative consequences associated with compassion and caring. Data regarding previously identified techniques implemented to define, establish, and maintain compassion are also included. An in-depth understanding of unique experiences involving sustaining compassion and caring behaviors while managing goals and expectations is imperative for the future of nursing. Ultimately, identification of practices used by nurse executives to strengthen their capacity to demonstrate compassion and caring behaviors may benefit not only nurse leaders, staff, and patients, but organizations as well, which will result in significant positive social change.

Theoretical Foundation

The theoretical foundation selected to provide the lens through which the data from this study was viewed is Watson's THC. In addition, I selected Schofield's analysis and explanation of compassion to assist with the identification of distinctions between caring and compassion that emerge from the study results. The organization and categorization of themes were discussed within the context of Schofield's conceptualization of compassion and the THC framework.

Theory of Human Caring

The purpose for developing the THC focused on four fundamental concerns. The first fundamental concern is the need to reestablish nursing as a caring, holistic practice. The second is an obligation to propel the establishment of a nurse centric foundation independent from the physician medical model. The third fundamental concern is, a lack of consensus regarding the role of caring as an essential component of the nursing discipline. The fourth is the need to establish a framework that encourages the provision of philosophical-ethical nursing care. Although originating from Watson's personal observations, experiences, and beliefs, the THC provides a platform for research in numerous disciplines, including but not limited to education and nursing, with practical principles that support and transcend the nursing discipline.

According to the THC, care is interpersonal, promotes health, is essential to nursing, and focuses on care not cure (Watson, 2008). Watson (2008) added acceptance of the patient based on their potential as well as their current state, carative factors denote areas of concern for the caring nurse, and the care environment to complete the seven fundamental assumptions associated with the THC. Watson (2008) posits, through the caring theory, that the nurse's role

is to promote healing and demonstrate respect for the whole patient, including physical and spiritual (Parker & Smith, 2010). These assumptions delineated in the THC demonstrate Watson's (2008) belief that interpersonal encounters are crucial to the caring process.

Watson Theory 10 Carative Factors

Carative Factor 1: Humanistic-Altruistic values. Humanistic and altruistic values are generated over time and include kindness, empathy, and compassion. According to Markakis, Beckman, Suchman, and Frankel (2000), humanistic values reflect respect for autonomy and the subjective experience of others. DeSteno (2015) argued that altruism reflects a desire to help others. Humanistic and altruistic values support healthcare professionals, including nurses in an executive leadership role, to exhibit caring by respecting other's view, ideas, and opinions.

Carative Factor 2: Instilling/enabling faith and hope. Hope is a protective human resource that is utilized as a positive coping mechanism during difficult situations. Conway, Pantaleao, and Popp (2017) explored the importance of hopefulness as expressed by the parents of children with cancer. Interviews were conducted with 50 parents who had children, 18 years of age and younger, with cancer undergoing treatment in the oncology unit of a children's hospital. The nurses provided patient care and education while emphasizing a positive outlook for the parents regarding the patient's progress and future treatment options (Conway, Pantaleao, & Popp, 2017). According to Conway, Pantaleao, and Popp (2017), participants in the study identified the provision of education, by the nurses, regarding future treatment options and plans strengthened their hope. These results demonstrated that caring nurse behaviors, such as education, connectedness, and compassion can instill hope in patients and families. In practice,

nurses in executive leadership roles are positioned to instill hope for staff through the generation of achievable, realistic goals.

Carative Factor 3: Cultivating sensitivity to oneself and others. Watson (2008) stated that self-awareness is necessary to engage in caring-healing relationships. Nurses who understand and acknowledge their beliefs, values, and feelings, become receptive to understanding the needs of others. The journey to successful leadership also includes self-awareness. According to Caldwell and Hayes (2016), cultivating sensitivity to self enables individuals to empower themselves and others.

Carative Factor 4: Developing a caring relationship. Transpersonal relationships, according to Watson (2017), are central to the caring environment and process: however, these relationships require trust. Watson (1989) acknowledged that nurses build trusting relationships through spending time with the patient, actively listening to the patient's needs, and responding appropriately. Similarly, nurse leaders build trust with staff through communication, connecting on a personal level, and responding to their needs.

Carative Factor 5: Promotion and acceptance of the expression of feelings. Feelings need to be acknowledged and validated to build trust and strengthen relationships. Patients experience a broad range of emotions including fear, anxiety, sadness, vulnerability, and relief. Beauvais, Andreychik, and Henkel (2017), argued that nurses who demonstrate empathy for patient's emotions and feelings also demonstrate greater levels of compassion. Stamkou, van Kleef, Fischer, and Kret (2016) stated that, for leaders in positions of power, such as nurse executives, being attentive to the emotions of others improves understanding and social functioning.

Carative Factor 6: Use of scientific problem-solving for decision making. For Watson (1979), the caring-healing process includes recognizing the patient as a physical and spiritual being. Additionally, Watson (1979), advocated for nurses to use the scientific-method of observation, assessment, intervention and evaluation to meet physical human health needs. However, nurses should also work with the patient to deal with emotional and spiritual needs in innovative ways acceptable to the patient. Leaders in all settings and industries are responsible for decision making at some level within their organization. As such, nurse executives have an opportunity to include staff in the innovative decision-making process.

Carative Factor 7: Promotion of interpersonal teaching/learning. Patients and families need information regarding their disease, treatments options, and potential outcomes. Watson (1979) stated that genuine teaching, which acknowledges the needs of the patient and their ability to comprehend the information, is empowering. The process of teaching/learning also strengthens the relationship between the nurse and patient (Watson, 1979). Therefore, nurse leaders can foster relationships with staff through clear communication based on their needs and organizational policy.

Carative Factor 8: Provision of supportive holistic environment. Watson (1979) deemed the physical, mental, sociocultural, and spiritual aspects of the individual as aspects of the holistic environment for health and healing. As such, nurses support the well-being of the patient by addressing their health needs in all of these areas. Nurse leaders increase the engagement of staff with the organization, colleagues, and management by providing a supportive, caring environment.

Carative Factor 9: Gratification of human needs and providing dignity. Assisting patients improve or maintain health is more than meeting their physical needs. Watson (1979) recognized that moving patients toward positive health outcomes included addressing needs of safety and security. Chen (2015) reported that, after interviewing 400 nurses, that organizational justice, trust, and security are key factors that impact staff engagement and retention.

Carative Factor 10: Allowance for existential phenomenological forces. Major life events, including illness, trauma, and death, often evoke existential questions regarding life, existence, and life view (Watson, 2008). Watson (2008) posits that as patients struggle with these thoughts regarding the meaning of life and nurses honor the process by remaining open to different beliefs and the possibility for other interventions beyond modern science. Disruptive and challenging events are a part of life and are not limited to patients and their families. Staff nurses also experience times of existential crisis. Nurse executives demonstrate compassion and caring during these difficult situations by respecting where and how others cultivate their hope and courage.

Theory of Human Caring Revisions

Watson's (2008) later iterations of the THC enriched the concept of therapeutic relationships through the identification of caring moments, when two individuals come together and interact during a certain point in space and time. These caring moments become part of the tapestry of the life of both individuals. The transpersonal caring relationship espoused by Watson (1997) recognizes a partnership existing between the nurse and patient, which potentiates the healing process. In this manner, both participants in the caring moment can potentially benefit.

The dynamic aspect of the THC has allowed for the retention of key features while adding new dimensions. The carative factors, enhanced by the addition of caritas processes, as outlined in the THC provide an opportunity to define nursing knowledge and allow both the patient and the nurse to engage in transpersonal caring. The carative factors/caritas processes are supported by the ontological component of the THC which recognizes the oneness of being and are designated by Watson (1997) as the core of nursing.

The caritas processes, or activities, align with the carative factors and reveal the connection between the individual task's nurses perform in their daily practice and the demonstration of caring. According to Watson (2008), the caritas nurse practices loving-kindness, is authentically present for the one they are caring for, cultivates their own spiritual practice, develop authentic caring relationships, support the positive and negative feelings of others, engage in creative caring practices, respect the world view of others, creates caring environments, assists with basic physical needs, and is open to attending to the spiritual needs of others. The refinement of the carative factors to include caritas processes demonstrates Watson's willingness to respond to other scholars' critique and more fully elucidate caring, what caring is, and how it is demonstrated.

Caring consciousness and caring field are newer facets of the caring paradigm that were added later by Watson in the theory's development (Watson, 2008). Watson (2008) defined caring consciousness as the intentionality of the nurse to build and maintain a caring nurse-patient relationship. This concept is particularly important to the demonstration of caring because it recognizes that a caring relationship requires effort. Transpersonal relationships between the nurse and the patient do not accidently nor automatically occur. A true

transpersonal caring relationship requires preparedness, thought, and an intentional desire to form the caring bond. The caring field denotes the quantum energy generated by intentional caring which melds the mind-body-spirit with the universe (Watson, 2002). As the THC continues to evolve, new concepts and subjective ideas, known as constructs, expand the ability of the theory to further address more aspects of caring nursing practice while adding to the knowledge of the discipline.

Several terms included in the THC originate from the value Watson (2008) placed on the development of a distinct language for the discipline of nursing. In the post-modern era, Watson (2008) believed that language could decrease the dependency of nursing knowledge on other disciplines and form a true nurse/nursing paradigm in place of the contemporary nurse/medicine stance. These words not only reflect the concepts of the THC in a linguistic manner but also communicate the core essence of the theory while encouraging others to systematically advance the caring in nursing. Additionally, by using these expressions nurses become conscious of the phenomena of caring within their own practice. Transpersonal relationship, caring moment, and caring occasion are central terms developed by Watson to encourage nurses to recognize, communicate, frame, and value their caring practice (Watson, 1997).

Watson's (2008) THC continues to be used to support and drive numerous research projects. However, despite the impact of THC on the discipline of nursing, there are still aspects of the theory that have drawn criticism. Interestingly, Im (2015) noted that over the last few years there has been a paucity of articles related to the topic of theory evaluation in nursing. Yet, since the publication of Watson's THC a few authors have offered their critique regarding the practicality and precision of the theory (Cohen, 1991; Philips, 1993; Sourial, 1996, & Jesse,

2010). The main limitations of the theory noted by these authors revolves around the ambiguity of the key concepts. By not differentiating between generic and professional caring, Cohen (1991) identified a lack of focus needed for a discipline specific theory. Philips (1993), perhaps with the harshest criticism, argued that a caring focus in nursing erroneously causes the concept to be overvalued. Jesse (2010) and Sourial (1996) focused the attention of their evaluation on the lengthy phrases and ambiguous definitions used by Watson. For Philips (1993) the number of caritas factors and processes delineated in the THC elicited concerns regarding the feasibility of applying them in a systematic and measurable manner. Although reasonable concerns have been raised by these authors, the THC's holistic approach remain attractive to nurse researchers.

The comprehensive nature of the THC allows the theory to be concrete as well as abstract and ethereal. Furthermore, the concepts and constructs of the THC have framed studies in the humanities, caring ethics, and critical scholarship. Smith (2004) performed a literature review of research published between 1988 and 2003 that focused on the application of Watson's (2008) THC. At that time, Smith (2004) identified the nature of caring, nurse caring behaviors, patients' perceptions of caring, and caring in nursing education as the major areas of exploration. Numerous researchers continue to utilize Watson's THC to frame studies regarding caring (Özkan, Okumuş, Buldukoğlu, & Watson, 2013; Brewer & Watson, 2015: Karlou, 2015; & Mikkonen, 2015). Recently, during an evaluation of published literature between 2015 and 2017 where the authors utilized the THC, 21 empirical research reports, excluding dissertation and thesis work, revealed three additional themes of interest: (a) education of new nurses related to compassion and caring, (b) patient satisfaction and nurse caring, (c) nurse administrator/leader

role in fostering caring behaviors of nurses. The geographical diversity of published data reinforces the global interest related to caring in nursing.

Theory of Human Caring and the Nurse Executive

Research focused on the concept of caring within the nurse administrator/executive role started to gain momentum during the 1990's. Several researchers began to explore the evolving role of the nurse executive seeking to understand how their training, development, and mentorship (Redman, 1995; Holloran, 1993; & Dunham, Taylor, Fisher, & Kinion, 1993). More recently, though caring research related to the nurse executive remains scant, Nyberg (2010) and Somerville (2016) have focused their research efforts on how nurse executives pursue instilling caring behaviors into the everyday practice of the staff and the organizational structure.

The THC is relevant to this study for three main reasons. First, THC recognizes the importance of the human relationship that underpins the process of caring, known as the transpersonal caring relationship. Second, the concept of transpersonal caring moments during which the individuals enter a reality of lived knowledge, provides a foundation for exploring the lived experience of individuals involved in the caring/caritas process. Third, the assumptions of the THC encourage the use of methods and techniques to improve caring skills. In particular, Watson suggests cultivating daily practices of self-care for the clinician including centering, meditation, yoga, prayer, and other forms of daily contemplation (Watson, 2008). Using Watson's theory, the information regarding self-care practices shared by the nurse executives/leaders can be assessed for potential similarities and differences between their lived experience and the THC theoretical assumptions regarding enhancement of caring behaviors.

Watson's desire to conceptualize caring through an explanatory theory stemmed from her observation of the marginalization of loving care as economic concerns began to take precedent (1997). Nurses in executive positions within organizations are at acute risk for deprioritizing compassion and caring toward others, particularly staff. Though the concepts of compassion and caring interconnect, both are key components of the generation of caring nursing practice. The participants in this study were encouraged to provide information regarding their lived experience of seeking to manifest compassion through caring behaviors in the face of competing responsibilities.

Compassion

The concept of compassion continues to garner a great deal of attention from researchers due to the lack of a comprehensive and practical agreed upon definition. The interchangeability of the term compassion with others such as sympathy, empathy, and caring, continues to plague those who wish to better understand the associations and distinction of these concepts. Compassion researchers, however, agree that the growing dissatisfaction of patients regarding the level of compassionate care they receive demands further exploration of the topic within the discipline of nursing. Schofield (2016) performed a concept analysis of compassion to expand the understanding of the phenomena within the domain of nursing. This analysis formed the foundation related to compassion in this study.

Individual theorists focused on compassion have developed their own definition of compassion to evaluate how to identify and measure the phenomena (Chambers & Ryder, 2016; Mitchie, 2012, & Gilbert, 2010). The common theme identified between these overlapping compassion definitions relates to the basic form of the concept. Researchers agree that

compassion at its core is an emotion (Chambers & Ryder, 2016; Gilbert, 2010). This key factor differentiates compassion, which is emotional, from caring which requires physical action. In this manner, compassion is viewed as one of the antecedents to the activity of caring. Therefore, compassion is the essence of caring, compels action, and supports Watson's (2017) tenet that caring is an intentional act.

A concept analysis often offers insights to a phenomenon by synthesizing the information reported by independent researchers into a further organized system of thought. Schofield (2016) found four main pillars of compassion that are relevant to the discipline of nursing. The first is the plethora of terms associated with compassion (Schofield, 2016). Kindness, empathy, sympathy, listening, responsibility are examples of words often used with and to represent compassion (Van der Cingel, 2009; Gilbert, 2010; Schantz, 2007). Second, is recognition that some terms are used interchangeably with compassion (Schofield, 2016). Caring, empathy, and sympathy are not just associated with the concept of compassion but in some cases are used to imply compassion (Schofield, 2016). Third, compassion is the link between identification and recognition of suffering and vulnerability and action. Through this pillar, the concept of compassion is distinctly identified as an understanding and emotion that moves the individual to caring behaviors. Fourth, compassion and caring share the same nursing ethics and values (Schofield, 2016). Von Dietze and Orb (200) specifically stated that compassion combined with caring supports nursing ethics and adds moral value. Together these pillars go beyond definition and address the complexity associated of the concept of compassion.

Schofiled (2016) included in this concept analysis of compassion an exploration of the required antecedents and conditions that support compassion. Leaders in this area of research

continue to debate the intrinsic (Schantz, 2007; Johnson, 2007; Ballatt & Campling, 2011) and extrinsic nature (Youngson, 2012) of compassion development for nurses. Researchers previously explored the potential for compassion training for nursing students and staff (Senyuva, Kaya, Isik, Bodur, 2013; Neff & Germer, 2013; Jazaieri et al, 2013) while others argue that compassion is an inherent characteristic of individuals who enter the nursing profession. In either case, researchers agree on three main antecedents associated with compassion, recognition of suffering and illness, self-compassion, and a compassionate work place culture (Schofield, 2016). This is particularly relevant to this study.

Schofield (2016) recognized that the work environment plays a major role in an individual's ability to demonstrate compassion through caring. Crawford et al. (2013) explained that when an organizational structure fails to support caring in favor of efficiency staff might experience threat stress leading to a decreased ability to function in a compassionate manner. This concept insinuates that there are two ways the organizational structure may support compassion. Organizations that value the caring behavior of the staff and demonstrate caring for the staff may maximize the staff's ability to provide optimal quality compassionate care.

Recognizing that a compassionate work environment is necessary for compassionate nursing care, greater attention should be focused building a compassionate organizational culture. This concept is particularly relevant for this study. Nurse executives are positioned within the organization to advocate for an organizational structure that supports compassion while modeling compassion in their own practice.

Review of the Literature

Nurse executives play a vital role in directing the inner machinations of healthcare organizations and fostering a culture that promotes quality patient care and positive outcomes for patients, families, staff and organization. The following literature review provides insights into the role of compassion and caring in nursing and nurse leadership and the consequences of implementing compassionate caring behaviors in all areas/roles of nursing practice. The literature also establishes a background, consistent with the scope of this study, to explore the lived experience of nurse executives seeking to provide a caring environment. Specifically, the review furnishes information on the consensus and controversy surrounding the importance of caring behaviors in the nurse executive role and techniques used to build and manifest compassion

Caring in Nursing

The roots of professional nursing run deep with the concept of caring providing the fundamental construct of the discipline. Florence Nightingale, recognized as the founder of modern nursing, argued as early as 1860 for the incorporation of formal training, compassion, commitment to patient care, and social reform as essential for the establishment of nursing (Ellis, 2008). Additionally, her vision included the adherence of nurses to ethical principles that demonstrate and support caring behaviors. Over the past few decades, several nurse researchers focused on expanding the theoretical foundation of caring by exploring the phenomenon as a set of behaviors, which include skill, attitude, and competence. The theories of Leininger (1988), Ray (2013), Roach (2002) and Watson (2017) are among the most widely accepted frameworks to support research investigating caring in nursing. From 2001 to 2014, hundreds of articles

published regarding caring in nursing reflected the growing interest of researchers to understand and define the attributes that facilitate the application of caring by nurses in numerous settings (Rundquist, Sivonen, & Delmar, 2010; Leyva, Peralta, Tejero, & Santos, 2015). Thematically, researchers agree that caring is a basic tenet of humanism, remains a moral imperative, and requires interpersonal interconnection for execution; yet, there are still facets of caring that remain elusive and unclear. As healthcare becomes more complex and technical, researchers seek to find a unifying definition of caring as nurses labor to maintain caring as the essence of nursing practice (Rhodes, Morris, & Lazenby, 2011).

Caring has variously been described as a state of being, driven by compassion and conscience, where interpersonal relationships preserve human dignity and ameliorate suffering (Andersson, Willman, Sjöström-Strand, & Borglin, 2015). Roach (2002) identified caring as an ontological experience that stems from the heart and includes compassion, competence, and commitment. For Leininger (1988), trust, humility, courage, and understanding, with a focus on cultural diversity, lead to the practice of transcultural caring. This societal component provides a context for understanding how caring behaviors evolve and are valued in communities. Peplau (1988) introduced the idea that the caring relationship between the nurse and the patient is based on communication. Subsequently, Watson (2017), acceded to the compassion dimension of caring while including interpersonal relationship building and intentionality of action to further define caring and caring behaviors. Godsell et al. (2013) additionally recognized that nurses consider caring as an obligation and service provided to patients, families, and peers. These theoretical and philosophical advancements in knowledge related to caring provide the basis for investigation into the practical applications of caring.

Nurse Perceptions of Caring

Societal and technological changes in healthcare continue to challenge nurses in all practice areas to incorporate and maintain caring behaviors. To describe the staff nurses' perceptions of caring, Andersson et al. (2015) performed a qualitative study involving 21 registered nurses. The participants were interviewed regarding how they conceive, conceptualize, and comprehend caring and caring behaviors (Andersson et al., 2015). The results of the study revealed that this population regarded caring as nursing interventions that protect the patient, recognize the patient as a person, and safeguard patients' rights (Andersson et al., 2015). Interestingly, the subjects also identified the environment as a key factor in the facilitation of caring behaviors toward patients (Andersson et al., 2015). The patient centeredness identified by the nurses is consistent with the popular theoretical constructs of caring and provide a transition from the philosophical to the practical demonstration of caring. In another study, Ross, Tod, and Clarke (2015) explored nurses' understanding and practice of patient centered care. The 14 nurses interviewed for the project demonstrated a clear understanding of patient centered care, the importance of relationships, and the value of patient centered care (Ross et al., 2015). Although the participants respected the principles of person-centered care, they reported that person-oriented communication often became task centered when the environment was busy (Ross et al., 2015). This insight reflects that not only do the working conditions of the staff affect their ability to maintain caring, patient-centered behaviors but skill and knowledge are insufficient to overcome environmental barriers to caring.

Patient Perceptions of Caring

Caring and caring moments occur within interpersonal relationships; therefore, a clear understanding of the expectations of all participants is important if alignment is to be achieved and caring interventions successful. Kitson, Marshall, Bassett, and Zeitz (2013) reported that patients expect a trusting and open relationship with their caregivers. This same sentiment was echoed by patient participants in the study conducted by Bramley and Matiti (2014). Additionally, Bramley and Matiti (2014) reported that patients view nurses who give of their time and provide compassionate communication to be caring. Most importantly, subjects stated that they wanted to be seen as a person, not just a patient. These findings are consistent with the theoretical constructs regarding caring as presented by Watson (2017) and Peplau (1988).

The universality of the concept of caring is demonstrated by research reports from countries outside the United States designed to explore how caring is perceived by other cultures. Han et al. (2014) reported the results from a study focused on the perceptions of caring expressed by Chinese children undergoing treatment for leukemia. In this study, communication was deemed an important factor for patients (Han et al., 2014). As children have different communication needs from adults, the content, form, and occasion of the communication was instrumental in ensuring a caring moment from the viewpoint of the child and parents (Han et al., 2014). Campbell, Scott, Madanhir, Nyamukapa, and Gregson (2011) examined the care expectations of patients receiving treatment in Zimbabway for HIV. Subjects who participated in the study reported kindness, understanding, confidentiality and acceptance as the caring behaviors they valued most from care providers (Campbell et al., 2011). The attention of this population on confidentiality and acceptance are not surprising due to the stigma often associated

with an HIV diagnosis. Moreover, these factors represent the underlying desire to be recognized as a person of value and worthy of respect. The findings also demonstrated that both patients and staff recognize that the environment often frustrated caring moments (Campbell et al, 2011). In Iran, Joolaee, Joolaei, Tschudin, Bahrani, and Nikbakh-Nasrabadi (2010) interviewed 16 patients and companions regarding their understanding of caring behaviors. Participants identified patient centered care, compassion, effective communication, and participation in the development of the treatment plan as requirements for caring interactions (Joolaee et al., 2010).

The results from these international studies reinforce the humanistic dimension of caring and compassion. In concert, these findings support the need for caring behaviors to be demonstrated in all interpersonal relationships including those in the hospital work environment. This type of organizational integration of caring may support improved patient experiences and leadership success.

Nurse-Peer Caring

Researchers tend to focus on the caring behaviors exhibited in the nurse-patient relationship; but, caring between nurse peers and with administration also impact the quality of care delivered. Interestingly, the literature related specifically to caring behaviors between nurse peers is conspicuously absent. However, the issue is addressed from the opposite perspective through the evaluation of incivility and bullying. This reverse approach may stem from the tendency for nurses to tolerate non-caring conduct toward themselves (Felblinger, 2008) while more naturally associating caring behaviors with patients. Nevertheless, how nurses and staff treat each other exerts a significant impact on patient outcomes (Felblinger, 2008; Laschinger, 2014).

The incivility, or horizontal hostility, reported by nurses and healthcare workers takes many forms. Felblinger (2008) reported that during stressful situations nurses show a propensity for lashing out at each other through critical statements that can be intimidating. This verbal abuse manifests through actions ranging from constant negative and condescending feedback to a refusal to work collaboratively (Felblinger, 2008). Confronted with intimidation, incivility, and bullying in the work place, nurses are less likely to report errors, clarify medication orders, or seek assistance from others when needed (Felblinger, 2008; Laschinger, 2014). The impact resulting from these non-reporting behaviors negative impacts the quality of care provided to the patient (Felblinger, 2008; Lee, Bernstein, Lee, & Nokes, 2014, & Littlejohn, 2012). According to Laschinger (2014) and Khamisa, Peltzer, and Oldenburg (2013), along with negative patient outcomes, a hostile work environment also leads to nurse absenteeism, lower retention rates, decreased team work, and poor morale. Particularly vulnerable to work place bullying are novice nurses. Berry, Gillespie, Gordon, Gates, and Schafer (2012) reported that 63% of new nurses report personal experiences of abuse.

Due to the multi-factorial nature of work place bullying, that is often entrenched into the culture of the organization, resolution of the problem will require more than a singular intervention. The development and implementation of measures that combat incivility and bullying, such as performance feedback and professional development, demonstrate an organizational commitment to the provision of a positive work environment (Lee et al., 2014). Researchers suggest that educational opportunities for staff designed to focus on enhancing compassion and caring towards other employees could, potentially, help reduce work place incivility (Watson, 2017; Lee et al., 2014). Most importantly, when nurse leaders are modeling

and promoting a caring culture, non-caring behaviors can be more easily identified and eliminated.

Nurse Education Related to Caring

Education is often the intervention of choice to rectify issues in the workplace; however, researchers continue to debate the practicality and efficacy of compassion and caring instruction Nursing students often identify compassion for others as a contributing factor to their selection of nursing as a profession (Adam & Taylor, 2014) which leads some researchers to label this phenomenon as an innate quality that one must possess a prior to be successful (Bray, O'Brien, Kirton, Zubairu, & Christiansen, 2014; Durkin, Gurbutt, & Carson, 2018). Sinclair, McClement, Raffin-Bouchal, Hack, Hagen, McConnell, and Chochinov (2016) argue that education, reflective learning, and experience support and foster the clinical application of inherent compassion and caring necessary for quality nursing care. McSherry et al. (2017), through interviews with adult nursing students, found an interrelationship between personal and professional learned caring which supports the concept of the potential enhancement of caring behaviors through education. With the growing need for nurses who demonstrate compassion and caring to ensure positive patient outcomes, nurse educators continue to grapple with the best method of compassion and caring instruction for students.

Technological advances in health care have changed the landscape regarding the skills and knowledge necessary for nursing practice. Nurse educators are continuously challenged to keep up with these innovations by helping students develop the necessary skills and knowledge to provide quality care while also maintaining the attitude of care and compassion (Adam & Taylor, 2014). Mikkonen, Kyngäs, and Kääriäinen (2015) investigated the impact of nursing

instructors who demonstrate empathy on students' professional growth and strength-based learning. The results of this study demonstrated that students who receive empathy from professors during the educational process achieve better academic results (Mikkonen, 2015). Although further research is needed, the connection between environment, empathy, and success was noted by the students as influential to their clinical practice. As nursing school is the gateway to a lifelong profession of helping others. As such, nurse educators play a pivotal role in preparing new nurses to meet the challenges of the profession and ensuring positive patient outcomes and experiences.

Controversies Regarding Caring in Nursing

The advancement of nursing as a discipline leaves some researchers seeking to position caring as a component of nursing but deny the foundational property of the concept in lieu of competence and technical skill. Additionally, authors, such as Phillips (1993) and Barker (2000) argued that the close association between nursing and caring might impede the advancement of the discipline. Phillips (1993) asserted that the close association of nursing and caring was misguided and erroneously promulgated the importance of emotional caring for the discipline. Barker (2000) contended that, while the virtue of caring has a place in nursing, the relationship between the nurse and the patient should be the foundational attribute. This mutual experience leads to an understanding of caring with the patient instead of for or about the patient (Barker, 2000). Furthermore, Barker (2000) contended that, for nurses, caring was more of an attitude and virtue than an action. Rogers (1994) held the belief that without a unique definition of caring for the nursing discipline using it as a defining characteristic is folly. Explicitly, for Rogers (1994),

without a uniquely nursing definition of the phenomenon there can be no nursing science or independent nursing discipline.

A definitive, nursing centric definition of caring continues to be elusive. Watson (2017) and Leininger (1988) sought to elucidate a specific nursing caring with theoretical and philosophical structuring but, to date, caring remains loosely identified with behaviors and attributes that are transferable to other disciplines (Watson, 2017). Furthermore, shortly after Watson (2017) introduced the idea that caring was the essence of nursing, researchers from other healthcare fields claimed caring as a pillar of practice as well, arguing that the application of caring is a humanist quality that is not unique to nursing.

Revolutionary at the time, Watson (1979) placed caring as the cornerstone of nursing practice. Equally important, Watson (1979) espoused interpersonal relationships as the condition within which caring takes place. Although well received overall, some issues have been identified with Watson's (1979) Theory of Human Caring. Namely, the theory does not furnish explicit direction about what to do to achieve authentic caring-healing relationships, caring behaviors are too time consuming to incorporate caritas into practice, and the personal growth emphasis not appealing to everyone.

Caring in Nursing Leadership

The role of the nurse leader is as varied as the settings in which they practice. Consequently, with the advancement of nursing representation at higher levels of healthcare administration, nurse researchers have sought to understand the responsibilities, attributes, and characteristics of the individuals who fill these nurse executive positions (Ray, 1989; Watson, 1985; Nyberg, 1990). Also, of interest to researchers is what type of leadership styles and

behaviors assist nurse leaders to be successful in these jobs (Nyberg, 1990). Educational programs designed to prepare nurses for the profession often include some instruction regarding the accountability of all nurses to lead as an individual contributor, team lead, or manager. However, with the opportunity for nurses to take a more substantial role regarding organizational governance, more extensive training is needed (Watson, 2017). The main responsibility of nurses in any executive administrative role related to caring, as delineated by most researchers, is to articulate the uniqueness and value of caring while modeling caring and compassionate behaviors (Boykin, Schoenhofer, & Valentine, 2013; Watson, 1985; Turkel, 2014).

Role of Nurse Executives

Interest in the nurse executive role regarding caring is not new but the reported research directly related to this population of nurse leaders remains sparse and uneven. Early research in this arena, focused mainly on the responsibility of nurse leaders to substantiate the importance of the caring nurse-patient relationship (Smith, 2013). Subsequently, researchers began to explore, on a limited basis, the impact of nurse executive caring behaviors within the organizational system (Anonson et al., 2014; Prestia, 2016). This pattern of evolution in the approach of researchers exploring caring in nursing leadership is discernable and follows the advancement of nurses into higher levels of corporate healthcare.

Historically, nurses had varying degrees of informal authority but were rarely included as part of the governance leadership (Turner, 1999). As such, early researchers focused their attention regarding nurse leadership on individual nurses and nurse managers seeking to advocate for caring as an essential component of nursing care (Nyberg, 1990; Ray, 1989; Valentine, 1997). This approach highlighted the perceived moral conflict between caring and

economics (Ray, 1989) as well as challenges associated with communicating organizationally the impact of caring on patient outcomes and cost reduction (Valentine, 1997). Similarly, Turkel (2001) explored the economic value of caring nursing practices but included administrators in the study population. The inclusion of the institutional perspective allowed for the revelation that staff nurses and administrators often differ in their perceptions regarding caring behaviors. In this study, nurses involved in direct patient care defined caring as a form of being and knowing that incorporates caring moments on a continuum; however, administrators viewed caring only in terms related to customer satisfaction and business outcomes (Turkel, 2001). These early studies positively position the economic value of caring provided by staff nurses; yet, information regarding the role and impact of compassion and caring behaviors demonstrated by nurse executives remained absent.

The elevation of nurses to higher levels of leadership within the organization demonstrate an appreciation for the strategic, business, and clinical competencies nurse leaders provide. In these executive positions, nurses influence the staff practice environment and culture, optimize productivity, convey the corporate vision, and ensure the delivery of quality patient care (Leach & McFarland, 2014). Additionally, the executive advancement of nurses reflects the value the organization places on engaging the largest group of health care providers within the institution while promoting global health (Read & Laschinger, 2015). Nurse executives provide the caring perspective, inherent in nursing practice, at the governance level for integration into the dominate business model which is critical for the identification of long term solutions to underlying organizational issues including quality patient care and staff retention (Feather, Ebright, & Bakas, 2014; Linette & Sherman, 2014; Watson, 2006). Acknowledgment of the

broadening role of nurse leadership to the corporate level has resulted in a proliferation of research to further elucidate the attributes and characteristics required for the position.

Characteristics and Competencies of Caring Nurse Executives

Successful nurse executives demonstrate behaviors that represent a commitment to quality patient outcomes, staff empowerment, and organizational goal attainment (Ray, 1997; Anonson et al., 2014; Prestia, 2016). From the staff nurse perspective, nurse leaders who maintain a passion for nursing, provide mentorship, and personally connect with staff effectively establish legitimacy and trust which drive results (Anonson et al., 2014). Moving beyond the traditional to embrace collaborative relationships throughout the organization demonstrates the transformational leadership skills necessary for navigating the rapidly changing healthcare environment (Turkel, 2001; Nyberg, 1990; Prestia, 2016). Nurse leaders who are characteristically optimistic, courageous, compassionate, and caring demonstrate the capacity to exhibit these critically important leadership behaviors.

Researchers and professional organizations continue to strive to provide nurse executives with a skills platform to support their transition to the higher corporate level while maintaining their intrinsic caring tradition. Established in 1967, the American Organization of Nurse Executives is committed to advancing global healthcare through innovative nursing leadership (AONE, 2018). The core competencies of the nurse executive identified by the AONE (2015) include communication, knowledge, leadership, professionalism, and business skills. Under communication, AONE (2015) promotes relationships built on trust with all stakeholders, including staff, as key to successful navigating the organizational culture. Unfortunately, references to compassion and caring are patently absent even though Watson (2006; 2017) and

Prestia (2016) stated that compassion and caring are key factors in establishing trusting, transpersonal relationships.

Development of Caring Nurse Executives

The Robert Woods Johnson Foundation (RWJF) is another organization that recognizes the role of the nurse executive in advancing improvements in healthcare (Robert Woods Johnson Foundation, 2018). RWJF initiated an Executive Nurse Fellows program to develop more effective nurse leaders (Robert Woods Johnson Foundation, 2018). In this three-year fellowship, nurse executives take courses focused on leading self, others, organizations, and healthcare. Participants can build support networks during the program and work with mentors who have demonstrated success in the executive role (Robert Woods Johnson Foundation, 2018). The Wharton School of Executive Education offers a nursing leadership program designed to prepare nurses critical skills function as managers and leaders in healthcare policy, advocates, and patient care delivery (Wharton, 2018).

Nursing caring moves beyond general good will to knowledgeable action (Boykin, 2001). Most nurses consider themselves to be compassionate and caring. However, to fully institute a caring practice, particularly for nurse executives, a deliberate commitment to acquiring the necessary caring skills and knowledge is required (Boykin, 2001). Furthermore, Watson (2017) encouraged the use of techniques that enhance the individual's ability to build and maintain a heart-centered approach including mindfulness, yoga, spiritual practices, and reflection among others. Together, training and self-care tactics may provide a foundation for a sustained caring practice (Houck, 2014; Watson, 2017).

Conclusion

The lack of caring and compassion remains a silent problem within healthcare institutions often due to creeping bureaucracy, inadequate education and preparation, and a divergence between the goals of nursing staff and the organization (Ulrich, 2014; Prestia, 2016). Nurses do not cease to be nurses when they move to an administrative/executive role but the stressors they encounter may require different techniques to maintain their caring approach toward others (Cutcliffe & Cleary, 2015). Several nursing theorists have developed frameworks to aid nurse executives build a leadership practice grounded in compassion and caring (Ray, 1997; Hewlett, 2014; Watson, 2017). Additionally, researchers have explored different techniques to support nurses and nurse executives build resilience, compassion, and caring behaviors (Ozawa-de Silva, 2012; Houck, 2014; Koren & Purohit, 2014; Reinert & Koenig, 2013; Watson, 2017). Recognizing that nurse executives consistently face changing demands and priorities; a deeper understanding of the techniques nurse executives identifies as helpful when seeking to manifest compassion as demonstrated by their caring practices toward staff is critically needed.

The purpose of this study was to gain a deeper understanding regarding the experience of nurse executives seeking to manifest compassion through caring behaviors toward staff. Chapter 3 provides information regarding the methodology that was employed to conduct the study. Additionally, information related to how participants were identified and recruited, what information was collected and how the data was collected, organized, and analyzed is included.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to understand the lived experience of nurse executives seeking to manifest compassion through caring behaviors toward staff while balancing competing priorities. Compassion and caring behaviors toward staff are key factors which contribute to overall organizational success. Nurse executives who demonstrate compassion toward staff promote positive patient outcomes (Wong, Cummings, & Ducharme, 2013). However, the successes and challenges experienced by nurse executives attempting to include compassion and caring in their daily practice remain unexplored.

Activities that cultivate and sustain caring behaviors are well-documented and focus on managing the essential understanding of oneself, or ego. The ego of the self is responsible for a person's ability to function in the real world (Freud, 1923/2014). When interactions with others are directed by the ego, people tend to hurt others, resulting in a loss of respect, trust, and an absence of caring behaviors (Freud, 1923/2014). Conversely, when the ego is controlled, through self-awareness, an individual tends to demonstrate more humility, a less judgmental attitude, and caring (Chopra, 1994). Processes designed to manage the self, or ego, are believed to facilitate transcendence from self-centeredness to focusing on the needs of others, which fosters trust and caring (Watson, 2017). These practices include self-reflection, centering, mindfulness, yoga, and prayer (Houck, 2014; Watson, 1997). Watson (2017) identified rituals, such as the practice of gratitude, forgiveness, and compassion, that build self-insight and a better understanding of others as conducive to enhancing one's ability to demonstrate caring behaviors. Watson (2017) also supported activities, such as self-reflection, mindfulness, prayer, gratitude

and forgiveness, as methods to assist nurse executives to successfully implement and maintain caring behaviors toward staff. What is not known is if and how these methods or other ego-controlling techniques are employed by nurse executives to nurture compassion and caring behavior.

In Chapter 3, I present the research design and rationale for the selection. Furthermore, in this chapter, I describe the role of the researcher and the methodology, including a description of the participant population, sampling strategy, and participant selection criteria. This chapter also includes explanations of procedures for participant recruitment and how the data were collected and analyzed. Additionally, potential ethical concerns and measures to meet required ethical standards are addressed.

Research Design and Rationale

The benefits of using the phenomenological approach in qualitative research are numerous. Specifically, the phenomenological design allows for the exploration of the universal nature of the phenomenon, an examination of first-person real-world experiences, and misconceptions related to the phenomenon of interest (Ryan, 2018). The interpretivist phenomenological approach focuses on how an individual in a certain situation, makes sense of a given event and addresses the researchers need for a deeper understanding of the lived experiences. For this study, the interpretivist phenomenological approach supports the exploration and analysis of nurse executives' experiences seeking to manifest compassion and caring toward staff.

Research Question

The research question is:

RQ: What are the lived experiences of nurse executives who seek to manifest compassion for their staff while experiencing and balancing competing priorities?

Research Tradition

The foundation of any research study is the methodology. Quantitative empirical research stemming from the positivist stance focuses on measuring information and performing numerical comparisons but does not allow for scientific investigation of phenomenon with a subjective and experiential nature (Creswell & Poth, 2018). Qualitative research, however, focuses on observations and descriptions interpreted by the researcher and reported as meanings or themes (Creswell & Poth, 2018). According to Creswell and Poth (2018), ethnography, narrative, phenomenological, grounded theory, and case study are approaches within the qualitative domain that effectively address different aspects of the human experience. This study employs the qualitative phenomenological approach.

The qualitative phenomenological approach was selected for this study for three reasons. First, phenomenology allows for the study of phenomenon with a subjective nature, such as caring and compassion. Heidegger (1927/1962), a philosopher known for his contributions to the development of phenomenology, argued that a subjective phenomenon could not be examined apart from an individual's real-world experience. Thus, Heidegger (1927/1962) encouraged the study of experiences to uncover the truth regarding a phenomenon. As such, Heidegger's stance supports the focus of this project to explore the lived experiences of nurse executives and how they manifest compassion. Second, the phenomenological approach incorporates the research participant and the situation during the investigation of the phenomenon. This holistic approach makes phenomenological research particularly attractive to

nurse researchers, as a more comprehensive understanding of the phenomenon is achievable and the goal of this study. Third, the qualitative phenomenological approach allows for new knowledge regarding the phenomenon of interest to emerge through both the details of the experience and the interpretation of the experience from both the individual's perspective and the interpretation of the researcher.

Phenomenology functions as both a philosophy and methodology. Philosophically, phenomenology is underpinned by the post-positivist view which maintains that, even though knowledge is based on incomplete information, focusing on the judgments, consciousness, perceptions, and emotions as experienced by the study participant through the physical world supports the scientific goal of reaching an understanding of reality (Creswell & Poth, 2018). According to Heidegger (1927/1962) humans experience life within the world, so an interpretation of the lived experience is more important to understanding a phenomenon than a description of the phenomenon (Heidegger, 1927/1962).

Heidegger's hermeneutical approach was used for this study due to fully explore not only nurse executives' experience with manifestations of compassion but also when, where, and how the phenomenon occurs. The hermeneutical interpretive design is more often used to understand a phenomenon within the setting, including, location, culture, gender, and employment, of the individuals experiencing the phenomenon (van Manen, 1990). For this study, examination of the setting and incident in which nurse executives attempts to manifest compassion and caring provided crucial information regarding how competing priorities influence the manifestation of compassion by nurse executives.

The interpretive phenomenological analysis (IPA) provides a process that melds the philosophical attributes of hermeneutics with a step by step procedure for analyzing collected data (Pietkiewicz & Smith, 2014) The IPA process encourages the researcher, using the phenomenological interpretive approach, to closely examine the detailed cases from each participant, including the context of the incidents then moving to the identification of similarities across cases. For this study, the IPA approach was utilized to perform a detailed examination of the lived experiences of nurse executives and the identification of themes associated with the manifestation of compassion and caring toward staff.

Role of the Researcher

The role of the researcher in qualitative studies is unique. Qualitative researchers are responsible for the design and execution of the study, similar to quantitative researchers. However, quantitative researchers utilize tools and instruments to collect the data while in qualitative research, the researcher functions as the instrument. Creswell and Poth (2018) state that even though an interview protocol and documents may be used, the role of the qualitative researcher is to identify and collect topic specific data for analysis. Additionally, the researcher must maintain an unbiased stance regarding the information collected. In this study, the role of the researcher was observer.

I have functioned in a nursing leadership/executive role for over fifteen years within the hospital and pharmaceutical industries. In these various leadership roles, I have been responsible for leading nurses, pharmacists, and physicians in clinical research and educational activities. Although my current role is as an executive director in a pharmaceutical company leading teams and a member of the American Organization of Nurse Executives, this was not a backyard study.

I was not associated with the participants on a professional or personal level except for infrequent professional interactions.

My professional experience regarding the challenges of leadership and balancing the needs of the organization with the responsibilities of caring for employees encouraged me to gain a better understanding of the lived experiences of nurse executives in all settings including hospitals, clinics, academia, and industry. I documented each step of the research process to control and expose any personal biases due to previous experiences. Additionally, each participant was informed that I would respond to requests for clarification of interview questions but I did not respond to questions regarding my personal expertise or experiences related to compassion or caring leadership. In tandem, a well-defined interview process was followed for continuity and to avoid any researcher bias emerging due to unavoidable personal or professional commonalities with the participants.

Methodology

The qualitative research method, in contrast to the quantitative approach, uses scientific observations to gather subjective data. This research method is particularly useful when exploring the meanings and interpretations of a phenomenon or event. The qualitative phenomenological approach as employed for this study and was the most appropriate research design to provide a path to a deeper understanding of the participant's experience.

Participant Selection Logic

A purposive sample of individuals who have functioned in the nurse executive role, such as Chief Nursing Officer (CNO), Chief Nursing Executive (CNE), Director of Nursing (DON), or Director of Academics, within a hospital, clinic, or university for at least 3 years, practiced

nursing for at least 5 years, and are interested in demonstrating compassion and caring behaviors toward staff was studied. All participants were older than 20 years of age at the time of the study and practicing within the US. The participants were recruited from the membership of the American Organization of Nurse Executives (AONE) and through recommendations from leaders of AONE. The membership criteria set forth by the AONE (2018) functioned as an additional measure to ensure appropriate candidates are identified for this study. The purposive sampling technique is commonly used in qualitative phenomenological research to ensure that all participants have experienced the phenomenon of interest and are able to share detailed information regarding their experience.

A sample size of 12 participants was anticipated for recruitment to explore the essence of the phenomenon of the lived experience of nurse executives seeking to manifest compassion. This sample size was determined based on similar previous studies which reported 7 to 11 participants (Gunawan, Aungsuroch, & Nazliansyah, 2018; Pare, Petersen, & Sharp, 2017; Powers, Herron, Sheeler, & Sain, 2018). Recruitment continued until empirical saturation was reached.

The AONE (2018) process for a researcher accessing their membership for recruitment purposes involves their review of the researcher's application and study design. Once AONE provides approval of the research request, the researcher is required to pay a fee to the organization for access to full membership contact information (AONE, 2018). AONE provided the contact information through a copy of the membership roster. AONE did not promote, coerce, or influence member participation in research projects beyond generically encouraging

constituents to recognize the importance of all research. The recruitment process began following the proposal and IRB approval of Walden University and AONE.

The potential participants taken from the AONE membership roster first received a letter listing a phone number and email address to request further information. The letter contained the inclusion and exclusion criteria, method of data collection and analysis as well as information regarding confidentiality and the publication plan. Once the individual responded regarding their willingness to participate, the potential participant received an email with a link to the SurveyMonkey website, which was coded to connect the link with their contact information. The first page of the SurveyMonkey site reflected all informed consent information for the study. Additionally, a statement was included to alert the potential participant that accessing page 2, where they will provide demographic information, constituted their consent to participate in the study. The electronic signature provided by the participants conformed to the requirements of Walden University, as the signer was the sender of the email and verified by originating from a private link on the SurveyMonkey website. Following the interview, participants were asked if they were willing to meet for a second interview to review the collected data and clarify any information. Only those who agreed were contracted for additional follow up and debrief.

Instrumentation

Open-ended, non-leading, neutral questions were used to explore what the nurse executives experience and how they experience it. Additionally, the interview process sought to uncover what barriers the participants have faced when seeking to manifest compassion. A list of questions, found in Appendix C, and interview process guidelines were used to facilitate the execution of the interviews.

Procedures for Recruitment, Participation, and Data Collection

The following procedure outlines the process for recruitment, data collection, data analysis, and validation following Walden IRB approval. Once the IRB approval letter is received, a request to purchase the AONE (2018) membership mailing list will be submitted to AONE (2018). An email/letter will be sent to AONE members with information regarding participation (see Appendix A). A follow up email will be sent to volunteers until 15 participants agree to participate. Fifteen individuals will be recruited initially to allow for attrition. If more than 15 eligible individuals volunteer for participation, additional subjects will be notified that I have achieved the number of participants needed to retrieve the information and have reached empirical saturation. Additionally, the first recruitment email stated that "recruitment will continue until I have received the number of participants needed to answer the research question". If less than 12 eligible individuals volunteer for participation, additional subjects will be recruited through recommendations from accrued subjects. Consent forms will be collected from all eligible subjects electronically. After receiving demographic data through the SurveyMonkey website, interviews will be scheduled at a convenient time and location for both the participant and researcher within two weeks of documented informed consent (see Appendix B). Interviews will be conducted in accordance with the interview protocol (see Appendix C). Following the interview, participants will be asked if they would be willing to participate in a second interview, provide additional information, and review notes and transcripts to ensure accuracy. Following the interview, notes will be shared with each participant to ensure accuracy. A 1-2-page document that summarizes the findings from the study will be disseminated to all participants. Second interviews will be scheduled with

participants who confirmed willingness to provide clarifications regarding the information they shared when necessary.

Data Collection

Data collection within qualitative phenomenological research includes techniques including observations, interviews, and journals. The use of open-ended, less structured interview questions encourages the study subjects to share more details and maximizes the depth of information collected regarding their experience. Data was collected using a two-phase approach that included self-report and semi-structured interviews.

Demographic information was collected through self-identification during phase one. Subject information for collection included age, length of time in nursing, length of time in executive leadership position, highest level of education, highest level of nursing education, and current title. Setting information for collection covered practice environment and number of employees.

In-depth semi-structured interviews were used to collect data in phase 2. During the interview process, information regarding individual lived experiences related to the manifestation of compassion and caring behaviors toward staff was collected. Information regarding circumstances, discussions, and examples was documented. Concurrently, participants were asked to provide information regarding methods they employed to build and sustain a compassionate and caring approach toward staff if any. Data concerning issues and barriers to manifesting compassion experienced by the participant was recorded. The length of the interviews was 90 – 120 minutes. Data saturation was achieved when enough data to answer the

research question had been collected, the same themes are recurring, and no new insights were given by the participants (Fusch & Ness, 2015)

Data Analysis Plan

The data collected for this study came from interviews, notes, and observations. The interviews where be recorded using a digital audio recorder then transcribed into a written format. Although using recording devices is very common in qualitative research, they are more than observation instruments. According to Nordstrom (2015), recording devices define boundaries as well as influence the setting, subject, and researcher. Therefore, these devices became a part of the interview and provide a richness that was captured through an intensive review process. I maximized the benefits afforded by these tools by performing the transcription of the recorded material personally. Self-transcription allowed for reflection on the emotional and cultural components while identifying meaningful data related to the phenomenon (Nordstrom, 2015).

The goal of the interpretive/hermeneutical phenomenological approach is to capture both the descriptions and meanings of the events as related by the participant (van Manen, 2014). Furthermore, the data analysis process requires differentiating the phenomenon from the experience to reveal the meaning (van Manen, 2014). Theme identification requires recognition of duplicative phrases and terms; however, this process should also reveal relevant data that illuminate the phenomenon (van Manen, 2014).

By combining empathetic and questioning hermeneutics, IPA sheds light on how the participant seeks to make sense of the world and the link between personal experience and extant literature (Smith & Osborn, 2004). I used the IPA technique with the NVivo software program

to organize the data transcribed from the interviews, highlight recurrent phrases, and develop themes. Following the IPA process steps, themes were identified, connected, and then clustered to provide the basis for the development of superordinate themes (Smith & Osborn, 2004). Concurrently, I searched the data for salient data points to further build meaning and understanding. Discrepant or negative cases that contradict emerging patterns were identified and noted. The analysis of the data continued until a majority of the cases and the deviant cases were explained.

Issues of Trustworthiness

Quantitative researches focus on demonstrating the reliability and validity of the tools they use to collect data to substantiate their findings (Creswell & Creswell, 2017). However, for qualitative researcher, establishing trustworthiness provides the framework to demonstrate the integrity of the findings (Creswell & Poth, 2018). The four main pillars of the trustworthiness framework are credibility, dependability, transferability and confirmability. Cope (2014) also advocated for the inclusion of authenticity as an additional facet of qualitative research to enhance the reliability of results. Yin (2016) suggested that the design of a qualitative study should support trustworthiness and encouraged researchers to incorporate these concepts from the beginning of the project. In accordance with these recommendations, specific techniques were employed during this study to accurately address these five areas of trustworthiness.

Phenomenological studies focus on real world experiences and depend on the participants to relate these occurrences truthfully. In turn, the participants have a reasonable expectation that the representation and interpretation of their experiences are accurate (Cope, 2014). Credibility denotes that reports from participants of the study are believable and align with the accounts

from others who have experienced similar events (Creswell & Creswell, 2017). In this study, I addressed credibility through engagement with the participants and allowing them to review the transcripts of their interviews, comparing interviews for conflicting information and findings, and providing detailed descriptions of observations, and audit documents (Cope, 2014).

Dependability is a key factor in demonstrating the trustworthiness of the interpretation and results in a qualitative study. The quantitative researcher uses instruments and tools to demonstrate a constancy of data collection. Conversely, in qualitative research, the researcher is the instrument; therefore, a method to ensure consistency of data analysis in similar conditions are needed. In this case, experienced researchers, through the Walden University process reviewed the research procedures and processes in the study design. Miles, Huberman, and Saldana (2014) proposed using a clear research question and collecting data that appropriately aligns with the phenomenon of interest. Interviews, documents, and observations are standard methods for collecting information in phenomenological studies and were used in this study.

Generalizability, commonly associated with quantitative data, is reconceptualized in qualitative research as transferability. The criterion for transferability relates to the applicability of qualitative results from one study to other settings and populations (Houghton, Caey, Shaw, & Murphy, 2013; Polit & Beck, 2010). I included in the results of this project a clear delineation of demographic data regarding the subject population and setting in which the phenomenon occurred. This information was included to allow others to evaluate the relevance of these findings to other populations.

According to Heidegger (1927/1962), in phenomenological research, the researcher is not able to completely remove their biases and viewpoints from the execution of the study. Yet, to

demonstrate confirmability, a method should be employed to account for these potentially confounding factors. Bracketing (Moutakas, 1994; van Manen, 1990), bridling (Vagle, 2014), and epoche (Creswell & Poth, 2018) are methods to separate the researcher from the phenomenon investigation. However, I provided information regarding the process of data collection and linked my conclusions with the data by providing rich quotes from the participants to demonstrate confirmability. I documented the consideration of other possible conclusions with full explanations regarding the selected theme and interpretation.

Authenticity denotes the accuracy with which the research relates the participants perceptions related to the phenomenon of interest (Cope, 2014). This includes both verbal and non-verbal communication demonstrated by the subjects. I transcribed interviews, notes regarding observations, and audio recordings to develop thorough descriptions of the collected data. I reviewed with the participants these descriptions to ensure that the information has been collected in a faithful manner (Polit & Beck, 2012). Any changes to the collected data were made in collaboration with the subject.

Informed Consent and Ethical Protection of Participants

The participants for this study were recruited following review and approval by the Walden University IRB of the study. I provided participants an informed consent document for their review and signature prior to the initiation of any data collection. All actual and potential risks and benefits to participation in the study were clearly delineated in the informed consent form. There were no foreseeable risks associated with participation in this study. Based on the nature and scope of the information that was collected for this study, no information regarding criminal activity or child/elder abuse was disclosed. Additionally, participants did not

experience any psychological symptoms beyond normal fatigue. No acute psychological symptoms necessitating a referral were exhibited. Each participant was informed that their participation was completely voluntary and that they could remove consent at any time. Participants were allowed to stop the interview for any reason. The face-to-face interviews were performed in a private location, e.g. participants personal office, a private conference room within their institution, a private room at a close by hotel, or a conference room at a public library, selected by the participant.

Confidentiality was maintained for participants by removing all identifiable information from interview notes, audio recordings, and transcriptions. All electronic documents were maintained in secure, password-protected files on my personal computer while non-electronic data was secured within a locked file cabinet in my home. Additionally, data was reported in aggregate form and all supporting quotes identified by pseudonyms/numbers.

For all SurveyMonkey responses, no contact information, institution, or company was named within the analysis or discussion. Only geographic location, type of business or healthcare setting, and number of employees was used for stratification. Demographic information was reported in terms of average age of participant, average number of years in nursing, average number of years in executive leadership, and number of employees supervised. Email addresses used to send the link to the SurveyMonkey survey were cross-referenced only to denote that the survey was completed, was only completed once, and that the consent form was signed by the participant.

SurveyMonkey services retained data collected only for my use in my account. SurveyMonkey did not otherwise retain the data, any rights to the data, or the identity of the

participants. I remain responsible for controlling the time period that the data is retained and for deleting the data. SurveyMonkey will not use email address for their own purposes.

Summary

The research design for this study was qualitative using the phenomenological approach to allow the participants to describe their lived experience of nurse executives regarding the manifestation of compassion. The phenomenological technique allowed for an in-depth examination of the real-world experiences of nurse executives related to compassion and caring behaviors. The role of the researcher was to identify and collect topic specific data related to the research question for analysis. Although I have experience as a nurse executive, my role as the researcher was limited to observer. The population for this study consisted of nurse executives with at least 5 years of nursing and 3 years of nurse executive experience. The participant population was recruited from the AONE membership using a purposeful sampling technique. Data was collected through SurveyMonkey or demographic data and in-depth interviews following the interview protocol for data related to real-world experiences. NVivo computer software was used to organize the transcribed interview data and assist with identification of themes related to the phenomenon. Additionally, the data were analyzed using the IPA technique to explore the meaning the lived experiences hold for the participants. The data collected during the course of this study was reported in aggregate and specific quotes from the interview transcripts were reported using a pseudonym/number to protect the confidentiality of each individual. All participants provided informed consent. In Chapter 4, the results of the data analysis are reported.

Chapter 4: Results

Introduction

Compassion and caring behaviors exhibited by nurses toward patients are critical components of direct nursing care; however, the function of caring in the daily practice of nurse executives remains an enigma. The purpose of this qualitative phenomenological study was to examine the lived experiences of nurse executives who seek to manifest compassion for their staff while balancing competing priorities. The phenomenological approach was selected to investigate and discover the core meaning of the individual's experience. Moreover, the application of the hermeneutical phenomenological focus provided the purpose to illuminate the core state of being as it relates to the lived experience of nurse executives demonstrating compassion and caring behaviors.

The research question for this study was:

RQ: What are the lived experiences of nurse executives who seek to manifest compassion for their staff while experiencing and balancing competing priorities?

Follow-up questions were included to further explore feelings, thoughts, and concerns of participants that related to the responses.

In this chapter, the purpose of the study, research questions, and setting are presented. Additionally, the demographics of the participants, data collection process, and data analysis are discussed. This chapter also includes evidence of trustworthiness, study results, and a summary.

Setting

Healthcare organizations remain volatile and fragile due to personnel, budget, and regulatory issues and restrictions (Clancy, 2015). All nurses who hold executive and leadership

positions within the healthcare system face these issues and challenges daily. Study participants in my study cautiously avoided naming other individuals involved in their responses to avoid repercussions. Additionally, each participant related behavioral examples of their experiences openly after reconfirming the confidentiality of their participation and responses. Following affirmation that the results of the study would be reported in aggregate form, participants provided detailed accounts of their experiences functioning within their individual organizations.

In general, the study was executed as proposed; however, there were some alterations due to unforeseen circumstances. The design of this study included a purposive method of sampling for the recruitment of 12 nurse executives who have knowledge and experience in managerial responsibility as well as strategic corporate responsibilities. However, ultimately, 10 nurse executives that met the inclusion criteria were accepted into the study as at this point no new information or findings were being provided by the participants. After obtaining the approval of the Walden University IRB (#10-05-18-0152291; see Appendix E), I procured the membership mailing list from the AONE to expedite the identification of an appropriate participant pool. Written letters were mailed to a first group of 80 potential participants, instead of an initial email, due to the AONE only providing postal mailing addresses. A follow-up email was subsequently sent in response to requests for further information about the study (see Appendix D). Eligibility for inclusion was determined through personal communication with each volunteer. A review of their professional online profile was also performed to confirm that they met the criteria for participation. Following verification of eligibility, an email was sent to each participant with the informed consent form. All other recruitment procedures were followed as predetermined in the study design.

Demographics

Ten nurse executives (n = 10) who met the criteria for participation and signed the informed consent form were selected for the study. Each participant signed the informed consent and completed a demographic questionnaire through SurveyMonkey. The questionnaire provided data on age, gender, race, education, and professional experience. Additionally, basic information regarding the organization where the participant is currently employed was also collected.

The participants ranged in age from 43 to 63 years (see Table 1). All participants were over the age of 20 as mandated by the inclusion criteria for the study. Of the 10 nurse executives who participated in the study, two (20%) were men, and eight (80%) were women (see Table 2). This greater population of women is reflective of the nursing profession, which continues to be dominated by women. All 10 (100%) participants were White/Caucasian (see Table 3).

Table 1

Participants' Demographic Information - Age

Variable	Frequency	Percentage
Age		
43	1	10.0
47	1	10.0
49	1	10.0
50	1	10.0
52	1	10.0
55	1	10.0
61	1	10.0
62	1	10.0
63	2	20.0

Table 2

Participants' Demographic Information - Sex

Variable		Frequency	Percentage
Sex			
	Male	2	20.0
	Female	8	80.0

Table 3

Participants' Demographic Information - Race

Variable		Frequency	Percentage
Race			
	American Indian or Alaskan Native	0	0
	Asian	0	0
	Black/African	0	0
	White	10	100.0
	Other	0	0

Six of the participants (60%) hold a doctorate as their highest level of education, while four (40%) obtained a Master's degree (see Table 4). Also, of note, the nurse executives who hold a doctorate reported their degree is in the discipline of nursing. However, of the individuals whose highest level of education is a Master's degree, two (20%) report holding a degree from another discipline. Eligibility to participate in the study was based, in part, on the number of years in nursing ($\geq$ 5 years) and number of years in an executive leadership role ($\geq$ 3 years). The demographic data collected demonstrated that all participants actually have spent more than 19 years in nursing and greater than 5 years in a nurse executive role.

Table 4

Participants' Demographic Information – Highest Education

Variable	Frequency	Percentage
Highest level of education		
Associate's Degree	0	0
Bachelor's	0	0
Master's	4	40.0
Doctorate	6	60.0
Post-Doctorate	0	0
Highest level of education in nursing		
	0	0
Associate's Degree	2	20.0
Bachelor's	2	20.0
Master's	6	60.0
Doctorate	0	0
Post-Doctorate		

The number of years in nursing practice and number of years in leadership role was significant for this study to ensure that participants would have the experience and knowledge to provide information relevant to the research question (see Table 5). Specifically, the amount of time spent in an executive role reflected the participants' ability to provide more in-depth information regarding the challenges associated with setting and achieving corporate goals. Furthermore, tenure as a nurse executive allowed the participants to provide diverse examples of the phenomenon under investigation. Additional information was collected regarding job title and the responsibilities associated with that position (see Table 6), as well as the number of employees they directly manage (see Table 7).

Table 5

Participants' Demographic Information – Professional Experience

Variable	Frequency	Percentage
Number of years in nursing practice		
19	1	10.0
23	1	10.0
27	1	10.0
28	1	10.0
30	1	10.0
33	1	10.0
34	1	10.0
39	1	10.0
40	1	10.0
41	1	10.0
Number of years in nurse executive/leadership role		
5	2	20.0
9	1	10.0
10	1	10.0
16	1	10.0
17	1	10.0
21	1	10.0
26	1	10.0
30	1	10.0
32	1	10.0

Table 6

Participants' Demographic Information – Executive Title and Role

Variable	Frequency	Percentage
Current role/ job title		
Chief Nurse Officer (CNO)	5	50.0
Associate Dean Academic Affairs	1	10.0
Division Chief Nurse Executive	1	10.0
Chief Nurse Executive	1	10.0
Chief Nurse-Mental Health	1	10.0
VP Chief Nurse Officer	1	10.0

(Table continues)

Variable	Frequency	Percentage
Major role responsibilities		
Administrative	9	90.0
Direct report management	0	0
Business Development	0	0
Operations	1	10.0

Table 7

Participants' Demographic Information – Direct Reports

Variable	Frequency	Percentage
Number of individuals that you directly assign work to and manage performance		
6	1	10.0
7	1	10.0
9	2	20.0
10	2	20.0
12	1	10.0
13	1	10.0
14	1	10.0
17	1	10.0
Number of staff which you do not directly manage but are accountable for their performance		
81	1	10.0
100	1	10.0
300	1	10.0
400	1	10.0
980	1	10.0
1200	2	20.0
2500	1	10.0
4000	1	10.0
4500	1	10.0

The nurse executive role is found in numerous settings. For this study, the participants' work organizations represented five (50%) hospital-community, one (10%) hospital-academic, one (10%) university, and three (30%) other including the government veteran's administration (VA). Various types of hospital and academic environments were included in the study to gain

insights regarding the context within which the nurse executive functions. Further information regarding the organizational settings of the participants is displayed in Table 8.

Table 8

Organization Demographic Information

Variable		Frequency	Percentage
Organization type			
	Hospital-Academic	1	10.0
	Hospital-Community	5	50.0
	Clinic	0	0
	University	1	10.0
	Other	3	30.0
Size of organization			
	≤100	0	0
	101-250	1	10.0
	251-500	4	40.0
	501-1000	2	20.0
	≥1000	3	30.0
Organization structure			
	Non-profit	8	80.0
	For profit	2	20.0

Data Collection

The data collection process began with a letter of invitation which provided a contact number and email for those who might be interested in participating in the study (see Appendix A). For each volunteer who responded, eligibility to participant in the study was established through personal communication and review of their professional online profile. Subsequently, an email was sent to the eligible volunteer to reiterate the necessary qualifications for inclusion in the study along with a copy of the informed consent form (see Appendix D). The same email detailed how the study would be conducted, time commitment of participants, and the utilization of SurveyMonkey to capture part of the information to be used in the study.

The collection of informed consent and demographic data was performed through SurveyMonkey. An email was generated and sent by SurveyMonkey to the potential participant which contained a link to the informed consent and survey along with the password to access the document. For two of the participants, their institutions web exchange blocked emails coming from SurveyMonkey. One participant who could not receive the email, chose to have an email generated from a personal email account sent and one opted to complete a hard copy of the consent and demographic survey. SurveyMonkey tracked completion of the survey by participant email and manual entry; however, the data continued to be private and could not be accessed by SurveyMonkey staff or their automated system. Thirteen individuals responded to the invitation to participate in the study and were eligible for inclusion. Ten participants completed the informed consent, demographic survey, and interview portion of the study, 2 potential participants completed only the informed consent and demographic survey, and one did not respond after the first email exchange.

After the study volunteers completed the informed consent and demographic data survey, I contacted each one by email to set up date, time, and location for each interview. I conducted ten interviews over an 8-week period from December 6, 2018 to January 21, 2019. Nine of the interviews were performed in the participants' private office. One participant requested the interview be held in a restaurant close to her home. The restaurant had a private area in the back that was made available for the interview. Each interview was conducted based on the availability and wishes of the participants.

Face-to-face interviews were conducted with each participant using semi-structured open-ended questions. Each interview was completed using the pre-prepared interview protocol

(see Appendix C). An audio recording of all interviews was made using a digital recorder. Documented field notes augmented the interview recordings. Interview audio files were saved to a secure computer drive that is password protected for transcription. All interviews were conducted in English.

The interview began with a quick overview of the purpose of the study and restatement that the participant could stop the interview or withdraw consent at any time. Participants were given the opportunity to ask any questions regarding the study, the demographic data collected, or about the interview process. Additionally, each participant was informed that the interview would be recorded and that any notes taken during the interview were subject to the same confidentiality as delineated in the consent form. Also, each participant was informed that numbers would be assigned to the interview transcripts and any quotations used during the reporting process

The duration of the interview audio-recordings ranged between 58 and 118 minutes long. Interview appointments were scheduled for 90 minutes to align with the data collection plan; however, based on the participants' competing responsibilities some interviews were shorter than expected. Displayed in Table 9 is a listing of the duration of each interview.

Table 9

Duration of Face-to-Face Interview

Participant (*Number*)	**Introduction (Hr:Min:Sec)**	**Length of Interview Audio-recording (Hr:Min:Sec)**	**Total Time (Hr:Min:Sec)**
P1	0:10:00	0:31:11	0:41:11
P2	0:15:00	0:39:58	0:54:58

(Table continues)

Participant (*Number*)	Introduction (Hr:Min:Sec)	Length of Interview Audio-recording (Hr:Min:Sec)	Total Time (Hr:Min:Sec)
P3	0:12:00	1:03:15	1:15:15
P4	0:21:00	1:00:00	1:21:00
P5	0:10:00	0:47:14	0:57:14
P6	0:20:00	0:26:40	0:46:40
P7	0:35:00	1:23:48	1:58:48
P8	0:10:00	0:42:08	0:52:08
P9	0:15:00	0:43:54	0:58:54
P10	0:20:00	0:55:04	1:15:04

All participants responded to all questions contained within the interview protocol. One interview audio-recording file was slightly distorted, but responses could be discerned and were aligned with the written field notes to ensure data accuracy for inclusion in the analysis. At the end of the interview, the interview questions and field notes were reviewed with each participant and they were provided with the option to expand or clarify any responses to the interview questions. No additional comments or edits were received from the participants.

Patterns in the participants' responses began to emerge after the eighth interview. Repetition in the collected data was also noted during the eighth interview including the responses to the probing questions used for clarification. An additional two interviews were completed and, as no new patterns emerged, saturation was deemed to be reached.

Data Analysis

The data analysis process for this study focused on understanding the lived experience of nurse executives' seeking to manifest compassion while balancing competing priorities. The IPA approach was selected due to the utility associated with this process when exploring experiences of major life events or the development of important relationships (Alase, 2017). Additionally, IPA combines an idiographic approach, which seeks to understand the meaning of a phenomena from each individual participant's perspective, with the traditional psychological and interpretive dimensions usually associated with a hermeneutical analysis (Pietkiewicz & Smith, 2014). When applied, IPA provides insight on how individuals in a given context interpret the meaning of a phenomenon. According to Palmer and Murray (2016), researchers who adopt the IPA approach move inductively through the data analysis by generating codes from the data collected regarding the experiential world of the participant. This is in contrast to using pre-existing codes from a theory or previous reports. The process of allowing codes to emerge organically facilitates the identification and development of broader categories and themes.

Qualitative data analysis can be an arduous process for the novice researcher due to the plethora of alternative approaches used to manage and investigate the data. Numerous authors report using different methods for the coding and thematic analysis of qualitative data; however, the majority of popular approaches share three main stages (Ajjawi & Higgs, 2007; Alase, 2017). According to Alase (2017), the first three steps of qualitative data analysis, code breakdown, condensed coding, and categorization, are associated with phenomenological portion of the IPA process. Ajjawi and Higgs (2007) labeled these generic stages as Immersion, Understanding,

and Abstraction. The Illumination and Integration stages were added by Ajjawi and Higgs (2007) to address the hermeneutical portion of the analysis in IPA. The idiopathic portion of the systematic IPA is accomplished during each stage of the process as all individual cases are explored, compared, and contrasted while inductively driving the analysis toward the identification of important themes. Table 10 provides an overview of each stage included in the data analysis and the associated tasks employed for this study.

Table 10

IPA Stages

IPA Stage	Tasks
Immersion	• Transcription of interview audio-recordings • Importation of interview transcripts and field notes into NVivo 12 • Line-by-Line iterative reading of interview transcripts • Preliminary identification of repetitive and common responses to facilitate coding
Understanding	• Identification of participant constructs (Primary) • Coding of data related to participant constructs using NVivo 12
Abstraction	• Identification of researcher constructs (Secondary) • Development of categories, and/or sub-themes
Theme Development	• Identification of relevant themes

Note: Stages of IPA from Ajjawi and Higgs (2017)

During the Immersion stage, I transcribed and edited the audio-recordings generated during the interview while listening to the audiotapes. Once all of the transcripts were prepared, they were imported into NVivo 12 for management of the data. Numbers were assigned to each participant transcript to protect privacy and confidentiality. The numbered transcripts were linked to the consent form and demographic data of each participant and stored on a secure, password protected computer. A node for each participant using their participant number was

programed into NVivo 12. Additionally, each question from the interview plan was identified as a node to facilitate response comparisons.

The word-frequency query feature of NVivo 12 was used first to identify the most frequently used words by respondents during the interview. This process yielded generic words but did not facilitated the manifestation of key concepts from the data. Alternatively, a list of words was generated from the line by line review of the transcripts. This technique provided a list of specific codes, 20 in all (see Table 11) that were then processed through NVivo 12 to explore the similarity and regularity of their use by participants. At this point, primary participant constructs began to take shape as the key words supported the development of codes related to the constructs.

Table 11

Preliminary Specific Codes: Key Words

Advocacy	Decisions	Finances	Prayer
Anger	Education/School	Influence	Respect
Beliefs	Experience	Management	Rounds
Crisis	Faith	Mentor	Structure
Culture	Family	Performance	Transparency

Primary constructs were identified and evaluated during the Understanding Stage of data analysis. Although manual coding was performed on the data related to the primary participant constructs, the NVivo 12 auto coding feature was engaged to perform pattern and descriptive based coding for confirmation and exploration for other potential codes. This exercise of in vivo

coding, which focused on the participants own language, produced constructs that fostered the transition to the Abstraction stage of the IPA process.

The coding procedure in each stage focused on the experience of the participants, their behaviors, and the context of the phenomenon of interest. The identification of secondary constructs included linking key words and ideas to the lived experience of nurse executives seeking to demonstrate compassion and caring toward staff. This alignment of the coding process with the research questions allowed for the emergence of categories and themes supported by the participants own words.

In this study, three main categories of interest regarding the nurse executives experience were explored, the role of the nurse executive, perceptions of nurse executives regarding compassion and caring, and influences identified by the nurse executive that affect their inclusion of compassion and caring in their practice. These categories maintained a central role in the Abstraction phase and were further developed based on emergent themes. Preliminary thematic findings are reported in Table 12.

Table 12

Examples of Preliminary Themes

Original Transcript	**Emerging Themes**
P3: "So then my boss at that point would say, well why don't you come do that, so why don't you go do that? And they were just grooming me, you know, until something opened up."	Attributing role success to previous leadership opportunities

(Table continues)

Original Transcript	Emerging Themes
P1: I knew I had the ability to change things, but I didn't have the ability to change it at some level because I wasn't at the table. I recognize that in order to really do some systematic changes, I needed to be in more of a leadership position along with the title.	Attributing power to advocate for nursing to executive role
P2: think my church involvement is what comes to mind first. Um, I grew up in the church and every year I'm more and more thankful that my parents made me be in church every Sunday morning, Sunday night and Wednesday, that, you know, that foundation, it cannot be substituted	Attributing success to spiritual beliefs
P1: when they're very angry. Okay. When they're very, angry about something that they want and it's a want, not a need, something they want usually in regards to themselves that um, no matter what you try to do, you're just not going to satisfy or, or no matter what action you take, until they have the ability to see things differently.	Recognizing emotional distress of staff as hindrance to positive caring interaction

The nurse executive role category was subdivided into preparation and execution. The category regarding nurse executives' perceptions of compassion and caring was divided by the provider's perceptions and the recipient's perceptions. These subcategories were developed from the nurse executives' statements related to how they interpret their caring behaviors and how they believe the recipients view the compassion and caring they receive. For the third category regarding influences on the nurse executive that either facilitate of impede their ability to demonstrate compassion and caring, the subcategories of internal and external were used to further detect the directional impact of the identified influence.

The identified themes formulated during the Theme Development stage of the data analysis process organically appeared from the intense scrutiny of the texts provided in the interview transcripts and field notes. In Table 13, the categories, themes and sub-themes that emerged from the collected data are presented. The relevancy and importance of these themes were supported by the frequency of discussion such that ≥50% of the participants referenced the topic and the essential nature of the theme exposing the lived experience of the nurse executive.

Table 13

Lived Experience of Nurse Executives: Categories and Themes

Category	**Themes**	**Sub-themes**
Nurse executive role: *Nurse executive role is challenging*	**Theme #1**: Preparing self to meet the challenge	Taking on tasks Taking risks Continuing to learn Being mentored
	Theme #2: Expanding professional sphere of influence	Influencing change Advocating for nursing practice Advocating for patients

(Table continues)

Category	Themes	Sub-themes
NE perceptions of compassion and caring: *Compassion and caring are central to NE role*	**Theme #3:** Expressing compassion through caring behaviors	Selecting applicable caring action Linking caring and performance management Mentoring others
Influences regarding compassion and caring: *Internal and external factors influence ability to express compassion and caring*	**Theme #4:** Striving to balance influences	Depending on personal spiritual beliefs Depending on personal values Learning from past experiences Coping with corporate culture Recognizing intense emotional distress Justifying unpopular decisions

During the analysis, few discrepant cases were noted; however, these unique representations were factored into the analysis by exploring the participant characteristics, behavior, and context related to the participants experience. Specifically, the imperative for formal education to function in the nurse executive role and corporate/financial barriers to demonstrating compassion and caring were the two controversial issues that emerged from the data. While over 50% of the respondents specifically identified formal education as a necessary part of preparing for the nurse executive role, one participant reported that formal education was useful but might not be the best measure for nurse executive role readiness. This discrepancy was accounted for in the development of the related theme by removing the imperative and listing formal education as an enrichment tool for the nurse executives' preparation.

The controversy regarding the role of corporate and/or financial barriers to demonstrating compassion and caring toward staff also provided an opportunity to further explore the experience of the nursing executive. A majority of the participants noted that corporate goals and financial constraints can disrupt their ability to demonstrate the level of compassion and caring that is requested by staff and, therefore, limits the effectiveness of their caring behaviors.

Nurse executives who reported that they have the full support of their executive team and sufficient resources included organizational influence as a positive support to their ability to demonstrate compassion to their staff. Based on this finding, the emerging theme incorporated both experiences by stating that corporate work culture has an impact on the demonstration of caring behaviors but removed any judgement statement regarding a positive or negative impact.

Evidence of Trustworthiness

Validity and reliability are common terms used in quantitative research; however, for the qualitative approach, the term trustworthiness denotes the establishment of the credibility, dependability, transferability, and confirmability of the study findings (Connelly, 2016). This step of demonstrating trustworthiness is critical to exhibit integrity of the findings (Connelly, 2016). Credibility, in particular, is the most important step in providing confidence that the findings of the study are congruent with reality.

For this study, credibility was supported through, interview comparisons to identify conflicting information along with detailed descriptions of observations and audit documents including field notes. Each participant was given the option to review the transcript of their audio-recorded interview or receive a summary report of the findings. Participants that chose to receive a copy of the transcript of the audio-recorded interview provided no comments or edits. Interview comparisons were performed during the first and second reading of each interview to identify commonalities in responses and begin theme development. Additionally, conflicting information and unique responses were noted. Field notes collected during the interview with each participant were combined with the corresponding transcript. These steps were used to improve accuracy, credibility, and validity of the study results.

Another technique incorporated to demonstrate the quality of the information collected for this study was data saturation. Once patterns began to appear in the participants' responses and no new data were obtained in the subsequent interviews, data saturation was met, and further participant recruitment was halted. These redundant patterns formed the foundation for theme development.

Dependability in qualitative research is often established through an external audit of the research plan which supports the repeatability of the study (Miles, Huberman, & Saldana, 2014). In this case, experienced researchers, through the Walden University process, reviewed the research procedures and processes in the study design. An interview protocol and audio-recorder were used as well to increase consistency during the data collection process.

Transferability implies the results of a qualitative study can be applied to individuals within a similar situation (Connelly, 2016). A clear delineation of demographic data regarding the subject population and setting were included in the results of this project. In addition, I provided a rich description of the procedure applied to conduct the study and information about the participants who participated in the study. This information allows the reader to transfer the findings to other similar populations and circumstances.

Lastly, confirmability for this study was supported through the use of an audit trail and reflective journaling. An outline of the steps used during the data coding process through NVivo 12, an explanation of how themes were developed, and their definitions were included in the presentation of the data analysis of the study. Furthermore, information regarding the process of linking the conclusions with the data by providing rich quotes from the participants was

included. Moreover, other possible conclusions with full explanations regarding the selected theme and interpretation were reported with discrepant cases.

Results

This section will address the four themes and related subthemes which emerged during the data analysis phase of this study that illuminate the essence of the lived experience of nurse executives. The identified themes related the study research question are defined and supported with participant quotes from the interview transcripts. The current study was guided by one research question; however, three key categories related to the lived experience of nurse executives assisted in the organization of the data into themes. The data collected from the participant interviews is presented by category and linked to the research question.

Nurse Executive Role

According to the AONE (2017b) a nurse executive is a licensed nurse practicing as part of the senior leadership team within a hospital, healthcare system, or school of nursing who focuses on optimizing nursing services. Many individuals practicing in the nurse executive role have completed formal education at least to the Master's level; however, most are educated at the doctoral level. At the beginning of each interview performed in conjunction with this study, the participant was asked a series of six questions; they were asked to describe their experience in the nurse executive role including how they came to formal nursing leadership, a typical day in their practice, and their current responsibilities. The emergent themes and subthemes related to the nurse executive role are presented in Table 14.

Table 14

Themes and Subthemes: Nurse Executive Role

Category: Nurse Executive Role is Challenging			
Themes/Subthemes	Number of Files	Number of Responses	Frequency of Occurrence (%)
Theme 1: Preparing self for NE Role			
Subthemes:			
Taking on tasks	6	10	60
Taking risks	6	8	60
Continuing to learn	5	11	50
Being mentored	6	16	60
Theme 2: Expanding professional sphere of influence			
Subthemes:			
Influencing change	8	20	80
Advocating for nursing practice	6	9	60
Advocating for patients	5	11	50

Theme 1: Preparing Self for NE role

The participants described their path to formal leadership as a combination of participation in leadership projects, formal education, and the identification of a mentor. In association with the theme of preparation for the NE role, four themes emerged that clarified how nurse executives related their progress to the nurse executive role. Each of the four themes are grounded in the data as demonstrated by the representative participants' quotes from the interview transcripts.

Subtheme 1: Taking on Tasks

A key finding related by six participants was the value gleaned from participating in different committees and taking on additional responsibilities prior to moving into formal leadership. Learning regarding the organizational social constructs and complex leadership tasks occurred during these real-world experiences. These professional opportunities exposed the participant to skills not usually associated with nurse's education. P1 recounted that, in the pursuit of impacting organizational change, the acquisition of informal leadership roles was helpful in understanding the political landscape of the institution.

> **P1**: I wanted to influence change, so I remained involved. I obtained progressive leadership positions formal and informal. I wanted to continue to learn so I held various different formal and informal leadership positions at the staff level.

P2 shared details about the experience of progressing from bedside nurse to leader. Although not seeking to move into management, P2 was willing to take on additional responsibilities when asked by the manager of the unit.

> **P2:** The supervisor went on maternity leave and they asked me if I would just do the schedule while she was on maternity leave. That's all they needed me to do, the schedule.

Several of the participants in the study spoke about having no interest in moving into management/leadership initially. Yet, they remained willing to participate by taking leadership responsibilities within the organization when asked. P3, however, actively sought out opportunities for informal leadership opportunities to move toward advancing levels of formal leadership. P3 completed formal education and obtained a doctor's degree but was not recognized by the organization's leadership as prepared to take on the challenges of an executive

leadership role. After entering the role of executive leadership, P3 related that the opportunities to lead informally allowed for additional, necessary preparation for the job responsibilities.

> **P3:** So, I just, you know, kept doing the charge nurse role. I kept asking for additional opportunities. At that point, my boss would say, well why don't you come do this, so why don't you go do that? And they were just grooming me, you know, until something opened up.

Subtheme 2: Taking risks

Risk taking is an important part of both personal and professional growth (Alan & Baykal, 2018). In this study, 60% of the participants related stories of taking risks that impacted their movement into higher levels of management. These reports included moving into leadership positions before they felt completely ready and risk taking as a staff nurse. P5 recounted the experience of the manager of the unit offering a formal leadership role.

> **P5:** I was a bit unsure of myself and I certainly didn't feel qualified. You know, on why are they asking me, (I said) I'm brand new here. Um, so that always kind of came out as a little bit of a mystery to me. You know, why I was being sought out. But I accepted.

P9 shared an experience where, when issues on the unit arose regarding policies about patient care, the staff nurses came together to take their grievances to the nurse executive within the organization. P9 functioned as the group's leader and spokesperson during this incident.

> **P9:** We went to the nurse executive as a group and I was kind of the leader (and we voiced our concerns). I ended up being the interim manager twice on that unit.

Subtheme 3: Continuing to Learn

Formal education is a traditional technique used to advance knowledge and skills while following a pre-designed curriculum moving toward degree attainment. Informal education includes self-directed knowledge acquisition through workplace experiences. However, the participants in this study related that, from their experience, a combination of education and workplace experience is optimal for career advancement. P1 recounted the value of informal and formal leadership positions for learning new skills while also receiving formal education.

> **P1:** I kept going on with different leadership challenges because I wanted it to continue to learn. So (I) start as staff nurse who became a charge nurse, you know, did the precepting thing, (and) went back to school while I was in those roles…I look back now and I was young…..had my first management position by 26 and a management position of a very visible unit. So, um, that taught me a lot.

Participants also spoke about their respect for the formal education path to prepare for the responsibilities associated with the nursing leadership/executive role. P3 articulated the desire to attain an advanced degree.

> **P3:** The moment I graduated I was ready to go back to school so I started taking pre-reqs and all that. So, I went back for my BSN and Master's pretty quickly.

P5 recounted the importance of an advanced degree for the nurse executive role and a personal commitment to formal education.

> **P5:** Obviously me being in the role that I am, a master's degree is required according to my job description, but you know, I went back to school long before it was required of me in my role and I'm thankful that I chose the experiences that I did as well.

Even though participants acknowledged the role that advanced formal education has in preparing for an executive role, not all participants planned to continue education for the purpose of moving into management. One participant did promote into the formal leadership capacity prior to continuing their formal education. Specifically, P2 reported no plans for going back to school to get a master's to be a manager yet was moved into an advanced leadership role. To account for this experience, subtheme three reflects that the participants accept that formal education is not mandatory but does enrich their management skill set.

Subtheme 4: Being Mentored

Moving from clinical bedside nursing to a management leadership role can be a daunting task for any nurse. Several of the participants in this study related both a reticence and aversion to taking on administrative responsibilities; however, with the support of a mentor/coach and staff peers, they were able to successful transition. Important to note, all of the participants in this study were recruited through the AONE professional organization demonstrating their ongoing commitment to networking and seeking support from colleagues. Recounting the experience of accepting a formal leadership position within the organization, P3 addressed the support a mentor can offer in facing the issues and challenges of a new role. P3 also shared how the mentor relationship often extends beyond the novice stage of a new job.

> **P3:** She was always that, that mentor person to help me and years later, she is still my mentor.

Another participant, P4, related how the career advice of a mentor supported the role transition.

P4: Luckily, I have a really strong mentor that encouraged me to take some leadership classes since nothing in nursing education had really prepared me for this type of responsibility.

The related experience of P10 further reinforced the concept that obtaining a mentor leads to successful transition into a formal leadership role.

P10: Like a lot of folks, (I) had zero training was not ready for that (management) role. Um, and, and truly would have failed if I did not have a very active mentor that kinda came and took me under her wing

Theme 2: Expanding Professional Sphere of Influence

Nurses are trained, through numerous formal and informal educational programs, to advocate for and lead change from the bedside (Porter & Strout, 2016). Often the change efforts of clinically practicing nurses focus on improving patient outcomes and safety (Porter & Strout, 2016). The respondents in this study reflected on how they were drawn to the formal leadership role by the perceived expanded opportunity to influence change that would improve patients' experience as well as the experience of the nurses providing care. The nurse executives' realization that changes could be advocated for on a larger scale within the organization through higher levels of authority led to the development of this theme and subthemes.

Subtheme 1: Influencing Change

Organizational change is often difficult and slow. Participants in this study reported that, while influencing change remains an arduous task, a formal position within the organization garners respect from other decision makers and facilitates effective change discussions. P4

recounted how recognizing the additional influence over change afforded by a formal, executive role inspired the move to an upper management position.

> **P4:** I realized pretty early that I needed a formal position to be able to increase (my) level of influence so I started to prepare to take on bigger roles within management.

P5 recounted how influencing change from the executive level within the organization is different from advocating from a bedside nurse position.

> **P5:** What I saw was an opportunity to advocate for staff and to support them and to continue to, you know, build on quality and safety initiatives, those kind of things in a, in a different way than what I could at the bedside.

Subtheme 2: Advocating for Nursing Practice

Further addressing the role of the nurse executive in influencing change, participants clearly articulated their perceived responsibility to advocate for nurses and quality nursing practice within the organization. For P3, advocating for patient safety and quality care are a critical part of the nurse executive role.

> **P3:** But I think overall, it's been a completely positive experience….
> to be an advocate for groups of nurses and patient care and patients, um, you know, safety and quality along the way.

Advocating for quality, evidence based, nursing practice, according to P7, includes coordinating the nursing staff's work.

> **P7:** Those people caring for (the patients) are kind of like my patients you know, so I'm advocating (and) coordinating their work (it) is what I do.

Subtheme 3: Advocating for Patients

Nurse executives ensure that nursing staff comply with existing professional regulations and practices. According to Jungquist et al. (2016), nurse leaders also orchestrate the development of a practice environment and work culture that supports best practices and patient safety. For P1, collaboration with other leaders within the organization facilitates patient safety.

> **P1:** I am responsible for working with the interdisciplinary leadership team to get the care that the patients need to them at their bedside.

P5 addressed advocating patients through educating others. P5 shared details regarding an incident in which the link between meeting the needs of staff and positive patients' outcomes needed to be communicated to other leaders within the organization.

> **P5:** I think the nurses in these executive roles are called upon a lot of times to explain to a (hospital) board member or non-nurses that we're talking about patient outcomes. I mean, where (to) you, it may look like that I'm just being nice. Well, being nice leads to them (staff) being nice to the patients which leads to better patient outcomes. And that's, I think, what we're here for.

Perceptions of Nurse Executives about Compassion and Caring

The focus of this study was to explore the lived experience of nurse executives' seeking to manifest compassion and caring while balancing competing corporate priorities. Each participant was asked three questions to explore their perceptions regarding how they provide compassion and caring toward staff and others. Under the category of nurse executives' perceptions unfolded the theme expressing compassion and caring along with the subthemes related to how nurse executives' manifest compassion in their practice. The provider perceptions

that appeared from the interview transcripts related the participants recognition of the importance of compassion and caring in execution of the nurse executive role. The number of responses and frequency of occurrence of subthemes reflecting the nurse executives' experience incorporating caring and compassion into their practice are listed in Table 15.

Table 15

Theme and Subthemes: NE Perceptions of Compassion and Caring

Category: Compassion and caring are central to NE role			
Themes/Subtheme	Number of Files	Number of Responses	Frequency of Occurrence (%)
Theme 3: Expressing compassion and caring			
Subthemes:			
Selecting applicable caring action	5	5	50
Linking caring and performance management	7	7	70
Mentoring others	5	6	50

Theme 3: Expressing Compassion and Caring

The nurse executives which participated in this study were interested in sharing their lived experience of demonstrating compassion toward staff. The participants were questioned regarding experiences of exhibiting caring. Additionally, the nurse executives answered questions related to barriers they have faced in their career when attempting to demonstrate caring toward others. The identified themes reflect the participants' perceptions regarding the caring process from the nurse executives' perspective.

Subtheme 1: Selecting Applicable Caring Action

A significant part of an IPA data analysis is to explore the context within which the phenomenon takes place (Pietkiewicz & Smith, 2014). Subtheme 1, which emerged from the data collected for this study, reflected the nurse executives' experience in selecting caring actions

suited to the situation and stake holders. P2 recounted an experience during which the options of caring actions were limited based on the nature of the situation; however, the selected caring behavior resulted in a positive response from the staff member.

> **P2:** I got a phone call from as staff member stating she had experienced domestic abuse and had left ….. so, I said, are you safe? Where are you? And she said that she'd gone someplace else, but she really needed a shelter…and so I just said, if you can get here to the hospital, you know, you're going home with me tonight

P4 discussed the use of excellence recognition programs as a caring action to keep staff nurses engaged with the organization.

> **P4**: I **(**Initiated) a recognition program for extraordinary nurses and make sure we celebrate nurse day/week. Rewards and recognitions have received positive feedback from staff.

In some circumstances, questioning the staff and listening to their needs facilitated the study participants selection of the appropriate caring action. P7 provided details regarding an experience where staff input led to a caring behavior that increased collaboration amongst organizational leaders.

> **P7:** The nurse leaders said they had never met (to discuss issues). So, I had a facilitator come in and help us do some team building and help us start to set some strategies.

Subtheme 2: Linking Caring and Performance Management

A unique and unexpected finding of this study was the significance the participants placed on caring and compassion as a technique to facilitate performance management and

improvement. This finding supported the development of Subtheme 2 from the data. P6 reported on an occasion when caring action included providing positive feedback.

> **P6:** (A patient family member complimented the care of one of the nurses.) So, then I came back (to my office) and I looked up (the nurses name). She had a different patient that day, but I looked her up and I shared the positive feedback.

For P7, a caring opportunity was identified during the resolution of a performance issue.

> **P7:** The first time I had demonstrated compassion towards the staff person was when I had to talk to her about her absenteeism and learned she struggled with substance abuse. Understanding what that means and understanding the things that you can put in place (actions) to help that individual and to bring them back to work (is important).

P10 described how dealing with performance management issues in a timely and caring manner is important to retaining talent.

> **P10:** …we have a responsibility to deal with things early and even though it doesn't seem like it's a big deal by not addressing it, we almost lost two of our highest performers in the organization**;** you know, if you have that baseline, that trust (from demonstrating caring), it makes (performance management) so much easier

Subtheme 3: Mentoring Others

While the other participants did not specifically delineate informal leadership projects as fundamental to their own experience, they did speak to using this technique with the individuals they are currently preparing for formal leadership roles. P3 detailed an event where a nursing staff member was seeking a new formal leadership role. Engaging with the individual and

discussing ways to expand her leadership experience, according to P3, offered a significant mentoring opportunity.

> **P3:** I said, if I let you jump that (many) levels (from staff nurse to unit manager) you're going to fail, you've got to do some of the steps in the middle…. She said, well, how do I do that? I said, that's why we're here. I said, let's talk about that…. what if I give you a project? she said, what do you want me to do?

P5 described how mentoring others includes not only subordinates but colleagues as well. Additionally, P5 related the importance of the reciprocal mentorship that occurs when colleagues support each other.

> **P5:** Our early morning risers ……. gives us (on the executive leadership team) the opportunity to connect, um, to mentor each other, to have very thoughtful conversations that early time of the day without the interruptions of the business of the day.

Influences regarding Compassion and Caring

Participants in this study were asked what factors they perceived as influencing their practice of compassion and caring as a nurse executive. Responses to these questions reflected both internal and external factors and included dependence on spiritual beliefs and values, experience, work culture, and emotional distress of others. Additionally, the participants discussed situations where they had to make an unpopular decision and work to justify that decision with their teams. The metrics regarding the subthemes are found in Table 16. Each subtheme is listed below with corresponding quotes from the interview transcripts.

Table 16

Theme and Subthemes: Influences Regarding Compassion and Caring

Category: Internal and external factors influence ability to express compassion and caring			
Theme/Subthemes	Number of Files	Number of Responses	Frequency of Occurrence (%)
Theme 4: Striving to balance influences			
Subthemes			
Depending on personal spiritual beliefs	8	16	80
Depending on personal values	6	19	60
Learning from past experience	5	6	50
Coping with corporate culture	5	13	50
Recognizing intense emotional distress	5	9	50
Justifying unpopular decisions	6	9	60

Theme 4: Striving to Balance Influences

Personal values are an important element in determining priorities in both personal and work settings (Mayo, 2017). Spiritual beliefs for some, also, are fundamental in understanding the world and the human experience. These core beliefs are the cornerstone of how individuals work and live.

Subtheme 1: Depending on Personal Spiritual Beliefs

Spiritual beliefs and practices have often been linked to compassion and caring behaviors; however, data to support how spiritual beliefs impact the caring practices of nurse executives remains elusive. The participants in this study responded to questions regarding life experiences that influence their leadership practice. Some participants pointed to family and parental training. Other participants, 80% (n=8), answered with reference to spiritual beliefs, spiritual practices, or spirituality. In particular, P2 discussed a long association with a religious organization.

P2: Think my church involvement is what comes to mind first. Um, I grew up in the church and every year I'm more and more thankful that my parents made me be in church every Sunday morning, Sunday night and Wednesday, that, you know, foundation, it cannot be substituted ….that foundation is something I've relied on and still every day.

P3 detailed an incident regarding staff and the state nurse union negotiations that was very stressful. P3 discussed how, as a nurse executive, remaining neutral and seeking to demonstrate caring behaviors was difficult. As such, P3 depended on spiritual practices to cope with the stress.

P3: For myself personally, there was a lot of prayer, there was a lot of reflection because I knew that I could not let my frustration come out.

Some study participants did not self-identify with a specific religious organization but instead spoke about spiritual well-being. P6 stated that dependence on spiritual values and morals assisted with remaining compassionate and caring during challenging encounters with nursing staff and others health care professionals within the organization.

P6: I'm very spiritual so I feel like spirituality is important, you know, and I try to live my professional life similar to I live my personal life.

Subtheme 2: Depending on Personal Values

In this study, compassion is defined as a positive emotion focused on the alleviation of suffering in others, which drives how individuals relate to one another. This definition includes placing value on compassion as a necessary precursor to the demonstration of caring behaviors. The data collected through the interview process revealed that the values of patient centered care, compassion, and caring compelled the participants to demonstrate caring behaviors such as

respect, transparency, and connectedness. P1 described how personal values, such as compassion, caring, justice, transparency, and respect, held by nurse leaders should be communicated to staff just as the institutional values are communicated.

> **P1:** People have to know what your values and beliefs are and they have to know what your expectations are.

According to P2, when nurse executives personally value quality nursing care they expect staff to focus on the patient's needs. However, for staff to maintain a patient centered focus, they need to feel cared for.

> **P2:** Well, there's one thing that's always my focus and that's the safety and care for patients. So that trumps everything; …. want every single thing right for that patient and if your staff doesn't feel cared for, they're not going to give you what you need.

P6 related an incident where, when renovating a department within the organization, the staff was consulted regarding suggestions that would improve the patients' experience. This process demonstrated the nurse executive's personal values of caring, respect for staff, and commitment to patient privacy and dignity.

> **P6:** We're all about the patient. So, what we (staff nurses and nursing leadership) did was we expanded and made the (pre-existing) closet into a bathroom so we can have locker rooms (included) and the patient didn't have to walk down the hallway in their gown.

Subtheme 3: Learning from Past Experiences

During the interview process, each participant was very amenable to speaking extensively about their past experiences as well as their current practice. The responses reflected the

participants understanding of how previous working relationships and experiences influence their approach to compassion and the expression of caring. For P1, a previous work environment that fostered a melding of work time with personal time did not provide a caring experience. Therefore, P1 now encourages an environment of life-work balance for staff.

> **P1:** I expect that same thing because I really do want them to have some type of (life-work) balance…. I mean, I worked one job one time where we would get up at 3:00 in the morning and check our phones because our CEO would be emailing at 2:30, 3:00 in the morning and you kind of just went along. So, I'm respectful of their time.

P2 detailed how previous roles within the organization provided insights and fostered a feeling of empathy toward staff regarding the issues and difficulties they face.

> **P2:** I was always glad I started out as a patient aid as a student because I knew those people. I knew where their hearts were. I knew their hardship.

Personal life experiences, according to P8, fostered the expression of a more caring and empathic approach in dealing with staff.

> **P8:** But what I learned through all of that I think is that people may make bad decisions, but it doesn't make them a bad person.

Subtheme 4: Coping with Corporate Culture

Corporate culture denotes the values and norms that permeate the work environment and drive behavior (Guiso, Sapienze, & Zinglaes, 2015). The effect of work culture can be positive or negative on an individual's ability to demonstrate caring behaviors. The nurse executives in this study delineated how work environments predicated on compassion often facilitate rather than hinder the demonstration of caring behaviors. Additionally, participants reflected on how

other executives in the organization, who do not have a nursing background, may not fully understand the impact of certain initiatives on staff thus limiting their ability to demonstrate compassion as they might wish. P5 provided details regarding the experience of being challenged by other executives regarding the implementation of caring behaviors toward nursing staff, such as open communication, transparency, rewards, and recognition.

> **P5:** I think the nurses in these executive roles are called upon a lot of times to explain to a board member or non-nurses that we're talking about patient outcomes. I mean, where it may look like to you that I'm just being nice. Well, being nice leads to them (nurses) being nice to the patients which leads to better patient outcomes. And that's I think what we're here for. So, um, so sometimes someone like that in the (non-nursing) VP role …. challenges you (and makes it harder) to be able to do everything you'd like.

P6 reported that, when the values of the organization include compassion and caring behaviors, demonstrating caring toward staff is easier.

> **P6:** we call those (caring) moments. So, I shared the (caring) moment with the nurse and then I also wrote her a note with that patient specific information that the family member shared with me of what she did to provide excellent care to her daughter.

P8 spoke to the benefit of having a close relationship with the CEO of the organization when dealing with corporate, staffing, and practice issues.

> **P8:** I'll work collaboratively with the CEO on those issues. Um, he has a little more clout than I do. So, um, we, you know, we kind of worked together on those things.

Subtheme 5: Recognizing Intense Emotional Distress

Participants in this study provided extensive insights regarding their experience demonstrating caring behaviors and their observations regarding how the staff responded to the behaviors. Of particular interest was the observation by P1 that highlighted how during times of stress, although the nurse executive was utilizing caring behaviors, recipients demonstrate a limited capacity to accept the behavior as compassionate or caring.

> **P1:** When they're very angry. Okay. When they're very, angry about something that they want and, it's a want, not a need, something they want usually in regards to themselves that um, no matter what you try to do, you're just not going to satisfy (them)**;** I've been cursed out, um, to the point that any other human being that was sitting on the other end of the fence would say, you're done.

Emotions, such as fear and anxiety, also can impact how individuals perceive the caring behaviors of nurse leaders. P8 recounted how, after discovering a compliance issue on the nursing unit, demonstrating support for the nurse staff member's appropriate reporting of the event was crucial to expressing compassion and caring.

> **P8:** …. she was crying. So, (I reassured her of my support) and it has calmed down, but it's really difficult when you've just got that corruptive thing going on and you never know what's happening underneath the rug, until it blows up.

Subtheme 6: Justifying Unpopular Decisions

According to the nurse executives who participated in this study, a core function of their role is to make decisions as well as supporting the decisions made at the organizational level. Participants reported that these decisions are not always popular with the staff. For the nurse

executives in this study, communicating the rationale for decisions that may not reflect the wants of the staff is particularly challenging. However, the responses listed below demonstrate the study participants desire to demonstrate caring behaviors during the process of disseminating unwelcome information. P1 recounted an occasion where a decision made by the nursing leadership was driven by the need to ensure patient safety but individuals of the nursing staff still struggled to accept the decision.

> **P1:** But sometimes that compassion is not as individualistic as the people want it because you have to treat the group compassionately. The night of the snow storm, we had five nurses that couldn't leave because I don't let people leave until there were relief arrives. Staff members were still upset.

Other study participants spoke to the difficulties associated with demonstrating caring in a way that is perceived by staff as caring. P8 observed how understanding the wants and needs of staff can impact how caring is demonstrated.

> **P8: …**you can't (always) accommodate (staff), you can't give them everything they want but you have to treat them with respect and you have to treat them as individuals, you know, understand what motivates them.

Summary

The purpose of this research study was to explore the lived experience of nurse executives seeking to manifest compassion through caring behaviors toward staff while balancing competing priorities. In Chapter 4, information was included to provide an audit trail of the processes used to recruit participants, and to delineate how data was collected, managed, and analyzed. There were 10 participates included in the study. A purposive sampling technique

was used to ensure all volunteers were knowledgeable in the area being studied and would be able to provide insights related to the research question. Each participant accepted into the study signed an electronic informed consent form through SurveyMonkey prior to the collection of demographic data and the face-to-face interview.

The first sections of this chapter, including setting, demographics, data collection and data analysis, contain information regarding the conduct of the study. Each section was expanded to include all components of the conduct of the study. Additionally, in the data analysis section, preliminary findings of emerging categories and themes were listed.

The section on trustworthiness provides information regarding the steps employed to provide evidence of credibility, dependability, transferability and confirmability. Credibility was established through the process of member checking during each interview and at the end of the interview. Also, as the responses from the participants became repetitive data saturation was met and participant recruitment ended. Two individuals, separate from the discipline of nursing but involved in healthcare and leadership, provided a review of the preliminary and final themes that emerged from the data supporting the dependability of the collected and analyzed data. Evidence of transferability was established through full disclosure of the demographics of the participants. NVivo 12 provided the opportunity to process the data collected in an organized manner which provided an audit trail suitable to relate confirmability of the results if analyzed independently.

In the later portions of Chapter 4, the results of the analysis were provided. While a plethora of data was collected through the interview process, the emerging categories, subthemes, and themes provided insights regarding the lived experience of nurse executives,

their responsibilities, and the inclusion of compassion and caring into their daily practice. The responses from all interviews and field notes were subjected to intense review and analysis to determine how each participant interpret their experience as a nurse executive.

Through reiterative readings of the interview transcripts, three main categories emerged. Identified subthemes and themes where grouped into the three categories including the nurse executive role, nurse executives' perceptions about compassion and caring, and influences that affect the nurse executives' ability to incorporate compassion and caring into daily practice. Most participants related that, in preparation and execution of the nurse executive role, a combination of formal education and experience provides the best foundation to be effective. Next, the nurse executives also detailed that as they seek to provide caring behaviors toward staff, emotional distress, such as fear and anger, often impede the recipients' ability to accept the behaviors as caring and compassionate. Another key finding during the data analysis process, concerned the influences nurse executives experience regarding compassion and caring. Of the respondents, 90% (n = 9) reported spiritual beliefs as a core internal driver of compassion and the desire to demonstrate caring behaviors toward staff. Overall, the categories, subthemes, and themes that emerged from the data elucidate the nurse executives' applied meanings and interpretations of their lived experience demonstrating compassion and caring toward staff. In Chapter 5, the interpretation of the findings, limitations, recommendations, implications of social change, and conclusions are reported.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Compassion and caring are key components of nursing practice; however, how nurse executives incorporate these factors into their roles away from direct patient care remains an enigma for researchers. The purpose of this phenomenological study was to explore the lived experiences of nurse executives seeking to manifest compassion in their daily practice through caring behaviors toward staff. Specifically, the scope of this inquiry incorporated how nurse executives interpret their lived experiences of being compassionate and translating that emotion into action. The phenomenological approach was adopted to gain a personal and comprehensive view of the lived experiences of nurse executives. Nurse executives play a crucial role in the formation of the work culture within their organizations. As such, they are well-suited to advocate for the demonstration of compassion and caring behaviors toward staff, which is linked to positive patient outcomes.

The phenomenological approach provided the methodological framework to explore the essence of caring within the real-world experiences of nurse executives. The IPA method was employed to allow for an in-depth evaluation of the data collected during face-to-face interviews with the participants. Unique among hermeneutical analysis methods, IPA includes an idiographic focus that encourages comparisons between the study participants' interview reports following the in-depth analysis of the individual participant interview reports. Each nurse executive participating in the study shared their experiences along with their understanding and perceptions related to their roles and responsibilities. The responses of the participants provided insights for researchers to develop statements of meaning that reflect their reality. The IPA

approach focuses on exploring important relationships, making it relevant to investigating the phenomenon of compassion and caring within lived experiences of nurse executives.

A key finding of this phenomenological research study was that respondents perceive compassion and caring as central to the effective execution of the nurse executive role. Furthermore, five of the participants recognized the influence of the work environment on their ability to demonstrate compassion and caring toward staff. Interpretation of the study findings along with an analysis of the data based on the theoretical framework and existing research, limitations of the study, recommendations, implications of social change, and conclusions are reported in this chapter.

Interpretation of the Findings

The intent of this study was to explore the lived experience of nurse executives as they manage competing priorities while demonstrating compassion through caring behaviors. Data analysis resulted in the recognition of four major themes and 16 subthemes. The major themes were compared with the literature reviewed for this study, recently published findings related to nurse executives, and assumptions of the THC.

Comparison with the Literature

This study was designed to explore the lived experiences of nurse executives as they seek to demonstrate compassion and caring. The interview questions used during the face-to-face interview elicited responses focused on the role of nurse executives, their perceptions regarding compassion and caring, and influences that impacted their ability to demonstrate compassion and caring. Accordingly, the themes that emerged from the data followed these categories.

In Chapter 2, a review of the literature was presented to position the study within the current research related to the roles of nurse executives, compassion, and caring. The literature review demonstrated that there were a limited number of studies that explored nurse executives' lived experience of incorporating compassion and caring behaviors into their daily practice. However, the themes that emerged from this study were mostly consistent with results of studies that were included in the literature review.

Theme 1: Preparing Self to Meet the Challenge

Executive leadership roles are complex and challenging. Nurse executives within the healthcare sector experience significant pressure to ensure the delivery of quality patient care, contain costs, and maximize staff outcomes (Adams, Djukic, Gregas, & Fryer, 2018). Such high-profile leadership positions require that individuals who take on these roles be well-prepared for the challenges they will face. Yet, for staff nurses and nurse leaders seeking to move into executive leader roles, a clear path to achieving advancement is lacking.

The first theme to emerge from the data analysis is reflective of the recognition by the participants that preparation and leadership readiness are important for successful transition to an executive leadership position. The four subthemes associated with this theme are taking on tasks, taking on risks, continuing to learn, and being mentored. The common understanding of the participants regarding the role of the nurse executive was that both formal and experiential learning are necessary to prepare for the demands of the job. Additionally, to execute the role effectively, a mentor is key.

Taking on Tasks

Healthcare continues to evolve, and nurse executives must contribute to defining new care delivery models and roles within the system. Participants in this study reported that even though the nurse executive role is rooted in facilitating quality nursing care, those outside of the executive role fail to appreciate that additional expertise is required. Six of the participants specifically said that different leadership opportunities and learning new nonclinical skills were instrumental in their ability to transition into executive leadership roles. In particular, taking on task responsibilities such as the staffing schedule cultivated informal leadership skills and groomed novice leaders for advancing levels of responsibility. As such, individuals need to augment traditional education with informal leadership opportunities.

The sentiments expressed by the participants in this study confirmed similar findings in the literature. Abraham, Burnette, Wannarka, and Weerheim (2013) said that leading work unit initiatives provides staff nurses with firsthand leadership experience. Programs designed to offer nurses the opportunity to develop leadership skills and understand organizational functions and processes can inspire them to leadership (Abraham et al., 2013). Player and Burns (2015) also acknowledged that gaining new skills through different informal and formal leadership opportunities strongly motivates individuals toward increasing levels of responsibility and leadership.

Taking on Risks

Along with taking on tasks to build their experience, participants related incidents that required they take risks to move forward in leadership roles. Participants revealed episodes when moving into formal leadership roles took courage due to lack of preparation. These

individuals accepted their new leadership roles and responsibilities, even though they were unsure of their ability to be successful. According to Barchard et al. (2017), nurses who are able to manage their fear and anxiety when placed in difficult situations or take on new responsibilities may appear resilient but they still benefit from mentor and management support during this time (Barchard et al., 2017).

Other participants related their experiences of taking risks through innovation and advocating for change. One incident involved the unit staff nurses coming together to voice their concerns regarding negative occurrences and issues with upper management. Informally leading this group evoked a sense of emotional distress and uncertainty but resulted in a positive outcome as management responded by making the changes requested by the group. Joseph, Rhodes, and Watson (2016) encouraged nurse leaders to embrace these types of smart risks that focus on positive outcomes for the organization while recognizing the needs of the individual. According to Joseph et al. (2016), disruptive innovation can be accomplished through risk taking that is strategic and enhances patient care.

Risk taking is an important part of resilience and innovation in healthcare; however, risks should be grounded in discovery and information relevant to the problem under investigation (Joseph et al., 2016). According to Mustika and Jackson (2016), some individuals with a propensity for risk-taking may try to justify their unsafe risk behaviors by pointing to a lack of organizational support. These types of unreasonable risk-taking actions should be monitored and discouraged. Preparing individuals to discern smart risks from unsafe risks may mitigate this issue and support innovations that improve patient care (Mustika & Jackson, 2016).

Continuing to Learn

Nurse executives who participated in this study quickly pointed to informal and formal education as an important part of their journey from bedside nursing to executive leadership. The participants reported informal education as learning opportunities that occurred outside of the traditional degree pathway and consisted of experience and job-related instruction. Ragoff, Callanan, Gutierrez, and Erickson (2016) stated that informal education is a meaningful activity designed to prepare the learner to attain more complex skills. The responses collected for this study support this concept regarding the nature of informal learning. Additionally, Joynes, Kerr, and Treasure-Jones (2017) identified that informal learning emerges from opportunistic encounters as well as planned activities. For some of the participants in this study the road to executive leadership was coincidental and prompted by requests from their manager to pursue a leadership path. Other participants reported how they had requested opportunities to build their leadership skills within their current role as they sought increasing levels of responsibility. These lived experience examples shared by the participants align with and support the concept that informal education is valuable and contributes to professional development.

Formal education, according to the participants, was delineated as degree attainment which is curriculum driven and important to preparation and execution of the executive role. Participants described their need for formal education in terms of a way to potentially meet the job requirements and acquire the skills needed to function in the role of a nurse leader/executive. Similarly, Kleinman (2003) reported that nurse executives link the importance of formal, graduate education with the broader accountability experienced by nurses in executive roles. Optimizing educational preparation through the attainment of a master's or doctoral degree

makes a significant contribution to the enhancement of the leadership acumen of nurse executives (Curtis, Sheerin, & de Vries, 2011; Kleinman, 2003;). Globally, nurse researchers continue to recommend an increase in educational standards for nurse executives to improve healthcare delivery (Hisar & Kradag, 2010).

Lifelong learning is another tactic participant in this study reported using to prepare for the nurse executive role. This practice is supported not only by previous research findings but also included in the recommendations delineated by professional health organizations. According to Kim (2016), lifelong learning is defined as an active process where the search for knowledge meets professional needs. In contrast to continuing education, lifelong learning is self-motivated and not directly linked to regulatory or certification mandated education. The Institute of Medicine (IOM) (Institute of Medicine [IOM], 2011) supports that nurses should be involved in lifelong learning. As such, commitment to lifelong education has become a competitive strategy for professionals seeking to advance in their chosen career (Kim, 2016).

The United Nations Education, Scientific and Cultural Organization (UNESCO) identified four pillars of lifelong learning: leaning to know, learning to do, learning to live together, and learning to be (Delors, 1996). The statements of the participants in this study aligned with these pillars of learning. Learning to know was reflected in the nurse executives' articulated desire to complete graduate level work. Learn how to learn was expressed through their willingness to gather knowledge from their experiences and the experiences of others. Participants spoke of learning objectives related to acquiring new skills which reflects learning to do. Learning to live together and learning to be were expressed by each participant seeking to

enhance leadership skills of understanding and communication through the formal educational system.

Being Mentored

The lived experience of the nurse executives as reported by the participants in this study demonstrate the importance of having a mentor to support progression from novice to expert. Other nurse executives also report that mentors and coaches have proven to be invaluable in their own experience. Leach and McFarland (2014) specifically reference the importance of ongoing support from a mentor for the success of a novice Chief Nursing Officer (CNO).

Eby, Allen, Evens & DuBois (2008), argued that all individuals can benefit from the mentor-mentee relationship. According to Keshavan and Tandon (2015) a mentor functions as teacher, coach, and counselor to support the development of others. As such, this mentoring relationship is critical for both personal and professional growth. Gibson (2004) identified that the essential nature of being mentored is to feel connected to someone who truly cares about the mentee's success and well-being. The responses from the participants in this study mirror these sentiments when discussing their own experience with the mentoring process.

Theme 2: Expanding Professional Sphere of Influence

Compassion as manifested through caring behaviors toward patients has long been held as important to facilitate quality nursing care. Numerous researchers continue to study and explore the impact of caring behaviors demonstrated by bedside nurses (Bramley & Matiti, 2014; Brunton & Beaman, 2000; Porter & Strout, 2016; Watson, 2017); however, the incorporation of caring behaviors into the nurse executive role remains contentious. The fear of compassion and the lack of a business model to support the use of compassion and caring at the executive level

extends the controversy (Gilbert, McEwan, Matos, & Rivas, 2011). While researchers continue to argue how compassion and caring should be viewed at the executive level, the nurse executives in this study share their view that compassion drives their decisions to influence change, advocate for nursing practice, and advocate for patient safety and quality care.

Influencing Change

When asked what brought them to formal nursing leadership, several of the participants credited their desire to broaden their impact within the organization and nursing. Participants identified that without a seat at the table influencing the decision-making process within the organization was difficult. Additionally, study participants recognized that broader changes within the organization were accomplished at the upper management levels and an executive position was necessary to provide a voice for nursing. Participants specifically noted that an executive leadership role provides the authority necessary to influence change.

Pettigrew & McNulty (1995) define influence as the capacity to affect the behaviors of others through power and persuasion. According to Tomajan (2012), competency, credibility and skill form the foundation of influence and supports the process of driving change. Nurse leaders function as influencers through building trust and relationships at all levels within the healthcare system. The participants in this study reported using influence as an important part of their daily function to improve the practice environment and promote quality patient care. This approach aligns with the findings of Alexander (2017) who encouraged the use of influence to improve nursing practice environments. Additionally, the recognition by the participants that influence is more pronounced at the executive level is consistent with the work of Stefancyk,

Hancock, and Meadows (2013). Alexander (2017) stated the behavioral shift accomplished through the practice of influence is true change.

Advocating for Nursing Practice

Individuals participating in this study function either as nurse executives responsible for nursing practice within their organization or as academic administrators supervising the preparation of nursing students for practice. As such, each participant reported how their role facilitated their ability to advocate for nurses and nursing practice. Participants responded that staff sustained performance "at every level" falls within the scope of the nurse executive role. Incidents in which a nurse executive led change in nursing practice resulted in a significant improvement in patient outcomes were reported by each participant. Additionally, respondents discussed providing a voice for nursing at the executive level and functioning as a "buffer" between executive management and the staff. All of the participants reported, in some fashion, their understanding that the role of nurse executive offered them the opportunity to positively impact healthcare by advocating for nursing practice excellence and providing a voice for nurses.

Advocacy, as defined by Tomajan (2012), consists of problem solving, communication, influencing, and collaborating for a cause or purpose. Therefore, every nurse advocates for the profession of nursing at each level within the organization. Nurse executives, however, have a greater voice at the organizational level and attain the ability to direct decision makers toward solutions that enhance nursing practice (Manning & Giannuzzi, 2015). Poter-O'Grady (2018) encourages nurse leaders to advocate for needed resources and the integration of strategic initiatives that improve the effectiveness of healthcare and nursing services. The participants in this study confirm these findings and affirm that the role of advocate is central to their practice.

Advocating for Patients

All nurses are uniquely positioned to advocate for patients (Davoodvard et al., 2016). However, in the executive role, nurse leaders can advocate for the needs of the patient on a corporate and system level potentially resulting in changes that improve patient outcomes. As these individuals seek to advocate for the needs of the patients under the care of the organization, patient safety and quality become of paramount importance (Jeffs et al., 2018). Nurse executives in this study reported how they embraced the role of patient advocate at the corporate level. Specifically, participants reported the importance of collaborating with interdisciplinary team members as a method of advocacy to meet the needs of patients. Tomajan (2012) encouraged the use of this technique when advocating for a purpose or goal. The end result of garnering positive relationships with others to address problems is the accomplish of goals that could not be achieved independently (Tomajan, 2012). According to Tomajan, nurse leaders are afforded the opportunity to bring teams together, engage staff in problem solving, and protect nurse resources. The participants in this study recounted examples where collaboration resulted in improved patient outcomes from the executive nurse position confirming the findings of Tomajan (2012). All of these examples confirm the activity of advocating for patients as a key part of the nurse executive role.

Theme 3: Expressing Compassion Through Caring Behavior

According to Nkongho (2003), nurse leaders incorporate different caring actions in different relationships and situations. Mayeroff (1971) identified eight critical elements of caring: knowing, alternating rhythm, patience, honesty, trust, humility, hope and courage; however, nurse leaders must decide which caring action best epitomizes these caring

characteristics in a given situation. Similar to Situational Leadership (Graeff, 1997), nurse leaders often need to adapt their caring approach to fit the needs of the individual, group, and organization.

Selecting Applicable Caring Action

The caring actions implemented during nurse-patient interactions stem from the basic factors of caring defined by Wolf, Giardino, Osborne, and Ambrose (1994). These five factors are assurance of human presence, knowledge and skill, respectful deference to others, positive connectedness, and attentiveness to other experiences. Through these factors, Wolf et al. (1994) captured the need for both professional skill and expressive caring for the nurse-patient relationship to be successful. Nursing executives translate these same caring elements to caring at the organizational systems level.

The nurse executives in this study demonstrated how they incorporate the five factors of caring through relating behavioral examples of caring moments. In each example, the caring actions of the nurse executives were individualized to the needs of the staff member or the group and based on the situation. Participant 2 shared a story that demonstrated the provision of safety for an individual staff member who was at risk following a domestic violence incident. This experience reflects the attentiveness to others experiences that drove the nurse executive to individualize her caring action to the need of the staff member. Other participants discussed situations where the nursing staff had experienced a traumatic patient death. As such, the staff was experiencing a broad range of emotions. The nurse executives demonstrated respectful deference to others by allowing the staff to decide how they wanted to deal with the experience. In these situations, the staff chose to stay together and continue to work. Later, the nurse

managers notified the nurse executive when the staff members were ready to take some time off to process the experience, which was provided as requested. The care provided by these nurse executives confirm that the basic factors of caring as identified by Wolf et al. (1994) continue to drive caring actions when applied at the organizational level.

Linking Caring and Performance Management

Individual performance management is the foundation of organizational success (Aguinis, Joo, & Gottfredson, 2011). As such, nurse executives utilize performance management as a process to obtain the best efforts from individuals, teams, and the organization. Aguinis (2011) argued that separate from performance appraisal, which is concerned with strengths and weaknesses, performance management is a process that allows for the evaluation of potential and developmental needs of the employee. According to Arguinis et al. (2011), effective managers and executives ensure that performance evaluations are reasonable and fair for all.

Nica (2016) explored the effect of how employees' perceptions related to organizational support on individual performance. Through the demonstration of organizational support, determined by employees' assignments, staff members commit to expanding their efforts to attain organizational goals (Nica, 2016). Nica (2016) stated that performance reports and discussions conducted with the caring behaviors of empathy, consideration, and organizational support further establish the reciprocal commitment of the employee to the organization. Additionally, the establishment of trusting relationships between leadership and the employee drives continued employee engagement (McManus & Mosca, 2015). This reinforces the concept that the establishment of caring, interpersonal relationships and the demonstration of caring

behaviors during the performance management process can lead to positive outcomes for the employee and the organization.

The results from this study confirm that trust and caring behaviors facilitate performance management as delineated by McManus and Mosca (2015) and Nica (2016) Although all phases of performance management depend on positive relationships, well-established, personal connections formed through the consistent demonstration of caring behaviors allow for open dialogue and commitment from the employee to improve behavior during particularly difficult performance reviews. Furthermore, findings reveal that the intercession of nurse executives on behalf of staff to resolve conflicts result in a positive experience for both the organization and employees. These examples support the concepts that caring behaviors demonstrated by nurse executives facilitate performance management and demonstrative organizational support leads to individual, team, and organizational success.

Mentoring Others

Mentoring is an intentional, trusting, development relationship that occurs within numerous model types. Nowell, Norris, Mrklas, and White (2017) stated that, for nursing faculty, mentorship models include dyad, peer, and group relationships and activities. Jakubik, Weese, Eliades, and Huth (2017) identified the dyad relationship between an experienced nurse and a less experienced nurse as the most common mentoring model used within the hospital setting. Separate from onboarding, orientation, or residency, which are offered by the organization, the goals of mentoring include life-long learning, professional development, employee engagement, and succession planning. Although some mentor-mentee relationships can last for years, some mentoring moments may occur within developmental opportunities that

focus on the career goals of the protégé (Jakubik et al., 2017). The trust and support required to enter into a mentoring relationship demonstrates the fundamental caring feature of mentorship.

The nurse executives who participated in this study reported working with individual students, staff members, nurse leaders, and other executives as a mentor. Participants reported mentoring nursing students, undergraduate and graduate, to complete projects and educational initiatives to meet their career goals. Other participants recounted experiences mentoring individual staff members seeking guidance regarding necessary steps to move toward an advanced leadership role. Participants also discussed how arriving early to work afforded an opportunity to engage in mentorship with others on the executive team. The responses of the participants support the findings reported in the existing literature and provide practical examples of how the role of mentor fits within the nurse executives' responsibilities.

Theme 4: Striving to Balance Influences

Numerous nurse educators and researchers have explored the determinates of caring behaviors exhibited by bedside nurses and those involved in direct patient care. Additionally, the impact of nurse leader support and encouragement of caring behaviors exhibited by nurses toward patients continues to be a research area of interest. However, data related to the influences and determinates that affect the ability of nurse executives to demonstrate caring behaviors toward staff remains limited.

Caring and caring behaviors continue to be central to the nursing role at all levels within the organization. As such, a few of the identified determinants that influence the staff nurse's ability to demonstrate caring behaviors toward patients may impact the nurse executive as well. Based on the responses from the participants in this study compared with the literature related to

factors that influence caring behaviors by staff nurses, the overlapping determinants are reflected in the following sub-themes.

Depending on Personal Spiritual Beliefs

Oskoui et al. (2006) identified religious beliefs as having a positive impact on the caring behaviors of staff nurses. For this study, eight of the nurse executive participants similarly confirmed that they employ their spiritual beliefs and practices to facilitate caring behaviors toward staff. Connection to a church and spiritual values were specifically referenced by participants along with the practice of prayer as important to their ability to manifest and sustain caring actions toward staff.

Depending on Personal Values

Rafii et al., (2007) argued that the caring behaviors of staff nurses are positively impacted by the individual's conscience and by managing their own emotions. Although similar, unique to this study was the focus and importance the nurse executives placed on personal values to support their caring behaviors toward staff. Participants reported that when balancing priorities and influences at the executive level it is very important to remain true to personal values. Participants also identified personal values as a key factor in successfully incorporating caring behaviors toward staff and prioritizing activities and organizational needs.

Learning from Past Experiences

Learning from participating in professional opportunities and holding positions of advancing leadership responsibility is recognized as an important part of preparing nurse leaders (Cathcart, Greenspan, & Quinn, 2010; McGill, 2018). However, the participants in this study also recognized moments and experiences outside of their professional role that impact how they

incorporate caring into their daily practice. Interestingly, prior personal experience emerged as a factor that leads to a deeper understanding of the importance of separating behaviors from the individual. Bad decisions do not denote that someone a bad person but often circumstances and priorities confound an individual's decision-making skills. Nurse leaders/managers who are able to distinguish negative behaviors from the person are more likely to demonstrate caring through empathy and consideration toward the staff person (Nica, 2016). Previous experiences within healthcare, though not in a nursing management or staff position, also provide insights regarding the struggles and concerns experience by all employees of the hospital according to study participants. Understanding the needs of others leads encourages nurse executives to embrace compassion and empathy while exhibiting caring behaviors. The information shared by the participants in this study expands the body of knowledge regarding the types of experiences that can assist nurses in preparing themselves for managerial and executive roles.

Coping with Corporate Culture

Organizationally, nursing executives' function in roles that require multiple agency. Scott (2011) states that the nurse executive is responsible to ensure the nursing care provided is safe and effective, while delivering expected/contractual behavioral and organizational outcomes. Nurse executives are also called upon to assist with developing and supporting a positive work environment for staff that facilitates compassion and caring behaviors (Schofield, 2016). The nurse executives who participated in this study identified the influences that impact their ability to establish a caring corporate culture and demonstrate compassion toward staff.

Unique to the findings in this study is the impact of the relationship between the CEO and the nurse executive on the manifestation of compassion and caring toward staff. Participants

specifically discussed how a positive relationship with their respective CEO allows them to advocate for a caring work environment that encompasses caring toward staff and patients. Participants also identified the political environment within the levels of upper and executive leadership as challenging when seeking to advocate for more caring behaviors toward staff if caring is not valued within the organization. This report from the executives who participated in this study highlights the need for education regarding influencing others and navigating a highly politicized environment when functioning in an executive leadership role.

Recognizing Intense Emotional Distress

The demonstration of caring is not effortless. Leaders are called upon to do things they do not want to do, look beyond what people want to what they actually need, and balance respect for the individual and the task at hand. Successfully practicing this type of tough empathy requires that the leader really care for the work and the employee while communicating authentically (Goffee & Jones, 2015). Employees need to see that leaders within the organization are truly committed to their role and the responsibilities entrusted to them.

There are times, however, when employees' emotional responses threaten to overwhelm even the most experienced leader. According to Goleman (2006), physiologically, neural networks within the human brain echo the distress of others and managing this natural reaction is necessary to stay calm and meet the needs of others. Boosting concentration on the issue that needs resolution allows the leader to intentionally move from emotional empathy to cognitive empathy, maintain the relationship with the employee, and actively attempt to resolve the conflict or issue. Most importantly, managers and executives must manage their own distress without disregarding the emotional distress and pain of others (Goleman, 2006).

Managerial skills including self-regulation and social skills, continue to provide a framework for researchers to explore empathy and compassion in the workplace (O'Boyle et al., 2011; Rezvani et al., 2016). The responses collected through the interview process in this study confirm the utilization of these skills by nurse executives in their own practice. In particular, the emotional distress of an employee, such as anger, frustration, and/or sadness, requires a compassionate and empathetic approach that acknowledges their pain while seeking to solve the problem. The study participants also reported that managing their own feelings of frustration, through self-regulation, during these times of emotional reactivity challenges their ability to demonstrate compassion and caring. This confirms the assumption put forth by Goleman (2006) regarding the necessity to remain calm and focused when dealing with the emotions and suffering of others.

Justifying Unpopular Decisions

Executives in all organizations face the unenviable task of making ethical decisions. By definition, as asserted by Bridges (2018), ethical decisions result in one group receiving benefit while another group suffers. Such decisions seek to positively impact the outcomes and process of the organization but are often unpopular because the repercussions feel very personal for staff.

Perceptions of the staff regarding the fairness of decisions made by the executive management team plays an important role in the climate of the general work environment and acceptance of the decision. Georgalis, Samaratunge, Kimberley, and Lu (2015) stated that when staff judge decisions to be unjust they experience increased levels of resentment resulting in lower work quality. Transparent, timely, and adequate justification of organizational decisions is imperative to facilitate acceptance from staff members. Additionally, the provision of key

information demonstrates management's commitment to caring for staff through respectful treatment (Georgalis et al., 2015). When sharing decisions with staff or implementing change, communicating to staff how and why decisions were made has a mostly positive impact on team members. Weekly town hall meetings, a common practice for many of the participants in this study, function to proactively keep staff informed regarding decisions that have been made and those that are under discussion. There are times, however, when providing the justification for an unpopular decision is insufficient at the moment but, with time and reflection, staff usually come to understand and move forward according to participants. These results confirm the work of Georgalis et al. (2015).

Findings and Theoretical Framework

The theoretical framework for this study, Watson's THC, furnished the foundation for the study design. Additionally, the compassion concept analysis performed by Schofield provided a backdrop for further exploration of the connection between compassion and caring behaviors. Both Watson's THC and Schofield's concept analysis of compassion provided a lens with which to sharpen the focus of the interpretation of the findings.

Malterud (2016) stated that scientific theory is a set of assumptions about a real-world phenomenon that predicts, explains and supports further exploration of the human experience. Nonetheless, in qualitative research, the role of theory is somewhat ambiguous. The inductive approach of qualitative research necessitates a less restrictive positioning of theory within the study than utilized within quantitative research (Malterud, 2016). Specifically, theory in qualitative research provides information regarding how the researcher might focus the data collection and analysis, identify items that are out of scope for the study, and provide a

framework that expands during the interpretation process (Malterud, 2016). Thus, the analysis and interpretation of the findings of this study provide an intersection where theory and new data converge to extend knowledge.

Theory of Human Caring

Watson's THC consists of seven assumptions, 10 carative factors, and 10 caritas processes. Although the THC focuses mainly on the caring relationship between nurses and patients, several of the key components are universal in nature and applicable to various caring relationships. Three key THC assumptions developed by Watson were identified to support the design of this research project: human relationships are important, transpersonal caring moments are important, and certain methods and techniques improve caring skills. A fourth THC assumption, which is that the practice of caring is central to nursing, was subsequently included as part of the study framework.

The nurse executives who participated in this study confirmed the utilization of caring behaviors to build relationships with staff and others within their practice. Specifically, five participants remarked that they routinely make rounds on all the nursing units to connect, elicit feedback, and remain accessible to staff. The participants reported that engaging in these activities with staff resulted in positive changes to the work environment and supported improved patient outcomes. These caring actions also align with the THC caritas processes of being authentically present and building helping- trusting relationships

Watson (2008) defined transpersonal caring moments as opportunities to honor the needs and wishes of others. Participants in this study reported how they identify caring moments as well as create caring moments. One participant recalled specifically a time when, after a

traumatic event when staff experienced a significant loss, the staff made requests to help them deal with their grief. These requests were honored and further accommodations were made by the nurse executive to support the staff during this difficult time. Another participant provided a behavioral example where, while on unit rounds, staff voiced concerns regarding structural renovations occurring and requested some alterations. The observations of the staff led to changes in the renovation plan that improved patient safety and supported quality patient care. Creating a healing environment at all levels is one of the Caritas Processes denoted by Watson (2008) which the nurse executives reported was a core function of their role.

Techniques that build and cultivate caring skills involve spiritual practices and embracing humanistic/altruistic values (Watson, 2008). Eight nurse executives in this study confirmed that they use their spiritual beliefs and practices along with personal values as a way to maintain compassion and support caring behaviors toward staff. One participant credited her religious upbringing and continuous church involvement as fundamental to her ability to demonstrate care toward others and staff. Other participants reported that they use prayer to maintain their spiritual connection and support their caring practice. The responses of all participants strongly aligned with a personal spiritual existence which triggered the development of a subtheme to capture this factor as part of the nurse executives' lived experience.

Each of the participants expressed that caring is central to nursing and central to their practice. This finding confirmed the THC assumption that caring is fundamental to nursing within all levels and practice settings. Interestingly, participants reiterated throughout the face-to-face interviews their responsibility to model caring behaviors and inspire their staff to be caring toward patients and each other. Several participants called out their practice of rounding

on the unit as a significant opportunity to simultaneously demonstrate and model the caring behavior expected from everyone within the organization.

The analysis of the data from this study revealed four major themes and 16 subthemes which reflect the lived experiences of nurse executives. Of the 16 subthemes, 12 aligned with the THC Carative Factors/Caritas Processes confirming their applicability to the nurse executives' lived experience and extending knowledge in the discipline of nursing regarding how nurse leaders develop and maintain caring actions in their daily practice. The alignment of the themes and sub-themes that emerged from the data collected in this study and the THC Carative Factors/Caritas Processes is presented in Table 17. The left column in Table 17 lists the four themes and the center column denotes the sub-themes while the right column identifies the confirmed THC Carative Factor/Caritas Process.

Table 17

Alignment of Themes to Theory

Theme	**Sub-theme**	**THC Carative/Caritas**
Theme #1: Preparing self to meet the challenge	Taking on tasks	N/A
	Taking risks	N/A
	Continuing to learn	**Carative/Caritas #7:** Promotion of interpersonal teaching/learning
	Being mentored	**Carative/Caritas # 4**: Developing a helping trusting, human caring relationship

(Table continues)

Theme	Sub-theme	THC Carative/Caritas
Theme #2: Expanding professional sphere of influence	Influencing change	N/A
	Advocating for nursing practice	**Carative/Caritas #9:** Assistance with the gratification of human needs and potential alignment of mind-body-spirit
	Advocating for patients	**Carative/Caritas #9:** Assistance with the gratification of human needs and potential alignment of mind-body-spirit
Theme #3: Expressing compassion through caring behaviors	Selecting applicable caring action	**Carative/Caritas #4:** Developing a helping trusting, authentic human caring relationship
	Linking caring and performance management	**Carative/Caritas #4:** Developing a helping trusting, authentic human caring relationship **Carative/Caritas # 7:** Promotion of interpersonal teaching/learning
	Mentoring others	**Carative/Caritas #4:** Developing a helping trusting, authentic human caring relationship **Carative/Caritas #7:** Promotion of interpersonal teaching/learning

(Table continues)

Theme	Sub-theme	THC Carative/Caritas
Theme #4: Striving to balance influences	Depending on personal spiritual beliefs	**Carative/Caritas #2**: Instilling/enabling faith and hope, being authentically present and enabling and sustaining the deep belief system **Carative/Caritas #3**: Cultivating one's own spiritual practices and transpersonal self, going beyond ego self **Carative/Caritas # 10:** Allowance for existential phenomenological forces
	Depending on personal values	**Caritive/Caritas #1:** Humanistic-altruistic values; practicing loving-kindness and equanimity within context of caring consciousness.
	Learning from past experiences	**Carative/Caritas # 6:** Systemic use of the scientific problem-solving method for decision making; engaging in artistry of caring-healing practices.
	Coping with corporate culture	**Carative/Caritas # 8:** Provision for a supportive, protective, and/or corrective mental, physical socio-cultural and spiritual environment at all levels

(Table continues)

Theme	Sub-theme	THC Carative/Caritas
	Recognizing intense emotional distress	**Carative/Caritas # 5**: Promotion and acceptance of the expression of positive and negative feelings
	Justifying unpopular decisions	N/A

Note. Carative Factors and Caritas Processes from Watson (2008)

Compassion

The phenomenon of compassion, as a nursing concept, is complex. According to Schofield (2016), compassion is a core emotion that serves as an antecedent to caring behaviors. However, the numerous terms used to denote compassion and the interchangeability of these terms leads to confusion for researchers and practitioners alike (Schofield, 2016). Ultimately, according to Schofiled (2016) compassion is the link between the recognition of pain and suffering and the move to caring behaviors.

The nurse executives in this study disclosed through their stories and experiences that their sense of compassion drew them to the nursing profession. Additionally, compassion has remained a driving force, across all their years and levels of practice, to incorporate caring behaviors into the execution of their daily activities. One participant acknowledged that the nursing skill of observation continues to be important at the executive level to recognize the needs of others and their pain and suffering. Other participants echoed this sentiment as they reported being vigilant while rounding on the nursing units and asking questions of staff to understand their needs. These responses of the participants confirm the assumptions of Schofield (2016) regarding the nature of the phenomenon of compassion.

Participants in this study reported that modeling caring behavior is an important step in encouraging staff to also demonstrate caring toward patients. This observation supports the premise set forth by Schofield (2016) that for an organization to embrace a culture of compassion the executive leadership team must demonstrate that compassion is valued. In addition, organizations need to maximize the opportunities for staff to demonstrate compassion to establish an organizational caring culture (Schofield, 2016). The reports from the participants in this study regarding compassion and caring affirm the assumptions of Schofield (2016) and provide a glimpse at how the link between compassion and caring behaviors is established in the daily practice of nurse executives.

Overall, the findings of this study confirm the concepts and constructs of Watson's THC and Shofield's conceptualization of compassion. Although no discrepancies were noted between THC and the collected data, the study findings extend the knowledge of how caring behaviors practiced at the bedside translate to other levels of nursing practice and leadership. Additional concepts that emerged from the data represent the need to acknowledge the integration of general management and leadership principles and nursing theory to advance the discipline of nursing.

Limitations of the Study

There are inherent characteristics of qualitative research that limit the generalizability of study findings. Particularly, the subjective nature of the data collected for qualitative phenomenological research can impact objectivity in relation to the results. Additionally, non-probability sampling strategy, sample size, researcher bias, ambiguous statements from participants, and response veracity impact trustworthiness of the interpretations (Creswell &

Poth, 2017). Qualitative researchers seek to control for as many of these issues as possible during the data collection and analysis process.

A non-probability, purposive, sampling technique supported the recruitment of participants who volunteered and met the inclusion criteria. The sample size was small as only 10 individuals were selected for participation. The small sample size and sampling technique were limitations of this study and put into question the generalizability of the findings.

Qualitative research data interpretation is also susceptible to bias when the researcher has a significant level of familiarity with the phenomenon of interest. To minimize the effect of bias on the findings of this study, a pre-prepared interview protocol was developed. The first questions were general and followed by more specific and behavioral questions. Researcher bias was also limited through the use of a theoretical framework, which provided scope to the project, and the suspension of personal assumptions regarding the phenomenon of interest (Creswell & Poth, 2017). Additionally, an audit trail describing the study analysis process provided support for the confirmability of the findings of this study.

The lived experiences of individuals are complex and their statements are often ambiguous (Creswell & Poth, 2017). During the interview process of this study, audio-recordings were made to capture subtle messages communicated by the participant and follow up questions clarified any ambiguous statements. The veracity of the participants' responses could not be verified; however, a review of the questions and researcher field notes performed at the end of each interview allowed the participant to add to or edit their responses.

Recommendations

The findings of this study provide a glimpse into the lived experience of nurse executives. This new knowledge offers insights regarding the expectations associated with the preparation and execution of the executive role while supporting the inclusion of compassion and caring into daily practice. Although these results are congruent with the published literature related to nurse executives and leadership, many questions remain unanswered. The recommendations for further research relate to the strengths and limitations of this study and the theoretical lens through which the results were evaluated.

The demographic information concerning the participants of this study demonstrated areas requiring further exploration. First, all the individuals included in the study were White/Caucasian. As such, further research addressing various races is recommended due to the potential differences in experience that might be revealed. Second, recruitment for this project resulted in a small sample of 10 which, while appropriate for a qualitative, phenomenological study, limits the transferability of the results. Additional studies that incorporate larger samples would facilitate the identification of discrepant cases and enhance the understanding of the phenomenon. Third, 60% of participants hold a doctorate degree and 40% a master's degree which supports the concept of formal education as preparation for the nurse executive role. Yet, the overall level of education of the participants may be related to the job requirements set forth by the institution. Further study of the role of formal education in preparing nurses to take on executive level leadership responsibilities is needed.

The THC by Watson provided the theoretical framework for this study. The findings reported from the participant responses were compared to the assumptions put forth by Watson

and synthesized with current reported research. The nurse executives reported that caring behavior demonstrated a positive impact on performance management and relationships, which is consistent with the THC. Further research, however, is needed to understand how staff perceive the relationship between caring behaviors from nurse executives and performance/relationship management. Additionally, further delineation of spiritual beliefs and practices is needed to understand which practices are employed and how they impact compassion and caring behaviors of nurse executives.

Implications

Compassion and caring behaviors are fundamental to nursing practice. Nurse executives, however, struggle to incorporate caring actions into their daily practice due to conflicting priorities (Jazaieri et al., 2016). Although other researchers previously explored various aspects of the nurse executives' characteristics, education, and practices, there remained a gap in understanding regarding the real-world experience of nurse executives (Leach & McFarland, 2014; Player & Burns, 2015). Thus, the goal of this study was to promote social change by providing a voice for nurse executives to express their views, opinions, perceptions, and experiences preparing for and executing the executive role while seeking to demonstrate caring behaviors toward staff.

Each participant provided valuable information about their progression from bedside nursing to executive nursing leadership, the challenges associated with the nurse executive role, and factors that impact their ability to manifest compassion through caring behaviors. The recorded responses expressed during the interview process reflected the nurse executive role is complex and challenging. All participants reported that a combination of experience and formal

education is needed to successful navigate the demands of an executive nursing leadership role. The insights that the participants shared could provide other nurse executives, educators, and researchers with important information regarding the provision of adequate support and resources to assist novice and expert nurse leaders.

The positive social change resulting from this study stems from the discovery of knowledge regarding the needs of nurse executives related to a successful transition into and execution of the nurse executive role. Over 400,000 nurses are actively functioning in a leadership role; however, the need for nurse leaders and nurse executives continues to expand. Due to the evolving role of nurse executives in the healthcare system and the increasing demand for nurse leaders, the applicability of the findings of this study are far reaching. Specifically, this deeper understanding of the lived experience of nurse executives seeking to effectively execute their position as advocate, influencer, and innovator with compassion and caring may be useful for those seeking to improve the staff work environment, quality of care, and patient outcomes.

In this phenomenological study, the participants shed light on the challenges and rewards of functioning in the executive role. Nurse executives related their passion for nursing and their commitment to safety and quality patient care. Participants also revealed their thoughts regarding barriers they experience when working to demonstrate compassion toward staff. Armed with this information, social change focused on addressing the needs of the nurse executive is possible.

Conclusion

The goal of this phenomenological study was to offer meaningful insights into the lived experience of nurse executives seeking to manifest compassion and caring toward staff. Most of

the responses provided by the study participants confirmed previous empirical data from the literature regarding executive nursing leadership and the nurse executive role. However, the findings of this study that focused on integrating compassion and caring into the daily practice of the nurse executive provided a new and deeper understanding of the nurse executive experience.

Exploring the real-world of nurse executives seeking to manifest compassion through caring behaviors allowed these nurse leaders the opportunity to express their understanding and the meaning they ascribe to their experiences. Individual responses of the study participants reflected their passion for quality nursing care and their commitment to ensure a positive experience for staff and patients. Participants were also able to reveal their best practices related to demonstrating caring toward staff and opportunities for improvement related to executive nursing leadership.

Finally, this phenomenological study accomplished its purpose by giving nurse executives a much-needed voice to express their day to day experience with nursing leadership responsibilities. The nurse executives revealed that their role is simultaneously challenging and rewarding. Additionally, the participants communicated that they consider compassion and caring central to the nurse executive role. Further, a majority of the participants sited spiritual beliefs as a fundamental factor in maintaining their compassion, which in turn supports their ability to demonstrate caring toward staff. As a phenomenological study is designed to increase knowledge and inspire additional investigation, the findings of this study support previous research while encouraging further exploration into the important role of the nurse executive.

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Appendix A: Sample Email Letter for Participant Recruitment

Dear AONE Member,

I am writing to let you know about an opportunity to participate in a research study concerning the demonstration of compassion and caring behaviors of nurse executives toward staff. I am conducting this study as a doctoral student at Walden University. During this study, you will be asked to participate in an interview session with me that will last approximately 60-90 minutes. I will ask you to share your experiences as you strive to demonstrate compassion and caring behaviors toward your staff while balancing competing managerial priorities. The information obtained from you and other nurse executives will provide insights and lead to the development of a deeper understanding regarding the experiences and strategies used by nurse executives to integrate compassion and caring into their practice.

I will be happy to discuss this with you in more detail; if you would like additional information about the study, please respond to this email or contact me directly at 760-845-5206. Agreement to be contacted or a request for more information does not obligate you to participate in any study.

Thank for considering this research opportunity.

Sincerely,

Rachel Stepp

Walden University Doctoral Student

Appendix B: Demographic Information Form

1. Age: _____ Years
2. Sex: ___Male ____ Female
3. Race: (check one)
    a. _____American Indian or Alaskan Native
    b. _____Asian
    c. _____Black/African
    d. _____White
    e. _____Other, specify: _____
4. Highest level of education:
    a. _____Associates Degree
    b. _____Bachelors
    c. _____Masters
    d. _____Doctorate
    e. _____Post-Doctorate
5. Highest level of education in nursing:
    a. _____Associates Degree
    b. _____Bachelors
    c. _____Masters
    d. _____Doctorate
    e. _____Post-Doctorate
6. Number of years in nursing practice: _____

7. Number of years in nurse executive/leadership role: _____
8. Current role/job title: _____
9. Major role responsibility:
    a. _____Administrative
    b. _____Direct report management
    c. _____Business Development
    d. _____Operations
10. Number of individuals that you directly assign work to and manage performance: _____
11. Number of staff which you do not directly manage but are accountable for their performance: _____
12. Organization type:
    a. _____Hospital – Academic
    b. _____Hospital - Community
    c. _____Clinic
    d. _____ University
    e. _____Other, specify: _____
13. Size of organization:
    a. _____ ≤100
    b. _____101 – 250
    c. _____250-500
    d. _____501 – 1000

e. _____>1000

14. Organization structure:

a. _____Non-profit

b. _____For profit

Appendix C: Interview Protocol

Thank you for agreeing to participate in this study. We are here to talk about your experience as a nurse executive. This interview will take about 60 to 90 minutes. As a reminder, you may stop the interview at any time. Additionally, you may interrupt the interview and ask any questions you may have. However, I will be unable to respond to questions regarding my own personal expertise or experiences regarding compassion and caring leadership.

Question 1: Please tell me how you came to formal nursing leadership.

Question 2: You have been a nurse leader now for (X number) of years now; would you explain your experience as a nurse executive?

Question 3: Tell me about your current responsibilities in your nurse leadership role.

Question 4: Tell me a story about a recent memorable event from your practice.

Questions 5: Describe a typical day for you as a nurse leader.

Question 6: Tell me a story about what happens when a day is not typical.

Question 7: What are some of your life experiences outside of your professional role as a nurse executive that might have influenced your current leadership practice?

Question 8: Tell me about some of your experiences when you demonstrated compassion toward your staff.

Question 9: What are some ways that compassion and caring experiences influence your leadership practice?

Question 10: Tell me about some of your experiences when you faced a barrier to demonstrating compassion.

Question 11: Tell me about some of your experiences about when you attempted to demonstrate caring behaviors toward staff.

Question 12: Is there anything you would like to add in relation to your experiences as a nurse executive?

Appendix D: Follow-up Email for Volunteers

Dear_____

Thank you for your willingness to participate in this study. Below is the consent form related to this project for your review. The first two pages of the survey will provide you with an opportunity to confirm your consent to participate. Please be sure to print or save this consent form from this email for your records.

Following your completion and submission of the survey, the researcher will contact you and schedule the face-to-face interview portion of this study.

The password for this survey is: **Nurse2018**

Thank you,

Rachel Stepp

Nurse Executives' Lived Experience of Incorporating Caring Leadership

CONSENT FORM

You are invited to take part in a research study about your experiences related to demonstrating compassion and caring toward staff in your role as a nurse leader/executive. The researcher is inviting nurse executives who have functioned in the nurse executive role for at least 3 years, practiced nursing for at least 5 years, and are interested in demonstrating compassion and caring behaviors toward staff while balancing corporate responsibilities to be in the study. I obtained your name/contact info via the American Organization of Nurse Executives (AONE). This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Rachel Stepp, who is a doctoral student at Walden University. You might already know the researcher as a nurse executive in the pharmaceutical industry, but this study is separate from that role.

Background Information:

The purpose of this study is to explore the lived experience of nurse executives seeking to manifest compassion through caring behaviors toward staff while balancing competing priorities.

Procedures:

If you agree to be in this study, you will be asked to:

• Complete an electronic survey to provide demographic information such as age, years of work as a nurse executive, what type of institution you currently work in, how many people you manage, and the state in which you practice which will take about 15 minutes to complete.

• After providing your demographic information, schedule a face-to-face interview which will last between 60 to 90 minutes. This meeting will take place at an agreed upon location.

• Respond to open-ended questions about your experiences as a nurse executive related to caring behaviors and the demonstration of caring behaviors toward staff.

• Provide information regarding what techniques/methods you use to maintain your caring behaviors toward staff and others

• Schedule a follow-up appointment to review a written document of your responses to the questions for accuracy and respond to any follow questions or clarify responses. (this is optional)

Here are some sample questions:

• Tell me about your current responsibilities in your nurse leadership role.

• What are some of your experiences when demonstrating compassion toward your staff?

• What role do compassion and caring hold in your leadership practice?

• What are some barriers you experience when demonstrating compassion?

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at AONE will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time. You may skip any questions that you do not want to answer. If you decide to take part, you are free to withdraw at any time. The researcher will follow up with all volunteers to let them know whether or not they were selected for the study.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as mild fatigue. Being in this study would not pose risk to your safety or wellbeing.

The benefits of being in this study include the opportunity to provide a voice for nurse executives regarding the challenges they face when seeking to demonstrate compassion toward staff and providing direction that may be useful for those seeking to improve the staff work environment, quality of care, staff retention, and patient outcomes.

Payment:

In return for your time, you will receive a gift card worth $10.00 immediately following the completion of the interview.

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. Codes and pen names (pseudonyms) will be used in place of names. Actual names will be stored separately from the data. The researcher will not use your personal information for any purpose outside of this research project. In addition, your name will not appear in any document about this study; the results of the study will be reported in aggregate (summary) form and all supporting quotes will be identified by pseudonyms. Data will be kept secure in password-protected files while all non-electronic data will be secured within a locked file cabinet. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at Rachel.stepp@waldenu.edu or by phone at 760-845-5206. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is IRB # 10-05-18-0152291 and it expires on 10-4-2019.

Please print or save this consent form for your records.

Obtaining Your Consent

If you believe you understand the study well enough to make a decision about it, please continue to the survey.

Appendix E: Walden IRB Approval Letter

Dear Ms. Stepp,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Nurse Executives' Lived Experience of Incorporating Caring Leadership."

Your approval # is 10-05-18-0152291. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on October 4, 2019. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. This includes maintaining your current status with the university. Your IRB approval is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, your IRB approval is suspended. Absolutely NO participant recruitment or data collection may occur while a student is not actively enrolled.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the Documents & FAQs section of the Walden web site:http://academicguides.waldenu.edu/researchcenter/orec

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data.

If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Both students and faculty are invited to provide feedback on this IRB experience at the link below:

http://www.surveymonkey.com/s.aspx?sm=qHBJzkJMUx43pZegKlmdiQ_3d_3d

Sincerely,
Libby Munson
Research Ethics Support Specialist
Office of Research Ethics and Compliance
Walden University
100 Washington Avenue South, Suite 900
Minneapolis, MN 55401
Email: irb@mail.waldenu.edu
Phone: (612) 312-1283
Fax: (626) 605-0472

Information about the Walden University Institutional Review Board, including instructions for application, may be found at this link:http://academicguides.waldenu.edu/researchcenter/orec