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College of Health Sciences

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Stacy January

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Dr. Linda Matheson, Committee Chairperson, Nursing Faculty
Dr. Janice Long, Committee Member, Nursing Faculty
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2019

Abstract

Positive Deviance Behaviors and Definition in Nursing

by

Stacy January, MSN, RN

MSN, Walden University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

November 2019

Abstract

The concept of positive deviance (PD) has not been studied in the context of nursing. Grounded in narrative inquiry and combined with vocabularies of motive and symbolic interactionism, the purpose of this study was to explore whether PD behaviors existed in nursing, and if so, to develop an operational definition of PD for nursing. The research question addressed what PD behaviors, if any, were present in nurses' workplace stories. Using posted flyers, eight participants either self-selected or were selected by snowball method to participate. Interviews were conducted in locations decided on by each participant. Interview data were obtained, transcribed, then categorized into the following behaviors: ability to flex with adversity (resilience), accountability for self and others, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, intentional, interdependence, moral empowerment, not driven by a level of authority, political astuteness, responsibility, self-empowerment, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. The findings from this study could impact positive social change in the following ways: (a) Nursing has its own definition to use: An intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, moral empowerment, self-empowerment, responsibility, or a combination of these attributes including a level of risk; (b) At the individual level, a way to define and back nurses' actions in a safe way or be used as a professional nurse expectation; and (c) At the organizational level, the identified PD behaviors and definition can be an expectation for employees of how to express themselves in a professional, honest, and direct manner.

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Dedication

This amazing journey is dedicated to my husband, Duane; my daughters, Brittany, Nicole, Caitlyn and Morgan; and my dad, William. You encouraged me, cooked for me, and had patience with me when I needed to work on this instead of doing other “fun life” things. To my mother, Darlene; my mother-in-law, Verlie; and father-in-law, Jan, although I lost you during this process, I know you were still by my side cheering me on. Thank you all for helping me realize this dream.

There are so many others that joined my journey along the way, I thank you too. I look forward to more journeys with everyone. Thank you, I could not have done this without all of you!

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Chapter 1: Introduction to the Study

Introduction to the Study

Registered nurses (RNs) are knowledgeable about improving the lives and safety of patients in their care; as many as "98,000 people die each year in the United States as a result of preventable harm" (Fagan, 2012, p. 426). RNs have a high degree of ownership for a culture of safety and are advocates for not only their patient populations, but for themselves, including the peer-to-peer and other colleague relationships in which they engage. Some of these conversations or interactions can be emotionally charged, with differing opinions, and those involved feel as if there is much at stake. Nurses are often engaged in highly charged issues that are characterized by opposing opinions, high stakes, and strong emotions (Patterson, 2002). A significant amount of the work that staff conducts relies on effective communication with each other. Duddle and Boughton (2007) emphasized that how each RN contributes in communicating with others is based on cultural norms and what each staff member brings in as a belief or expectation for communication. There can also be concerns about how RNs will be perceived when, and if, they decide to speak up or when exhibiting positive deviance (PD; Duddle & Boughton, 2007).

One aspect of positive social change the results of this study can provide is insight into whether behaviors of PD are demonstrated by RNs within the culture of nursing. When, and if, behaviors can be identified where nurses show the ability to express themselves in a professional, honest, and direct manner, at the right place and time, positive social change can occur in nursing practice. For example, as a positive deviant

on a nursing unit, the RN might understand the complexity of the care and issues of the environment. This can help to create a situation where this RN is in the perfect place to use the positive deviant behaviors to engage not only themselves but others to resolve issues in a productive and proactive way. Another aspect of positive social change impacted by the findings of this study is that by developing a nursing definition, a foundation is provided for further development and testing of this concept in nursing. Those factors identified as positive deviants could be potentially recognized as organizational change agents, valuable in finding innovative approaches to health care issues, and as a problem-solving technique (Gary, 2013; Ladd, 2009).

Background of the Study

Guaranteeing patient safety is problematic at best when the work is unpredictable and fast paced or when crucial decisions require quick clinical assessments and clear and effective communication (Pian-Smith et al., 2009). When challenging perceived or real authority in relation to standing up for what is right the following barriers are noted: “1) assumed hierarchy, 2) fear of embarrassment too self or others, 3) concern over being misjudged, 4) fear of being wrong, 5) fear of retribution, 6) jeopardizing an ongoing relationship, 7) natural avoidance of conflict, and 8) concern for reputation” (Pain-Smith et al., 2009, p. 85). Nursing is an extremely social profession where peers and colleagues are needed not only for care of patients but for many other important reasons. There can be issues with violations of trust, feelings of being devalued because of their lack of experience or novice status in an area of expertise, and concerns over being negatively gauged by others (Pian-Smith et al., 2009). Failure of communication is attributed to 65%

of medical sentinel events and medical errors that harm patients (Fay-Hillier, Regan, & Gallagher Gordon, 2012). Without RNs having exhibited behaviors of PD, medical errors may continue and the culture of safety will be impaired.

The PD approach has been applied in health communication. This was done as a process in which the community can self-discover both processes and ideas and where dialogue and *social proof* result in an organic spread of the innovation (Singhal, 2010). When PD is intentionally applied individuals are labeled as *positive deviants* because their *deviant communication* behaviors are not considered the norm and are *positive* because they model the necessary prevention behaviors (Singhal, 2010).

The idea of PD was generated 20 years ago as a behavioral change process to help with health-related challenges developing around the world (Lindberg & Clancy, 2010). The main idea being that there is someone in every community, whose successful diverse practices, are discovered by the unit or group community, and then, the practices are spread through the community to make the changes required for community success (Lindberg & Clancy, 2010). With this style of change comes a messiness and uncertainty that those engaged in the process need to be able to endure to model the necessary prevention behaviors (Lindberg & Clancy, 2010; Singhal, 2010). PD considers the community's existing assets or strengths (Marsh et al., 2004). A noteworthy point brought out by using the skill of PD is that the success rests on the ability to assemble the community to identify role models that use unusual processes as strategies to successfully take on common problems (Marsh et al., 2004).

In a continuing education article by Gary (2013), PD was defined as an "intentional act of breaking the rules in order to serve the greater good" (p. 26). Gary discussed PD specifically related to nursing, stating that the concept of PD centers around the idea that the choice to *break the rules or not* is solely within each nurse themselves. As a noun, PD, is a term that is describes a person as focused, persistent, optimistic, high achiever, and trailblazer (Gary, 2013). PD had also been defined as a few at-risk individuals who follow uncommon, beneficial practices and consequently experience better outcomes than their neighbors who share similar risks (Marsh et al., 2004). Overall, the idea is that the concept of deviation is not new in any of the areas it had been used in. PD, although a normal part of any work environment, had not been studied in nursing practice.

RNs can cultivate and create the work cultures they want to be part of every day and in the future (Fabian, 2013). RNs can be change drivers in that they can help with (a) increasing the longevity of employees; (b) bringing workplace automation; (c) increasing processing power; (d) bringing new communication tools, such as PD; (e) requiring new and different literacies beyond the written work; (f) social technologies that create new procedures if assembled; and (g) value construction and national interconnectivity placing diversity and flexibility in the middle of the organizational processes (Almost, 2006; Duddle & Boughton, 2007). Fabian (2013) asserted that an important point of social intelligence is the ability to connect in a significant and deep way to others. Unlike technology that is not able to have this type of relationship with others, the transdisciplinary or interdisciplinary ability to understand concepts across multiple

different disciplines, groups, or roles is important for working in groups or teams in the future (Duddle & Boughton, 2007).

Problem Statement

RNs are knowledgeable about improving the lives and safety of patients in their care; yet, in the report, *To Err is Human: Building a Safer Health System,* Kohn, Corrigan, and Donaldson (2000) recognized that, even with RNs' knowledge of needing to communicate and give feedback especially when nurses see practices or potential risks to staff or patients, hundreds of thousands of patients continue to be harmed during their healing time by fundamental problems in the shared behavior of these same professionals. Maxfield, Grenny, McMillan, Patterson, and Spreitzer (2005) asserted that "earlier studies have shown that greater than sixty percent of medication errors are caused by mistakes in interpersonal communication" (p. 1). To make the healthcare work environment safer for patients and staff, it is important that nursing is ready and able to speak up when there is risk.

The Institute of Medicine (IOM; 2001) has expectations that patients remain safe from injury caused by all care systems and, specifically, that further considerations are in place preventing and mitigating errors. Safe practice is dependent on individual and group safe practices; this is inclusive of effective and efficient communication and collaboration by all team members (Lapkin, Levett-Jones, & Gilligan, 2015). A significant amount of the work that staff conducts relies on effective communication with each other. The problem is that even though RNs witnessed incompetence, poor teamwork, disrespect, and colleagues cutting corners or making serious mistakes, fewer

than 1 in 10 discussed these concerns with a colleague (Maxfield et al., 2005). PD is described as a behavior that involves an intentional act of breaking the rules to serve the greater good (Gary, 2013). This definition has been found in sociology, business, and organizational studies as well as nonreferenced nursing journals (Gary, 2013; Lindberg & Clancy, 2010; Marsh et al., 2004). As such, PD is regarded as nonprescribed practices or strategies that are intended to produce or do produce better outcomes than traditional standard practices (Gary, 2013). Trust, respect, and teamwork are key components to effective collaboration amongst team members (O'Daniel & Rosenstein, 2008). Without these key components, safety in communication can be inhibited; some nurses are prohibited from using positive deviant behaviors if confidence, esteem, and teamwork are not present. In one report, staff stated that a significant number of colleagues created communication issues that were common, frequent, persistent, and dangerous, and as such, staff were not comfortable speaking up (Maxfield et al., 2005). Conversely, there are times when those that are part of a community deliberately break a rule and risk safety for the greater good (Marsh et al., 2004). Presumably, this would be some of the behavior's RNs would demonstrate in their workplace stories. The problem that I addressed in this study was whether positive deviant behaviors exist in the professional nursing environment, and if so, to develop an operational definition of PD for nursing.

Purpose of the Study

The purpose of this study was to explore if, and what, behaviors of PD were exhibited within RN workplace stories and develop an operational definition of PD for nursing. I completed the study using narrative inquiry combined with vocabularies of

motive and symbolic interactionism. The participants were RNs that worked within the western United States.

There was an increased need to gain an understanding of whether RNs demonstrate behaviors of PD because I was unable to locate information in the nursing profession literature on this subject. I found this be an increased need to better understand if these PD behaviors were demonstrated by RNs because I thought that if they did exist these behaviors could bring a positive aspect to nursing. If behaviors of PD were demonstrated or exhibited within the RN workplace stories in the study, my plan was to identify an operational definition of PD specifically for the nursing profession. The nursing specific definition of PD could be further explored and applied in additional studies in the future. Lindberg and Clancy (2010) referred to PD as intentional, and Gary (2013) stated that PD had components of innovation, creativity, and adaptability. Therefore, my preliminary operational definition of PD for this study was an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, and adaptability or a combination of these attributes, including a level of risk.

Research Questions

I reviewed previous research literature on PD and did not find a direct link between nursing practice and PD behaviors. Therefore, I sought to answer the research question: What positive deviance behaviors, if any, are present in nurses' workplace stories? Additionally, the data were obtained from the narratives were used to refine the operational definition of positive deviance as it applies to nursing.

Conceptual Framework

In this qualitative study, I used interviews to gather information from participants with *vocabularies of motive* positioned in the conceptual foundation of narrative inquiry. Vocabularies of motive are defined as "capturing the language by which people describe their motivations and account for their conduct" ("Vocabularies of motive," n.d.). This was used to help identify key descriptive terms of the behaviors labeled by the participants. In conjunction with symbolic interactionism, I used vocabularies of motive to explain how meanings that people attribute to things are derived from, or arose out of, social interactions, and in turn, their actions are based on distinctive meanings (see Blumer, 1986). Analysis of the data in their entirety is important and significant in order to understand the utmost reasonable explanations of the data to identify both the occurrence and the most likely reasons for the outcomes, including what the researcher brings in to the study based on their scope and experience, which plays a role in the analytic approach (Merriam, 2009).

Nature of the Study

Narrative inquiry is more than storytelling; the story is what happened, and the narrative is how the actual telling of the story is structured and scripted within the context of the story (Patton, 2015). This psychological approach focuses significantly on the participant's personal side, including their thoughts and motivations (Merriam, 2009). Narrative analysis emphasizes "inductive processes, contextualized knowledge, and human intention" (Merriam, 2009, p. 33). One of the reasons this methodology was appropriate for this study is that it is holistic in its approach, acknowledging the

cognitive, affective, and motivational dimensions of meaning from the participant (Merriam, 2009). This approach also allows the researcher to consider both the biological and the environmental influences on development (Merriam, 2009).

Vocabularies of motive occur when participants describe their meanings and how they describe those experiences or motives that are more acceptable in some groups versus others ("Vocabularies of motive," n.d.). In other words, regardless of the fundamental psychological motivation, the participant, in this case, the nurse, may make different motivational claims about their meanings dependent on the person(s) they are talking to, whether it be a peer, a researcher, or someone they perceive to be in a place of power ("Vocabularies of motive," n.d.). The benefit of symbolic interactionism combined with narrative inquiry and vocabularies of motives is the opportunity to explain the meanings each individual construct had and how these meanings influence their actions (Charmaz, 2014). If nurses can understand their environments, whether it be a work location, home, or a living environment, they may be able to see where the problem-solving or the recognition needs to occur to help the community (Lindberg & Clancy, 2010). Because the positive deviant knows the community, they can think *outside the box*, and when success is seen by others, they would be followed, and their techniques replicated (Ladd, 2009). This may happen outside the normal ways in a community, especially if the ways that were being used were not currently bringing about the resolutions needed no matter what the issues were.

In this study, I presupposed that an understanding of the behaviors that allowed nurses to speak up in risky situations to support and ensure a safe work culture are

currently present in some RNs. These behaviors could be used in the environment and could be taught to others that do not demonstrate the behaviors. Nurses who choose to use these behaviors and valuable skill set as well as identifying barriers that do not align with the behaviors could potentially enable others to have significantly safer patient care environments.

Narrative inquiry, informed by vocabularies of motive and symbolic interactionism, provided the approach for the study. The participants were RNs responding to the flyers or snowball sampling technique. The setting for the interviews was at an agreed upon location between the participant and me because some nurses may have not felt safe enough to be interviewed within the location of their employment. Semi structured interviews were able to generate rich, contextual data for analysis. Interviews were approximately 60 to 90 minutes in length.

My goal was to interview up to 10 RNs at a location of their preference. This was to allow for personal comfort and safety for the participant. It was important to have participants that were able to help inform an understanding whether it be for or against what the I think they may have as outcomes. Data collection stopped once saturation was clearly reached.

Definitions

In this section, I describe terms that were frequently used to discuss the research issues and problems under investigation. These terms are defined according to the limited context of the study.

Positive deviant: This term is recognized as both organizational change agents, valuable in finding innovative approaches to health care issues, and as a problem-solving technique (Gary, 2013; Ladd, 2009)

Vocabularies of motive: "Capturing the language by which people describe their motivations and account for their conduct" ("Vocabularies of motive," n.d., para. 1).

Assumptions

There were four underlying assumptions for the study. I assumed that there are RNs in the work environment who were currently acting as positive deviants. These were RNs in the unit who defy the current culture of "that is the way we do it" even if the actions of doing it that way were harmful to those on the unit. These RNs would go against the cultural norm even though they risked alienating themselves from others on the unit for help with patients, coverage, or friendship. Advocacy is a natural skill for many RNs when it comes to their patients; however, when it comes to advocacy for themselves, it appears to be a more difficult skill to master.

It was also assumed that the participants were representative of the population of nurses in the western United States. Another assumption in the study was that interviewed participants would answer the questions honestly instead of answering how they believed the questions should be answered because they felt safe enough to answer truthfully. My final assumption was that the nurse may have made different motivational claims about their meanings dependent on the person(s) they were talking too. For example, if they were telling their story to a peer, a researcher, or someone they perceive to be in a place of power, their story could change slightly.

Scope and Delimitations

Conflict is believed to be inevitable in multiple different work environments because of "essential differences in goals, needs, desires, responsibilities, perceptions, and ideas" (Almost, 2006, p. 444). Conflict can create an atmosphere where peers do not feel comfortable speaking up in a professional and honest way with each other even though they know it was the right thing to do. This clash could decrease the ability to speak up and may lead to additional communication errors, adding to the already known 65% of reported communication breakdowns among health care providers occurring in hospitals (Fay-Hillier et al., 2012). The Joint Commission (2012) reported that in 2010, 82% of sentinel events were caused by poor communication. Of 21 healthcare sentinel events identified by the Joint Commission, poor communication was one of the top three causes for 17 sentinel events, and the main cause for the following three sentinel events: delay in treatment events, elopement-related events, and fire-related events.

When reviewing the literature, I could not locate any extant research on PD, specifically in nursing practice, although PD in school nurses' in a leadership role was the topic of one article. I believed that the concept fit well into nursing practice and, in fact, believed that there were PD behaviors modeled by some RNs and wanted to identify those behaviors. When I looked at possible types and sources of data, it was important to understand what met inclusion and exclusion criteria. I believed that the RNs in the western United States were representative of the RNs in the United States. The inclusion criteria included: participants be a RN, work in the Western United States, are English speaking, are over 18 years of age, and have written informed consent. Therefore, the

exclusion criteria were: participants including all other roles, those that work outside the Western United States, non-English speaking, under the age of 18 years of age, and have no written informed consent.

Limitations

Although I exercised extensive care to minimize the limitations of this study, many possible limitations were relatively unavoidable. The limitations consisted of the (a) conceptual limitations, (b) situational limitations, and (c) methodological limitations. A conceptual limitation of the study was that since the participants were telling their story regardless of their fundamental psychological motivation, the participants may have made different motivational claims about their meanings dependent on the person(s) they were talking too, whether it be a peer, a researcher, or someone they perceive to be in a place of power ("Vocabularies of motive," n.d.).

One situational limitation I identified in this study was the interview locations. Participants self-selected to be part of the study; therefore, those possible subjects that were comfortable being part of a study may have been only those that volunteered. This could have been a powerful group to help refer others to be part of the study if they felt safe enough. Some of the participants may have felt awkward or uneasy at their place of work while engaged in an interview. Every effort was made to be available to meet participants at locations outside of the work environment.

In this qualitative study, I used vocabularies of motive positioned in the conceptual foundation of narrative inquiry in conjunction with symbolic interactionism, which allowed me to observe and build from the data gathered in the interviews. In this

study, there was no independent or dependent variables as there are in other study types. This type of qualitative study allowed me to develop a complex picture of the phenomenon under study to identify the data that emerged (see Creswell, 2009). The aim of this study was for generalizability more than reliability in that the sample size may not be representative of another organization's staff and should be repeated to see if the result is similar.

The semi structured interviewing format was most suitable for this study when compared to other data collection techniques in terms of the validity of the information obtained (see Merriam, 2009). Using this format, there was sufficient opportunity to probe for clarifications and ask questions appropriate to the participants' knowledge, involvement, and position. As Patton (2015) discussed, interviewing is the best way to find out what is on someone else's mind. In addition to interviews, I transcribed participant responses and observed them during the interviews as a major means of collecting data. These data collection methods gave a firsthand account of the situation under study. When combined with the interview method, they allowed for holistic interpretations of the phenomenon being investigated. Participant observation maximized the advantages of the human being as an instrument, but in this very advantage, there may be problems with the data I collected through observation (see Merriam, 2009).

Most important to note and recognize were the biases that may have been involved in the situation. These biases, inherent in the investigation, may have affected how data were seen, recorded, and interpreted. An observer cannot but affect the settings, and this affection may lead to a distortion of the real situation.

Significance of the Study

Nursing and nursing practice require not only improved technical skills but also critical thinking and communication skills (Gary, 2013). Working on interdisciplinary teams requires staff to communicate with each other openly, not allowing stressful unproductive conversations to linger. Unit cultural norms can play a factor in how staff relate to each other in their communication practices, beliefs, and expectations. Communicating effectively is significant to effective team performance (Paulson, 2011). It is a nurse's obligation to speak up to create a culture of safety for patients as well as provide peer feedback to collaborators and colleagues (Oregon State Board of Nursing, 2008). In this study, I sought to provide positive social change in the culture of nursing by providing behaviors demonstrated by RNs showing the ability to express themselves in a professional, honest, and direct manner at the right place and time.

By developing a testable definition of PD in which a foundation was provided, further development of this concept can be studied in the field of nursing in the future. This development can continue to contribute to positive social change moving forward. Within this process, those identified as positive deviants are recognized as organizational change agents, valuable in finding innovative approaches to healthcare issues and applying problem-solving techniques (Gary, 2013; Ladd, 2009). Gary (2013) stated that PD was a way to improve clinical performance outcomes. An example of this was shown by nurses solving problems on their own by citing guidelines or laws to support their actions yet going against the cultural norm.

PD not only involves behaviors that are characterized by moral intentions and self-governing outcomes but are often seen in a creative and valuable light (Gary, 2013). This concept aligns with the nursing standards that require a nurse to go against the guidelines if following the guidelines compromises patient safety (American Nurses Association [ANA], 2010). If RNs were confident to speak up in their culture or demonstrate PD behaviors, there could be a decrease in instances of witnessed incompetence, disrespect, poor teamwork, and standing by while colleagues cut corners potentially endangering patients and peers alike. One of the strongest positive social change implications would be that, in time, PD behaviors in nursing could be the expected norm and not the exception. According to their professional standards, RNs are responsible to give feedback while enabling a safe environment and creating a collaborative environment amongst the various team members (ANA, 2010). I did not find demonstration of PD behaviors in nursing in the literature with the exception of school nurses in their leadership role, although PD behaviors were found in the sociology literature. If RNs were found to be demonstrating PD behaviors and a definition were to be formed specifically for nursing, perhaps the communication issues in the healthcare environment would have fewer negative impacts. The findings that would lead to positive social change for society are RNs speaking up for greater prevention and mitigation of errors, such as witnessed incompetence, poor teamwork, disrespect, and colleagues cutting corners or making serious mistakes (see Maxfield et al., 2005).

Significance of the Study

Significance to Practice

Gardner (2015) contended that “the profession of nursing, by its very nature is wrought with significantly complex moral and political disagreements” (p. 179). Gardner also stated that these situations cannot be downgraded as private, individual conversations because the outcome is too important to the greater good. It is also important that nurses learn how to *develop skills in public discourse* to be able to provide a bridge between practice and the profession. If nurses showed behaviors of PD that could help provide the bridge between practice and the profession of doing what is right even when it is against the culture on the unit, then those PD behaviors could engage others on the unit in healthier behaviors for a healthier and safer unit culture. Instead of staff being afraid to voice their opinions, perhaps a significant number of colleagues would speak up when encountering communication issues that were common, frequent, persistent, and dangerous, which would in turn, decrease these issues creating a safer culture.

Significance to Theory

Qualitative theory is used as a broad explanation for behavior and attitudes (Creswell, 2009). The IOM (2001) identified that it is imperative to bring about a change in the communication patterns of healthcare staff, because of the number of errors due to communication, to have a culture that functions at its highest reliability and safety. It is also important to have a mechanism in place to give feedback to peers according to the IOM. By identifying behaviors of PD in nurses and bringing these behaviors to the RNs’

awareness, the behaviors may be looked at as more accepted. The process of detecting the same or additional behaviors in other healthcare roles could be recognized and allow teams to function using the same language and expectations to communicate with each other. This could create a system that functions in a more reliable and safer way for both staff and patients. This theory could then be used in a generalized way across roles within the healthcare industry. Nursing could have a theory or concept of its own and not need to borrow from other disciplines. This concept or theory would also be specific to nursing, making the behaviors relatable and explicit to nurses.

Significance to Social Change

The results from this study may contribute to positive social change by providing behaviors or having the ability to teach the behaviors of PD that were demonstrated by RNs that can express themselves in a professional, honest, and direct manner at the right place and time when under stress. Another aspect of positive social change is by developing a testable definition. Once a definition is understood, a foundation can be provided for further development of this concept in nursing. The concept of PD could then be introduced to multiple different roles in healthcare so that similar processes can be followed and understood.

Summary and Transition

In Chapter 1, I provided an overview of the study including the background, problem statement, purpose of the research, research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance to practice. I conducted a qualitative study with vocabularies of motive

positioned in the conceptual foundation of narrative inquiry using interviews to gather information in conjunction with symbolic interactionism to explain how meanings that people attribute to things are derived from, or arose out of, social interactions, and in turn, actions are based on idiosyncratic meanings (see Blumer, 1986) and determine what, if any, positive deviant behaviors there were in a RNs' practice and develop a definition of PD for nursing. Eight semi structured interviews with self-selecting, English-speaking RNs practicing in the western United States were conducted to obtain the data required. In the next chapter, I will provide the literature search strategy, literature review, and conceptual framework for PD.

Chapter 2: Literature Review

Introduction

The IOM (2001) discussed that it is important to implement mechanisms for feedback and learning from error. This statement helped to emphasize how important it is to be able to not only give feedback but to receive feedback. Giving and receiving feedback were not always skills that nursing staff were comfortable with, especially if there had been less than desirable responses when previously trying. The term PD in nursing was identified as having been used with school nurses in leadership in the current literature search. Although, PD was discussed in sociology and business literature, I identified a gap in the nursing literature concerning this topic; therefore, it was important to review other literature to define the PD concept.

Literature Search Strategy

I used the Walden University Library and Google Scholar websites to search various databases and search engines for literature pertaining to this study. The initial databases and journals searched were ProQuest, Cochrane, EBSCO, Medline, *Journal of Advanced Nursing*, and *Journal of Nursing Management.* The search terms used were *positive deviance, positive deviant, team member conflict, conflict in nursing, conflict resolution, stress management, resilience,* and *conflict and communication*. My search of these databases and journals using these terms led to additional databases and journals, such as Research Gate, Sociology, Health Communication, Philosophy, National Center for Biotechnology Institute, *Business Communication Quarterly*, and *Journal of Environmental Health*, where additional supportive information was located.

I received confirmation early in the literature search that the search term PD was not represented in the nursing practice. This showed a specific gap in the nursing literature. This specific search term was discovered in a limited way in business journals and discussed in terms of the organizational view, not at the individual role level or concerning the potential impact to nursing practice. I also found literature on PD in sociology, where those in specific communities studied could bring about positive changes to their communities in areas, such as better nutritional outcomes in children within specific societies.

I also searched the term conflict because conflict behaviors have shown significant increases in job dissatisfaction, absenteeism, and turnover for RNs who stay in the job remaining chronically unhappy (Almost, 2005, p. 444; Boughton & Duddle, 2007). Process conflict focuses on how nurses disagree about whose accountability it is to complete the content or the goals of the work (Almost, 2005). If the process conflict continues over time, the effects can change the original cause of the conflict or create new causes to the conflict (Almost, 2005). In other words, behaviors of the positive deviant could be misidentified as conflict behaviors by those that are uncomfortable with differences in goals, needs, and desires (Almost, 2005; Boughton & Duddle, 2007). Conflict behaviors have also been shown to influence RNs on their perceptions of the work environment (Fackler, Chambers, & Bourbonniere, 2015; Higazee, 2015; Lees, 2016; Rosenstein, Dinklin, & Munro, 2014). Many work hours are spent dealing with the effects of the perceived conflicts by managers (Strutton & Knouse, 1997).

The term culture of safety was searched and reviewed because this terminology was frequently used when talking about patient-centered care and the reporting of safety issues. It was also a term that I had heard in conjunction with speaking up. It appears that both of these concepts go together because in order to speak up, a person must be willing to work in a culture of safety. It is important to have open dialogue that facilitates safer practices and not look for a culture of blame (Scott-Cawiezell et al., 2006). This was how to set the culture up for success in the long run.

I reviewed stress management and leadership in the literature because nurses needed to have good stress management and leadership skills. Either could be actions or strategies adopted in adverse circumstances or providing assets necessary for effective operations and available to navigate the complex environments that they work in. Stress may occasionally be mistaken for PD behaviors (McVicar, 2003). The positive deviant could require better than good skills with stress management because they could be under more stress as they step out of a normal RN role and into the role of challenging some of their peers and colleagues in their beliefs and thoughts in the way things have always been done previously (Higazee, 2015; McVicar, 2003; Rosenstein et al., 2014). The positive deviant could not only help support teammates on their unit or in their clinical area in their current state of stressful work, but they will be able to provide team leadership with a positive response to conflict (Pipe et al., 2011). This could be especially true when they show team members how to talk to each other under stressful times, have a clear understanding about the purpose of their team, and can help explain the significance of these discussions (Ellis, 2017; Pipe et al, 2011). Potentially any RN,

including the positive deviant, may be living dangerously by being a leader in the team; using authentic behaviors and creating and sustaining high quality care environments is what leadership is about (Jackson & Daly, 2011; Pipe et al, 2011). This is thought to be possible when challenging other beliefs or comfort levels (Higazee, 2015; Rosenstein et al., 2014).

The term resilience was reviewed because as a RN, it can be important to show signs of resilience in behaviors for the everyday work that needs to get done. The RN, as the positive deviant, may need to call on their professional network in order to get the work done (Jackson & Daly, 2011; Jackson, Firtko, & Edenborourgh, 2007). A potential, natural side effect of the positive deviant leader is the need to show their increased vulnerability; however, it may be important that the positive deviant, as it is for all RNs, to reconcile their own actions and decisions knowing that they have brought critical thinking and equity to these decisions among other important things (Jackson & Daly, 2010; Jackson & Daly, 2011).

Conceptual Framework

The conceptual framework for this study was the vocabularies of motive positioned in the conceptual foundation of narrative inquiry that was used in interviews to gather information in conjunction with symbolic interactionism. The concept of vocabularies of motive was first developed by Mills (1940) to capture the language that people use to describe their motivations and account for their conduct. Mills was interested in how people talk about their motives, specifically their social contexts. This concept has been used by sociologists due to their concern of the ways that talk helps

interaction proceed smoothly and their exploration of sources of motivational statements (“Vocabularies of motive,” n.d.). For this study, I used vocabularies of motive to “capture the language by which people describe their motivations and account for their conduct” (“Vocabularies of motive,” n.d.).

Narrative inquiry is best for capturing the life story or experience of a small number of participants (Creswell, 2013). The narrative inquiry in this study was an oral history, in that there is a specific contextual focus, a personal narrative or lens from the participant regarding their stories on PD (see Creswell, 2013). Symbolic interactionism is used to explain how meanings that people attribute to things are derived from, or arose out of, social interactions, and in turn, that actions are based on idiosyncratic meanings (Blumer, 1986). In this narrative inquiry, I captured the life story from the lens of the participant, and symbolic interactionism helped to explain the meanings that the participants have assigned to each narrative or story.

Lastly, vocabularies of motive helped me understand if the participant answered the questions based on the person they were talking to. An example of this would be how the participant answered the same questions when they were talking to their boss versus talking to a researcher or peer. The answer to this could be an indicator of whether those that believed they are positive deviants truly are. If they would answer differently to different people, they may not be as much a positive deviant as they think they are. Together, these three concepts were used to see what, if any, positive deviant behaviors are found in RNs’ actions and how PD is defined in nursing. Nursing can be a very hierarchical profession, and the best solutions do not always come from the hierarchy but

from those that work on the frontline with an understanding of the situation and the complexity of the issues and nursing practice required for success (Bevan, 2013)

To provide a safe and effective culture, in this study, I sought to explore how the unit culture and the RNs' professional obligation could assist with their challenges and barriers to speaking up. The culture on each unit can be defined in such a way that staff may feel that they are confined by the hierarchy versus what their professional obligation is according to the ANA's (2015) Scope and Standards. The ANA's Scope and Standards identified three specific standards that empower a nurse to create a culture of safety: (a) Standard 14, which states that RNs will share their knowledge with others and provide feedback to peers with a caring attitude; (b) Standard 9, which asserts that the RN communicates with others to enable a safe environment and shows respect for others; and (c) Standard 10, which discusses the importance of teamwork amongst RNs and other healthcare team members and their commitment to each other, the patient, families, and the organization. These standards align well with the use of PD behaviors in the nursing work environment, thereby creating a culture of safety.

Literature Review

The concept of PD is a new topic for nursing. In my comprehensive literature review, I did not identify any research studies on this concept; however, five authors shared their observations. Gary (2013) asserted that, although professional nursing standards guide patient care and lay the groundwork for best practices to be utilized for documentation, they are not enough when it comes to nurses needing to make decisions that involve multiple levels of uncertainty and risk in their practice. Nurses may need to

respond resourcefully to meet the needs of their patients, and as such, they may employ the concept of PD to help guide their actions (Gary, 2013). Gary described positive deviants in nursing as "atypical nurses who practice differently and more effectively than their peers" (p. 28). Within the nurses' scope of practice, positive deviant behaviors are categorized by: (a) honorable intentions, independent of the outcomes; (b) workarounds are often seen in a negative way; however, they can be inspired, innovative, and valued; (c) these actions can be extremely risky for the person that is deviating both from a level of personal comfort and protecting their license and livelihood; and (d) the ability to stand back and view new ways to approach and solve problems (Gary, 2013). PD is often described as a process to organizational change or as a framework for understanding organizational behaviors and managing complexity by a potentially effective means of affecting parameters, such as (a) numbers and nature of relationships in an organization, (b) differences and diversity in perspectives and actions, (c) the level that power is centralized or shared, and (d) the degree that variability and experimentation coexist with order and standardization (Gary, 2013; Lindberg & Clancy 2010).

Some authors suggested that PD can be used as a management strategy to improve clinical outcomes. Marsh et al. (2004) discussed that PD has been used to successfully improve child health in some of the poorest communities where a few individuals or groups realized good health. PD is also a quick, low-cost method to identify both the strategies used and roles needed to encourage the remainder of the community to adopt the behaviors (Marsh et al., 2004). The success of the PD methodology falls largely on the ability to get the community to identify those that use

unconventional, yet successful strategies when tackling common problems for that specific environment (Marsh et al., 2004). The PD component is thought to work because when dealing with health-related challenges, such as childhood malnutrition, HIV/AIDS prevention, and maternal and neonatal mortality in the developing world, there are individuals or groups whose deviant practices produce better than average outcomes than their colleagues with access to identical resources (Lindberg & Clancy, 2010; Marsh et al., 2004).

PD has been discussed from the perspective of school nurses due to their unique kind of role. School nurses have a select relationship with students, teachers, administrators and parents because they can be positive deviants in their school systems as well as use their leadership and caring skills to bring health and healing to this unique environment (Ladd, 2009). A specific leadership opportunity, where the positive deviants can contribute, is described as an unhealthy environment that is characterized by cognitive dissonance, where staff and students feel undervalued, lack common goals, and have an environment permeated by negative legends and a widespread us versus them attitude (Ladd, 2009). In these emotionally negative environments, differences are the primary focus and the heighten perceptions of conflict (Ladd, 2009). Dissonant cultures are not equipped with the structures to resolve conflicts quickly and leadership is not trusted; therefore, conflicts continue to grow (Ladd, 2009, p. 12). The school nurse brings harmony to the school environment by promoting cultural consonance; they decrease the conditions, such as bullying, violence, or other environmental components not conducive to optimal mental health and learning (Ladd, 2009). RNs have an obligation to bring in

the skills of working as a team (i.e., Standard 10), communicating well with others to create a safe environment (i.e., Standard 9), and providing feedback as needed with a caring attitude (i.e., Standard 14; ANA, 2015). The RN, acting as a positive deviant, would have an obligation, as all other RNs would, to use Standards 10, 9, and 14 in their practice.

It was also pointed out that the PD process helps to identify the positive deviant in the community; as well as, uncover their effective practices and then through rampant assignation, increase the spread of the desired practice (Lindberg & Clancy, 2010; Marsh et al, 2004). PD was studied in a few attempts in the sociological literature by Ben-Yehuda (1990) and Dodge (1985) and they were met with great disapproval that PD can exist as a concept (Spreitzer & Sonenshein, 2004). Yet, Lindberg and Clancy (2010) introduced the concept of PD years later as a way to engage RNs to improve clinical and administrative outcomes. Ultimately, the success of the PD approach is based on the capacity to assemble the community to identify role models within it who use uncommon, but demonstrably successful, strategies to tackle common problems (Marsh et al., 2004).

PD is sometimes discussed as an approach and not a practice. Regarding health communication, when the PD approach has been used by the community it self-discovers ideas, and then dialogue and social proof ultimately result in an organic spread of the information (Singhal, 2014; Marsh et al., 2004). In other words, PD allows the communities to discover what they already know and magnify the knowledge or sharing

of this information; even though the potential for help within the communities using this approach to benefit health or other benefits is underutilized (Marsh et al., 2004).

Although no specific PD behaviors were called out for RNs in practice in the literature searches completed. In reviewing the literature, the following behaviors are ones that I believed may be identified as PD ones: ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, inspiration, interdependence, observant, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. This review had shown a gap in the literature, identifying specific RN PD behaviors in nursing practice and this phenomenon should be further explored. Using the phenomenon of PD could be a favorable practice in the nursing environment to create healthier staff and patient environments.

Conflict

As participants described behaviors of PD, I was concerned that the participants may describe behaviors of conflict. Some behaviors that have been successful for those considered positive deviants, are behaviors that equate to creativity, being innovative, adaptability, or some combination of these traits (Gary, 2013; Ladd, 2009; Lindberg & Clancy, 2010); whereas, those that are considered as argumentative, rocking the boat or not going with the flow could be also be another perspective (Gary, 2013; Lindberg & Clancy, 2010).

There are several types of conflict. There are three types of conflict: relationship, task, and process. When relationship conflict is present there are interpersonal

mismatches including tension, interpersonal clashes, trust issues, and annoyance (Almost, 2006; Langfred, 2007). Task conflict is an awareness of differences in viewpoints and opinions affecting a team task, including ideas and differences of opinion about the task, and can have both positive team productivity and negative effects on dissatisfaction. Lastly, process conflict presents itself when determining how task success should proceed, who is responsible for what, and how things should be delegated, essentially, focusing on how tasks would be accomplished (Almost, 2006).

There were many ways to interpret words and their meanings. It was important to have an understanding and standard way to discuss what appears to be simple words, in order to attach the same meaning to the context. Conflict, as a verb, is defined as incompatible, variance, or clash (Conflict, 2019). Deviant, as an adjective, is defined as departing from usual or accepted standards (Deviant, 2019). Negative, as an adjective, is defined as indicating that a certain substance or condition is not present or does not exist; and positive, as an adjective, is defined as expressing or implying affirmation, agreement, or permission (Negative, 2019; Positive, 2019). Almost (2006, p. 444) discussed that conflict is unavoidable in any work environment due to innate differences in “goals, needs, desires, responsibilities, perceptions, and ideas”. Ongoing conflict within the work environment was damaging to the work climate and negatively affects individuals physical and mental well-being resulting in decreased coordination and collaboration, reduced efficiency, and without the skills to participate in these highly risk, highly charged conversations the outcomes were often less than positive for any of the parties involved (Almost, 2006; Patterson 2002). If conflict was unavoidable in any work

environment (Almost, 2006) then it seems reasonable that there may be conflict that the positive deviant saw in the work environment whether there was a different level of conflict was unknown; however, conflict by its very nature was not necessarily a negative concept nor are the outcomes necessarily negative.

Subjects become taboo when there was anxiety or stress in discussing a specific topic or when the focus of said topic was too emotionally charged, especially when the issues are not addressed in some way to help preserve the relationship (Patterson, 2002). Westphal et al. (2015) asserted interpersonal work-related conflict was an identified common and psychologically taxing stressor in the healthcare work environment. With the importance of preventing burnout along with damaging health consequences, it was not only significant, but vital, to help staff understand how to protect themselves against stress, while allowing them the ability to change (Westphal et al., 2015). In a *communicative space* people can come in on equal footings to discuss high intensity, common issues or problems and reach agreement on an action that may bring fear when people come together under a different situation to discuss (Bevan, 2013). This knowledge allows those in the community to converse and arrive at outcomes or answers that were not levied by those with power but by those in the group; thus, the potential for success is greater (Bevan, 2013).

The literature shows that under some circumstances such as fear of retaliation, negative labels, or harming work relationships nurses do not speak up (Lebel, 2016), but some nurses do speak up in cultures where peer collegiality exists (Padgett, 2013). The skill of speaking up appears to be a needed behavior of any RN working in the workplace

environment, therefore it would be a sensible expectation that the RN that may exhibit behaviors described as positive deviant behaviors could include speaking up. However, behaviors of PD within RNs were what I was hoping to find in the context of this study.

Conflict in Nursing

Conflict in nursing has existed for decades. There are many studies that show not only how conflict can get in the way of quality patient-centered care but also how communication issues were conflict ridden. Conflict can be “positive or negative, healthy or dysfunctional” (Higazee, 2015, p.2). Conflict influences the perception of the RNs work environment and the quality of their care (Fackler et al., 2015; Lees, 2016). Conflict that is dealt with in an inappropriate way can lead to negative consequences for nurses and their colleagues (Higazee, 2015; Lees, 2016). As RNs are asked to do more with less, as payers and regulatory agencies look to reduce costs and inefficient costs, high quality, safe, satisfying care, increasing pressures, organizations are governed by increased needs for performance measures, and targets enhanced communication and collaboration will become more necessary than ever (Fackler et al., 2015; Lees, 2016; Rosenstein, et al., 2014).

Other circumstances that contribute to organizational conflict are leadership transition, weak leadership, and persons having too many jobs or roles (Strutton & Knouse, 1997). Managers are reporting that they spend at least 20% of their time dealing with conflict (Strutton & Knouse). Whether nurses work 8 or 12 shifts, 1 day or up to 5 days a week, conflict in the healthcare environment exists every day to some extent. The

level of how the conflict was perceived was different according to each person and each offers a different point of view (Higazee, 2015; Rosenstein et al., 2014).

> There were three types of individuals on the continuum of conflict. Rosenstein et al., 2014) stated at one end there were the really: disruptive individuals that cross the line of professional behavior; in the middle were the individuals that have difficulties developing positive working relationships that compromise effective communication and collaboration; and at the other end were those that refuse to adhere to appropriate protocols, policies, and standards of care. This last group is the most serious threat to relationship-based care (p. 36).

This last disruptive group was usually accounting for only 3% to 5% of staff, yet they can have a profound effect on the organizational dynamic (Rosenstein et al., 2014). Disruptive RNs were verbally abusive to their subordinates and junior peers, threaten them with body language, and humiliate them, with lateral violence (Higazee, 2015; Rosenstein et al., 2014). This group was significantly different from the positive deviant in that the positive deviant was an expert in the culture, whose goal was for a positive community outcome (Marsh et al., 2004). One important aspect that I think we might find was interdependence of the positive deviant and the team they work in to meet the needs of those within the team (Rosenstein et al., 2014).

Behaviors that could be found by those that identify as positive deviants may be looked upon as conflictive. The reasons they may be looked at as conflictive are: (a) things that create discomfort are usually looked at as conflictive in nature; (b) when issues are taken on by the positive deviant, others beliefs can be challenged; (c) those

uncomfortable with conflict may shy away from the positive deviant due to discomfort of their actions; (d) managers or colleagues in hierarchical positions may want the situation to go away so they do not have to *deal with it,* therefore, even though the correct thing to do was to support the positive deviant they may punish or push them down (Rosenstein et al., 2014; Strutton & Knouse, 1997). There could be a combination of these too.

Culture of Safety

Patients have a reasonable expectation to be kept safe when they enter the hospital or clinical area for care. There are many unspoken expectations that, as the name implies, that were never stated; yet, these expectations should be delivered in the patient-centered care arena. There are also many stated expectations; these come primarily in the form of regulatory expectations. An environment conducive to open dialogue to facilitate safer practices was often referred to as a culture of safety (Scott-Cawiezell et al., 2006). In the United States, the healthcare environment is becoming increasingly complex with regulatory compliance, both spoken and unspoken patient expectations; as well as, reform in practice and reimbursement based on performance demanded by federally sponsored programs and healthcare payers (Lockett et. al., 2015). It was important to understand this as a RN because this helps to be patient centered in the care that we give and focused on patient safety. Patient safety and patient-centered care can help to create high-reliability organizations. High-reliability organizations have a culture that was essentially fixed on patient safety; thus, this culture can only be achieved when everyone holds-up self and peer accountability (Lockett et. al., 2015). The IOM (2001) “highlighted risks to patient safety and offered strategies to improve patient safety through a tangible care

delivery processes, such as medication administration, infection prevention and organizational struggles such as clinicians not speaking-up" (Lockett et al., 2015, p. 558). It was important to stress in a culture of safety the importance of reporting; that the idea of a culture of blame was counterproductive if what you are wanting was to get to the bottom of the issue and honest reporting (Scott-Cawiezell et al., 2006). Behaviors that significantly undermine a culture of safety were: (a) intimidating and disruptive behaviors including overt actions such as verbal outbursts and physical threats, (b) passive activities such as refusing to perform assigned tasks, and (c) quietly exhibiting uncooperative attitudes during routine activities (Joint Commission, 2008, para 2). PD behaviors could include speaking up even when it was uncomfortable, clarifying information in a professional way, observant and accountability for self and peers. The need for these behaviors to align with conflict behaviors that were seen when staff were not well versed in how to deal with stress, or have the resilience needed in today's highly complex organizations.

In order to have a culture of safety, staff have to be willing to speak up when they see processes that are not correct or speak-up to other staff in order to keep patient centered care in focus (Scott-Cawiezell et al., 2006). As staff were asked to complete more with less in these complex environments and patients continue to have unspoken expectations, it would be significant to see what positive deviant behaviors if any are exhibited to encourage reporting and the culture of safety for patients and staff. This was important to look at as part of the study.

Speaking Up

Speaking up could be a beneficial skill, that if identified in the study, could help the positive deviant to be effective as a colleague and peer; as well as, a leader for patient centered care. As we will see the data does not confirm that this comes as a natural skill for the majority of RNs (Garon, 2011; Sayer et al., 2011). There are currently 1,649,480 inpatients and 128,180 outpatient licensed RNs in the United States (Bureau of Labor, 2017). Nurses are a key component to healthcare organizations and have a unique advocacy role within these organizations (Garon; Sayer et al). Patient care and safety can be significantly compromised when nurses do not or believe they cannot speak up (Garon, 2011; Sayer et al., 2011). Speaking up was defined as "using voice to make specific information that is privately held known to someone - positional power or authority – to take action" (Detert & Edmondson, 2006, p. 10).

Nurses work within an interdisciplinary and intradisciplinary team and often in high stress environments, which can result in conflict with physicians, peers, and colleagues (McVicar, 2003). This can set a foundation for multiple different reasons to not speak-up if the nurse did not see a direct impact to the patient, a perceived lack of leadership support, fear of retaliation by peers or colleagues, and fear of losing the network required to get the day to day work completed. Therefore, even though RNs witnessed incompetence, poor teamwork, disrespect, and colleagues cutting corners or making serious mistakes, fewer than 1 in 10 discussed these concerns with a colleague (Maxfield et al., 2005).

The concept of power and that said power for some RNs can have a significant influence on how they perceive their work environment (see Fackler et al., 2015) and may be important to consider. Especially when influences in work environment such as acquisition of knowledge, experience, self-confidence, building relationships, and advocating for patients (see Fackler et al., 2015). Behaviors of successful communication are believed to include assertion, clarity, and transparency (Garon, 2011; Timmins & McCabe, 2005).

Sayer et al., (2012) told us that instead of RNs speaking up in conflict situations they prefer to address these situations by avoidance or accommodation. In the literature, I found registered nurses do not prefer assertive behaviors and are much more likely to quietly acquiesce to others in the conflict, in essence ignoring the need to communicate their own value and worth (Sayer et al., 2012; Timmins & McCabe, 2005). Although, the role of power relations and the concept of RNs as an oppressed group is an important one, Roberts (1983) asserted that nurses, as other oppressed groups have silenced themselves. The thought being that if these nurses did not speak up, they can avoid the conflict and stay in their comfort zone; however, they did not advocate for their patients or themselves in a selfish way (Garon, 2011; Sayer et al., 2012; Timmins & McCabe, 2005). Another influence to consider was organizational structure and practices; this could influence the communication environment (Garon, 2011; Sayer et al., 2012).

Fackler et al., (2015) asserted that there was a "positive relationship between components of a RNs work environment and quality patient care" (p. 268). One of these being the relationship between quality of care as autonomy and control over practice;

whereas, the concept of nurse to colleague perception of power does not appear to have the same affect (Fackler et al., 2015). Although, important themes from the studies included that the participants ultimately believed that building positive relationships with others, whether they be nurses, physicians, or other colleagues, was significant in both developing and sustaining a sense of power (Fackler et al., 2015; Garon, 2011; Sayer et al, 2012).

According to a study by Fackler et al. (2015), the nurse's voice being listened to and heard; the nurses' knowledge recognized and acknowledged along with the relationships the nurses nurtured felt powerful (p. 269). They did feel as if they were on the same page as other colleagues normally in a hierarchical level, when they felt more in a collaborative decision- making model (Fackler et al., 2015, p. 270). The belief was that knowledge of ones' expertise is the first step in exercising power (Fackler et al, 2015) and perhaps this will show in the behaviors of becoming a positive deviant for one's culture. For those that will speak-up, as this was a potential behavior that may come out as needed by those positive deviants, regarding peer support was important because the speaking up was believed to have an effect, be low risk for those speaking up, was thought out, deliberate, and there were both direct and indirect costs with speaking up (Garon, 2011; Premeaux & Bedeian, 2003). Direct costs include the time and energy spent speaking up; indirect costs include potential weakened public image, retaliation from those with opposing viewpoints, antagonistic relationships, or a wounded ego if views are reduced or ignored (Premeaux & Bedeian, 2003).

Speaking up could be shown to be an invaluable resource for the positive deviant. If it was shown that behaviors of speaking up were required in order to be successful as a positive deviant whether it was believed to be low or high risk. As a positive deviant creating and maintaining relationships could potentially be shown to be an important behavior and skill in order to bring about positive social change on the unit and within teams depending on what and if behaviors of PD are shown to exist in RNs.

Stress Management

Stress management skills were important as these behaviors could be correlated with negative behaviors and misconstrued or misunderstood as positive deviant or conflict behaviors. Employees report being stressed at work (Grawitch et al., 2015; Holton et al., 2016). Thirty-five percent of staff report that their job is harming either their physical or emotional well-being, 42% say job pressures are interfering with their family or personal lives, 50% report more demanding workloads than they had a year ago, and 51% report some amount of lost productivity due to stress while at work (Holton et al., 2016; Harris Interactive, 2011). Stress is a "process that occurs when there is a stimulus (stressor) that produces a physiological, emotional and/or cognitive reaction (stress response) requiring an expenditure of effort that taxes existing resources (coping)" (Grawitch, Ballard, Erb, 2015, p. 264-265). Stress has been identified as an important issue for nurses and other healthcare leaders in previous research studies and research (IOM, 2004; Boorman, 2010). With the increasing requirement of being more efficient in the healthcare environment instead of focusing solely on the problems of stress management, recommendations are shifting to focus on the perspective of more effective

and efficient ways of building resilience and agility (Pipe et al., 2012). The PD behaviors could be mistaken for negative stress or conflict behaviors show as negatively charged emotions. to help the culture support teammates in their current state of stressful work (Pipe et al., 2012). Decisions are "significant, imperative and the high stakes of communication, teamwork and decision making is very high" (Pipe et al., p. 12). There are times in the work environment when stress affects the whole team potentially due to a shared experience i.e. "increased workload, or a significantly difficult incident that occurred in the work environment, or it could be the fact that a team member is ill or having a rough time" (Ellis, 2017, p. 54; Grawitch, 2015).

One thought of managing stress was to generate a positive team culture; which was when team members talked to each other, and had a clear, shared understanding about the purpose of their team (Ellis, 2017). Positive emotions helped to broaden the team member's ability to think which allowed them to reach into a higher level of influences and wider range of possibilities or ideas (Ellis, 2017; Pipe et al., 2012). For example, the respondent's that were optimistic reported being more "receptive, creative, making better decisions, having improved communications, making new connections, experiencing new ways of being and finding new learning opportunities" (Pipe et al., 2012, p. 13). It was also important to allow a healthy work-life balance (Ellis, 2017). Even with the programs supplied by many organizations there was an expectation that a certain level of employee involvement was required for the best results (Grawitch et al., 2015). If RNs had a way to provide and promote self-care for themselves and viewed this as important, they viewed self-care as an important component of positive team culture.

This could potentially have provided a link to a shared understanding of positive team culture, which may have helped positive emotions to grow allowing a team member to potentially influence a wider range of possibilities (Ellis, 2017; Pipe et al., 2012).

Conflict was often associated with anxiety, anguish, and stress. For the nurse that may have demonstrated positive deviant behaviors, it was interesting to see what behaviors correlated with conflict like behaviors. Other behaviors would potentially be that the positive deviant RN was able to see the opportunities that will bring about the positive changes that were required for safer patient care and culture and created a better leader in nursing moving forward. These behaviors could potentially reflect not only a beneficial practice in the RN themselves, but benefited their patients, peers and the organization. PD may not be a specific stress management practice such as breathing, taking a walk or even the nurse envisioning them self in a wonderful place. However, the positive deviant may need or require some of the stress management techniques to put into action PD, the intentional act of departing from a current cultural established norm in order to change it. Especially since changing the cultural norm often entails challenging purposely or unintentionally another's core beliefs or what is believed to be fact when it may not (Higazee, 2015; Rosenstein et al., 2014).

Leadership

There are many positive sides of leadership behaviors such as authenticity, courage, inspiration, connectedness, vision, and political astuteness; in other words, it was the responsibility of the nurse leaders to create and sustain high-quality, safe and effective patient-centered care (Jackson & Daly, 2011; Pipe, et al., 2012). There was

another side that was not talked about nearly as much, the living dangerously side, meaning that RN leaders are seen as "very face of unwelcome organizational change, the root cause of poor performance, or the reason for perceived shortcomings in service provision" (Jackson & Daly, 2011, p. 22). These same RNs may

> manage sensitive and potentially difficult situations involving human distress, such as work-based interpersonal conflict, crisis management with little warning and few resources, and provide support and assistance to traumatized and distressed patients, families, and health professional staff, and these situations can represent workplace adversity (Jackson & Daly, 2011, p. 21 & 22).

As such any RN showing these behaviors could be considered living dangerously, because when leading people through tough change, their challenges what they believe in most, including but not limited to, their daily routines or habits, tools, loyalties, and perhaps most importantly, their ways of thinking (Jackson & Daly, 2011; Rosenstein et al., 2014; Strutton & Knouse, 1997). These beliefs could be such a deep way of thinking that staff may not realize that this was the unspoken expectation that was being breeched. Therefore, if these behaviors were shown as results in the study for the positive deviant, it would be important to be aware and observant to the surroundings to see these things when they come up; as well as to anticipate unspoken expectations as a possibility. Potentially if a nurse leader were to operate as a positive deviant too, they can be viewed as an unwelcome face of organizational change, or the reason for poor performance (Jackson & Daly, 2011). This can add additional challenges to the role if colleagues have

barriers working with leaders; however, this can also be a way to bring that colleague into the solution (Rosenstein et al., 2014; Strutton & Knouse, 1997).

The ANA Scope and Standards (2015) asserted that it is a RNs obligation to bring in the skill of working as a team, to communicate well with others to create a safe environment and provide feedback as needed with a caring attitude. This was part of being a leader in the nursing world and potentially part of the behaviors that may be identified of a positive deviant. If this was true, I can easily see the dangerous side of leadership showing in up for the positive deviant as well since they may be inadvertently challenging "the way we have always done it" which will make some uncomfortable. Challenging those in the community was a byproduct of being a leader it was not meant as a negative approach.

Resilience

Resilience has been defined as "ability to adjust to adversity" (Jackson et al., 2007, p. 22). Those that are labeled as resilient have been associated with having emotional insight, reflexivity, the ability to draw on a supportive professional network, as well as being able to remain optimistic and alert to the positive elements of challenging situations (Jackson & Daly, 2011; Jackson et al., 2007). Vulnerability could be increased for nurse leaders that work in a situation of poor role clarity, with additional high demands and moderately low autonomy (Dellve & Wickström, 2009). Jackson and Daly (2011) asserted that truly resilient leaders must be able to reconcile their own decisions and actions within the workplace; especially since they have brought critical thinking, ethics, justice and concern about fairness and equity to the decisions. Nursing needs

strong resilient leaders not only because they are essential for achieving excellence in nursing care, reaching optimal patient outcomes, workforce stability, and healthier working environments for nurses (Jackson & Daly, 2010, 2011).

The positive deviant could be identified as needing to have flexibility especially when potentially challenging peers and colleagues' values or beliefs in a professional positive way. If behaviors identified through the study call for the positive deviant to have resiliency that allows them to be clear, with an appropriate level of autonomy for both critical thinking and equity to their decisions to achieve the outcome(s) they are working for. The act of resilience was not about trying to achieve at the expense of others or run over colleagues to benefit only themselves; it was to bring about a positive social change in patient-centered care.

Summary and Conclusion

In Chapter 2, I provided details of the literature search details, conceptual framework and literature review. Although the term PD could be found in the leadership view of nursing, sociology, and business the term PD was not located in nursing practice in the literature. Although the literature search confirmed the gap regarding PD in nursing practice having been studied previously; this study worked to identify what, if any, behaviors of PD RNs exhibited through a conceptual framework of vocabularies of motive informed by narrative inquiry that was using interviews to gather information in conjunction with symbolic interactionism. Based on the behaviors that were identified, a definition would be developed that could be further studied at a later date, specifically for nursing practice. Participants may consider conflict and PD behaviors the same or they

may consider them different. ln the next chapter, I have provided details on the qualitative research design, and rationale for this positive deviance study, the role of myself, methodology, issues of trustworthiness, ethical procedure, and summary.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore if, and what, behaviors of PD were exhibited within RN workplace stories and define PD in nursing. I used narrative inquiry combined with vocabularies of motive and symbolic interactionism in this study. The participants were RNs that worked in the western United States.

There was an increased need to gain an understanding of whether RNs demonstrated behaviors of PD. I was not able to find if RNs demonstrated these behaviors in the literature. I wanted to know if RNs did demonstrate these behaviors; because, if they did validate the existence of PD behaviors this could have an impact on nursing. If behaviors of PD were demonstrated or exhibited within the RN workplace stories in this study, my plan was to develop a testable definition of PD specifically for the nursing profession from them. The nursing specific definition of PD could be further explored and applied in additional studies in the future. For this study, I chose the following preliminary operational definition of PD for nursing: An intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, or a combination of these attributes including a level of risk. In this chapter, I review the research design, rationale, role of the researcher, and methodology of the study.

Research Design and Rationale

In this qualitative, exploratory study, I used a vocabularies of motive concept positioned in the conceptual foundation of narrative inquiry through interviews to gather

information in conjunction with symbolic interactionism to answer the research question: What positive deviance behaviors, if any, are present in nurses' workplace stories? I also had the goal of developing an operational PD definition for the nursing profession. Narrative inquiry is about collecting stories about the participants "both lived and told experiences" (Creswell, 2013, p. 71). There are times that the stories are "co-constructed between the researcher and the participant; thus, this could create a robust collective component as the story emerges through the interactive dialog of the participant and the researcher" (Creswell, 2013, p. 71). There were many ways to collect data with narrative inquiry.

The narrative inquiry approach allows the participants to tell stories from their perspective (Creswell, 2013), and symbolic interactionism helps explain the meanings that the participants had assigned to each narrative or story (Blumer, 1998). I used vocabularies of motive to help me understand if the participant answered the questions based on the person they were talking to (see Mills, 1940). This methodology was chosen because it is important to understand the phenomenon from the perspective of the participant and the best way to do so was by stories that promoted dialogical construction of the participants' experiences and views on PD. This grouping of methodologies was explicitly useful for this study because the concepts operated under the assumption that there was not one truth, but because the stories were seen through the lens of the participants, there were many truths.

I wanted to understand what, if any, positive deviant behaviors were demonstrated by RNs. I decided to investigate the question if PD behaviors were demonstrated by RNs;

but first I needed a tentative operational definition to work with. For the purpose of this study, I used the tentative, operational definition of PD as an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, and adaptability or a combination of these attributes including a level of risk.

Clandinin (2013) emphasized that “in the end narrative inquiry is about the participants’ life and living” (p. 14). These events had a past, present, and an implied future (Clandinin & Connelly, 2000) and had meaning to the participant and the researcher who could situate themselves in relational ways with the participants, influencing the participants being and truth (Clandinin, 2013). The story was part of the participants’ actuality and reality, influencing who they were.

Face-to-face interviews provided the data for this study. I recruited 8 RNs to participate in the study. Participants had the opportunity to have their concerns addressed and questions answered prior to starting the interview. Informed consent was obtained prior to starting the interview. Written into the informed consent form was the ability to audio record the interviews, have the participants read a short passage to acclimate the Dragon Naturally Speaking, Recorder Edition Digital 13 issue, and the opportunity for me to reach out with follow-up questions if deemed necessary. I explained the purpose of recording the interview was for the accuracy of transcription and meaning. It was important to let the participants know that they could remove themselves from the study at any time. Data gathered were carefully assessed, and common themes were determined

in a fair and objective manner. Meetings were held at an agreed upon location between the participant and me.

Role of the Researcher

My role as the researcher was to be aware of my biases at all times. It was important to convey to the participants how my background and what I hoped to gain from the study would inform the interpretation of the study (see Creswell, 2013). It was also important to answer any participant questions honestly and with as much transparency as possible. This was important information for me to share with each participant so that they could understand my motivations, have an increased trust level with me as well as to alleviate any concerns or misunderstandings. I tried to be aware of bias during data collection and stifle any emotional reactions I had during the interviews. I made note of times when something a participant said surprised me because that indicated I was expecting a different answer.

For some, speaking up was difficult, and it was important to get as close to the truth as possible for the best study results. I began to consider why that was and why with all the different methods available for staff to use to speak up, what behaviors were present for those that do speak up. Turning to the literature, the term PD was found in the field of sociology and in one article on school nurses using PD in leadership roles, but not anywhere else in nursing practice. In qualitative research, the researcher can become a disengaged component of the study, even with the face-to-face interviewing of the participants; listening to their stories; analyzing their stories to establish patterns; and

writing the report to include the participants' voices, flexibility of the researcher, the interpretation of the problem, and its contribution to the literature (Creswell, 2013).

Before conducting this study, I completed the National Institute of Health's web-based training course, Protecting Human Research Participants, which demonstrates knowledge of research processes and ethical behavior. The study was conducted with approval of the Walden University's Institutional Review Board (IRB). No risk to participants were identified.

Methodology

Participant Selection Logic

Participants were RNs who worked in the western United States, were older than 18 years of age, and spoke English. Participants self-selected to be part of the study or were referred to the study by a participating RN. I selected this population due to the potential alignment of the RNs. RNs have an obligation to bring the skills of working as a team (i.e., Standard 10), communicating well with others to create a safe environment (i.e., Standard 9), and providing feedback as needed with a caring attitude (Standard 14; ANA, 2015); therefore, they potentially engage within the culture of safety components of speaking-up initiatives in any hospital. Overall, RNs are expected to speak up, not only when there were concerns of safety, but for feedback as well (ANA, 2015). There was considerable work being done in many organizations regarding the need for RNs to speak up (Garon, 2012). This study aligned with those efforts trying to find ways to bring better safety into the nursing practice. The sample size for qualitative research is difficult to determine; therefore, for this study, 8 interviews (see Creswell, 2013).

Instrumentation

I kept a journal with observations made before, during, and after the interviews as well as any other thoughts that crossed my mind throughout the interview process of the participants. The data collection instrument was a questionnaire. The questionnaire was a document that I produced (see Appendix A).

The interview questions were:

- Tell me what you think this interview is about?
- Tell me about a time that you acted in a way you knew was correct but went against unit culture.
    - What was the outcome?
- Tell me about a time that you saw another nurse act in a way he or she knew was correct but went against unit culture.
    - What was the outcome?
- What characteristic do you have that helps you speak up?
    - Perhaps a characteristic that other nurses who don't speak up lack?

Follow-up probes and questions were used depending on the participants' responses. The last question that was asked was: Is there anything else you would like to tell me? Upon apparent completion of the interviews, participants were asked, "If any additional questions come up, would you be alright if I reach back out to you?"

Qualitative studies are different from quantitative studies in that the same unyielding set of standards or guidelines and technical procedures are not interchangeable or the same method of validation (Creswell, 2013). The important truth about personal

narratives are that they are what the participant believed, knew, or had seen as truth at the time. These beliefs could change over time if the participant's belief changed over time. Therefore, qualitative research findings cannot be assessed by the same validity or reliability measures as quantitative studies.

Procedures for Recruitment, Participation, and Data Collection

I recruited participants through flyers sent out to staff educators at local hospitals that were strategically placed in prominent locations. The flyers had the Institutional Review Board approval number from the Walden University 03-26-18-02822523 imbedded in the flyer so that participants knew that the study had been given the proper endorsement. Participants were able to self-select for the study or be selected through snowball sampling. Prior to discussion with any participants, I received approval from the Walden University IRB. Prior to any questions being asked, the research study was be explained to all participants for their willing participation and all questions about the study were answered prior to their signing the informed consent form and starting the interview. I reviewed the form with participants, emphasizing that the interview was voluntary, and the participant could withdraw from the interview at any time by asking to stop the interview. Part of the consent process was the request that the participant read a short passage for the Dragon Naturally Speaking, Recorder Edition Digital 13 issue that would acclimate to the individual's voice. This voice recognition program helped ensure accuracy of the transcription of the interview. No incentives were offered to the nurses for their participation in the study.

I conducted interviews until data saturation was reached, which was after the 8th one. Interviews were completed on an individual basis, so the participants were comfortable giving their own true answers as they saw them. I recorded my observations during the interviews and kept field notes, adding to the data pool. Additional questions that came up were clarified, and participants were asked if I could reach out to them if further clarifications were needed as explained in the consent form. The debriefing procedure was an exit e-mail thanking the participants for their time and help. I provided them with a link in the e-mail that gave the participant access to the final study for their review. Participants may not have remembered the answers they gave, or their memories could be different over time so asking them to review their responses prior to publishing may not have been helpful.

Data Analysis Plan

As the interviews were completed the plan was to transcribe them within 48 to 72 hours using Dragon Naturally Speaking, Recorder Edition Digital 13 issue. This way there was less chance of losing any of the nuances of the interviews. All the interview observations were written down in the field journal to capture any of the observations that would not have been captured by the interview questions. If possible, themes that were seen were placed into individual categories. The easiest way to do this was on small colored post-it notes placed on large post-its on the wall. This hermeneutical approach to qualitative research ensured that further data collection in the study tested and validated potentially relevant themes. This way as the individual categories change it is easy to change the individual categories or themes around. I looked for elements that fit into the

preliminary operational definition of PD of an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, or a combination of these attributes including a level of risk. Although I was be flexible and malleable to all findings.

The primary way interviews were done for this study were face-to-face, although observations during the interviews and journaling were used for data points as well. The interviews were recorded and transcribed verbatim for review and analyzed. According to Riessman (1993) stories are analyzed thematically, structurally, or by dialogic/performance (Creswell, 2013). There were four steps to the process: (a) transcribe the interviews using a software program, (b) review the content, (c) place into themes and buckets, and (d) draw conclusions from the results.

Once the interviews were completed the journal notes, consents, and audio tapes were brought to my workspace, de-identified, and locked up in a safe until they could be transcribed. Within 24 to 72 hours following the interview, the audio tapes were removed and transcribed, reviewed for accuracy comparing the audiotape and the transcribed document. Data related to the study will remain in a locked cabinet for a period of 5 years and will be destroyed after the 5-year period. In the narrative, names and identities were classified as Participant 1, Participant 2, and so forth.

The information was then reviewed along with the journal notes for that participants interview. Additional questions or ideas were written down as they were thought of or thought to be of importance to upcoming interviews; and the need to go back and contact the previous interviewees. Placing the emerging themes into buckets

was done with each interview and additional ones were added as each interview became complete. This way each emerging theme will be able to be seen and a point of saturation could be recognized. Review of the content was done once all the required interviews have been done, the transcription completed, the review finalized, and it was time for the end results whether they are they expected or not. At various points throughout this process discussion times were set up with committee chair to review thoughts and progress.

Mills (1940) argued that "intention or purpose is awareness of anticipated consequence; motives are names for consequential situations, and surrogates for actions leading to them" (p. 904). It was important to ask the open-ended questions in such a way to get the participants answer and not what the participant believed I wanted to hear. This way the participant would give their true answers and thoughts in their stories not what they believed was the expected answer for the person they were speaking with. Symbolic interactionism is the aligning of the participants actions towards matters within their worlds and acting on these matters based on the meaning they have for the participants (Blumer, 1998). Blumer (1998) asserted that it is important for the researcher to understand the participants matters as they see them, to substitute a meaning could be a huge error for a researcher to make.

Issues of Trustworthiness

Credibility

One of the biggest strengths of qualitative research is validity (Creswell, 2013). If themes are created with the basis of multiple sources of participant data uniting this

process can be said to add to the validity of the study (Creswell, 2013). It was important to review the transcripts to ensure that there were no obvious mistakes in the transcription that has been done (Creswell, 2013) as this could significantly impact the final results. Credibility could be increased by presenting information that was contrary to the themes as this may help others better understand the concepts or for the researcher to spend "prolonged time in the field" (Creswell, 2013, p. 246) to better understand the phenomenon they were studying. The themes could have been checked with the participants that were interviewed in sections that had been completed for accuracy (Creswell, 2013) once that had occurred it was believed that saturation had occurred. By presenting information that was contrary to the findings as an option as to why it was not found or having a participant review a section for accuracy credibility could have been validated on the findings the researcher had presented. For example, once a transcript had been transcribed and reviewed a section of the interview, perhaps the first three questions, could have been given to the participant to review for meaning and transcription accuracy. A better way to share the results would be a one to two-page summary for a more generalizable distribution. This may continue to be done with each participant as long as new interviews are being done.

Transferability

One of the components of creating transferability was for the researcher to create detailed descriptions and transporting the readers to the setting of the shared experiences (Creswell, 2013) which is part of the art of narrative inquiry. Variation in participant selection was obtained from self-selection and snowball technique because one type of

participant was not sought out. Although transferability would be optimized as much as possible. With qualitative research, it was impossible to be 100% sure of transferability; however, by using the field notes that were taken at each of the interviews, as long as good descriptions were written down to allow the reader to be transported to the setting of the interviewee (Creswell, 2013). Prior to the interview starting I arrived at the location to add setting information into the journal in order to be able to focus on the interview and what was happening at the time of the interview when it occurred. Having the journal ready to write in, when the interview started allowed for focused attention on the interviewee and the questions. Following the interview, and after thanking the interviewee for their time, it was important to write any additional final thoughts or reflections written down to not lose or forget them. These needed to be transcribed with the rest of the data obtained from the interviews. This information helped bring the reader into the same setting both the researcher and interviewee were part of.

Dependability

If themes were created based on bringing together several sources of data from participants, then that added to the validity of the study or dependability of the study (Creswell, 2013). It was important to have someone that was not familiar with the study to provide an objective assessment of the study both during and at the end (Creswell, 2013). Dependability was part of the results by having 8 participants. By incorporating several data points the dependability is strengthened. For our studies, we have a committee member that was assigned who does not know the study as intimately as we do and who helped to provide checks and balances both during and at the end of the

study. By taking the themes that emerged out of the interviews, including but not limited to, those that were hopefully behaviors of RNs exhibiting PD and placing them all side-by-side, the more data points there were the more trustworthiness there was in the results.

Confirmability

Reflexivity was where the researcher identifies their own bias's values, personal background anything that influenced how they interpreted the results of the information they gather (Creswell, 2013). It was important that each researcher did this reflective deep dive to understand where they needed to be aware of their own biases towards concepts in the study or even participants in their studies. Without completing this honest reflective thinking, they could inadvertently affect the study results. I made sure that reflexivity was included in the interpretation of the results. That this was accounted for or at least reflected upon and not forgotten in the study results. This was part of the field notes that were kept with every interview as it could affect the themes that were reviewed or found.

Ethical Procedures

Institutional Review Boards (IRB) exist to help ensure that participants were protected (Creswell, 2013). For this study, there was 1 IRB approval required, from Walden University, and 1 IRB review from the site organization that was posting many of the fliers requesting participants. Two quarters ago there was an opportunity to meet with one of the IRB staff from the site organization that many interview fliers were going to be posted in regarding the general outline of the study. They did not think there were any concerns regarding the study being held up for any ethical concerns from their

standpoint. Their statement was that there were studies done at their site organization that were much more sensitive than the one that was being proposed.

If a participant would like to refuse to be part of the study or to withdraw from the study early, they only had to say and do so. I was familiar with resources that other researchers had used, if an emotional response occurred because of the interview the participant would be referred to a local county crisis line or their own practitioner for any adverse responses or events.

In regard to the data, as long as the data were in a secure, password protected computer and the audiotapes were secured in a locked cabinet that only I would have access to for a period of 5 years this was considered protected. The data will be destroyed after 5 years. Participants were labeled as Participant 1, Participant 2 etc., on the audio tapes as well as the field notes journal so they will be confidential. When I asked the site organization in the review IRB about the self-selection process planned, they said since the participants self-selected this would not be an issue.

Summary

In summary, the purpose of this study was to identify what if any PD behaviors RNs exhibited in their workplace stories and develop an operational definition for nursing. I detailed the research design and rationale, role of the researcher, methodology, participant selection logic, instrumentation, procedures for recruitment, participation, data collection, issues of trustworthiness, and ethical procedures. Once this proposal was reviewed, approved and IRB approval was given from both the site organization and Walden, I was able to start gathering data.

Chapter 4: Results

Introduction

The purpose of the study was to explore if, and what, behaviors of PD were exhibited within RN workplace stories and develop an operational definition of PD for nursing. In this study, I used narrative inquiry combined with vocabularies of motive and symbolic interactionism. The participants were RNs that worked in the western United States.

I wanted to understand whether RNs demonstrated behaviors of PD. If behaviors of PD were demonstrated or exhibited within the RN workplace stories, I would use them to develop an operational definition of PD specifically for the nursing profession. The nursing specific definition of PD could then be further explored and applied in future studies. The preliminary operational definition of PD I originally created at the start of the study was: An intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, or a combination of these attributes including a level of risk.

I identified 15 PD behaviors in my review of extant literature; consequently, I looked for these 15 behaviors in the data along with any new behaviors that might be identified. The selected PD behaviors were the ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, inspiration, interdependence, observant, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. The first step I took was to review all the interviews

individually and identify when and if these behaviors were present in the participants' stories. Each of the previously identified behaviors were applied as a title, then under this, I placed an alphabetically assigned name of an interviewed participant, and under this, any supporting narrative statements by the interviewed participant.

Secondly, I reviewed the individual participant interviews once again looking for evidence of the preliminary operational definition of PD. This evidence was organized slightly different in that I went through each interview and labeled where I saw preliminary operational definition with the appropriate intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, and level of risk. These two steps helped me organize the data and identify the patterns in the stories of the participants. This process also helped to identify behaviors that were new and not previously identified in the literature.

In the previously completed literature review on PD, I had not found a direct link to nursing practice and behaviors of PD. In this study, I sought to answer the research question: What positive deviance behaviors, if any are present in nurses' workplace stories? Furthermore, the data from the study were used to refine the operational definition of PD as it applied to nursing.

Setting

I gave each participant a fictional, female name, selected alphabetically. The fictional name was an easier way for me to keep processes straight when thinking of the participants, rather than assigning participant numbers as originally planned and described in Chapter 3. To create the safest condition for each participant, each

participant chose the location for the interview. The locations varied from an empty classroom in the organization they worked to a public place, such as a coffee shop, an outside weekend market sitting area, or in a quiet secluded office. The goal was for the location of the interview to be a safe space that the interviewee felt they would be able to freely and authentically talk. Seven of the 8 interviews were completed indoors, with the last completed outside in a park. Each participant interviewed selected a location that appeared to allow them to process and reflect. I saw each participant visually going back in time as they thought about the situations they discussed. Each interviewee had some level of moral issues that they experienced in their professional work life.

During the interview time period, there were events occurring for some of the participants that may have affected the way that they answered their questions. For example, Delaney was leaving the organization 60 days after the interview had been completed. Emma had new leadership and a toxic work environment that she was going to retire from at the end of the year. Fran was employed by a rural organization where she worked in an inpatient area and moved to an outpatient area a short time after the interview. For her, the position description was changed for the inpatient position she had been in. Fran stated she decided that the position was not a safe one as it was currently outlined and decided to move to a different position. Hadley had retired from her organization approximately 16 months prior to the interview.

Some of the interviews were conducted during a time that the exempt employee contract renewals were happening. That meant this specific group of employees were finding out if their annual work contracts were going to be renewed or not. A few

participants had learned prior to their interview or just after their interview that their contract was not going to be renewed. Almost all of the interviews were conducted with those considered exempt employees. For others, the interviews were during a time that their organization had been acquired by another larger local organization and many processes and procedures were in chaos and change. Three of the 8 participants were told their positions had been eliminated within 3 weeks of the interview. One of the participants had been told their position was going away, and 4 weeks later, they were told the position would be brought back; however, the position description was different, and they would need to reapply and interview for the positions.

Demographics

I interviewed participants from March 2018 through August 2018. The participants chose the location, date, and time of the interviews. The nurses interviewed were all experienced, having a minimum of 12 years' experience with some having 36 years of experience in the profession. Participant demographics are shown in Table 1.

Table 1

Participant Demographic and Characteristic Information

	Females (n = 8)	Males (n = 0)
Age	41 – 66	N/A
Race	White	N/A
Nursing degree:		N/A
BSN	1	
MSN	6	
PhD	1	
Works at urban organization (at time of interview)	6	N/A
Works at rural organization (at time of interview)	2	N/A
Locations of employment: Less than 2:	2	N/A
Greater than 2:	6	N/A
Years worked as a registered nurse	12 - 36	N/A

All participants were RNs that had been professional nurses for at least 12 years. The eight participants all worked in the western United States, of which two of the nurses worked in a single location as a professional nurse for their whole careers. All the other participants had worked in two or more locations over their professional careers. One nurse was retired from her organization at the time of the interview. Two of the participants left the organization that had employed them shortly after completing the interview process. The minimum education of any participant was a Bachelor's in Science Nursing (BSN), although this participant was currently working on completing their Master of Science Nursing (MSN), having three courses left. The remaining

participants had MSNs, and one had their Doctor of Philosophy (PhD). All stated an interest in evidence-based research.

Data Collection

Interviews

I interviewed each participant once. Once each of the participants had reached out to me stating their interest in the study, they received an e-mail that included a sample question and a copy of the consent form so they could review it ahead of time among other components for the interview. The lengths of the interviews were between 38 and 93 minutes. This included up to 15 minutes reviewing and answering questions on the participant consent. All of the participant interviews were recorded using a Dragon Naturally Speaking, Recorder Edition Digital 13 issue, digital device. The interviews were transcribed immediately after the interviews. I listened to the interviews and compared the recordings to the transcripts to ensure that they had been transcribed accurately and corrected as required.

One deviation from my data collection plan outlined in Chapter 3 was that there were not any audiotapes, and they cannot be removed because the Dragon Naturally Speaking, Recorder Edition Digital 13 issue was a digital device. The other deviation from what was written was that I replaced participant number titles with female names, starting with the first letter of the alphabet going through the letters until I had named all participants (e.g., Anne, Bailey, and so forth). This was done not only for participant anonymity but to assist in keeping the participants straight and identifying them while writing up the results.

I wrote down observations and kept field notes for better reliability and for additional data for the pool. Generally, the interviews occurred in public places. Six of the 8 interviews happened in a public venue where a semiprivate space for talking was created. Two of the interviews took place in the interviewees' office space behind a closed door.

Anne requested to meet at the organization where she worked in one of the educational classrooms in the basement with no windows. The walls were painted a light almond color with five framed photographs of local popular city sights that hung on the walls. The room seated 24 people. We sat across from each other at a long, rectangular table that could seat two people side-by-side. The meeting was scheduled for 10:00 in the morning. We met for 47 minutes in total for the interview. At the finish of the interview, Anne smiled and said, "that wasn't bad."

Participant Bailey and I met at an open-air market at 8:00 a.m. on a Saturday. We both purchased a hot cup of roasted coffee prior to sitting down for the interview. We reviewed the consent, and she signed with no questions. We sat at a black, round, rod-iron table, each of us on a chair that matched the table, overlooking the various vendors that had set up for the market. One component of the interview that I found interesting was the reflection and purposeful answers that Bailey took her time to give. We met for 84 minutes for the interview. Some of this was time for her to stop and think about how she wanted to answer the question. It was almost as if at times she was going deep inside to think about her reply; for example, she would sit back, she would start thinking deeply, and then she would start talking her way through the answer. At times Bailey would look

up to see if I was listening, and I would be looking at her or give her a verbal queue, such as "hmmm" or "tell me more," and she would continue. After the interview was completed, I asked if there were any questions, and Bailey was the only one that asked if "positive deviance was the best fitting terminology or perhaps we are using similar words or there is something that doesn't sound so harsh?" She was concerned that the term was too harsh. She asked where I found the term, so I explained. Once I had provided this explanation, she said "Thank you for explaining. That makes sense and it sounds less harsh, I can appreciate the term, I think I need to think about it some more."

Participant Casey requested that we meet in her office. I found it interesting that when I sat down in the chair on the opposite side of her desk, my chair sat significantly lower than her chair. There were lots of windows in this office, and the sun was shining in at 2:00 p.m. in the afternoon. From reviewing the consent to the end of the interview, the total amount of time was 38 minutes. She was the only participant that validated that the interview was confidential and that I was the only person who would know who she was, which I confirmed.

Participant Delaney and I met in her office. We reviewed the consent, which she signed, saying she had reviewed it, did not need to discuss it, and she had no questions. This interview lasted 68 minutes. The office we met in was small and dark, with some twinkle lights, art from local street artists, and the light from her computer. I sat in a chair across from her, so when she turned around our knees touched. We were drinking tea. She was about to transition to another role that she was not sure of yet. As Delaney answered the questions, I could detect hurt in her words and stories. As I sat listening and

watching her as she spoke, I could feel the aching and disdain in her words. Her body language was clear, her arms flying about, voice louder, then softer, and at times, she looked close to tears, while others she looked as though she was going to battle.

Participant Emma and I met in the organization that she worked at in one of the cafeterias. We sat in a booth across from each other at 11:00 a.m. It was starting to get busy for the lunch hour; however, the traffic did not appear to bother Emma as she was very focused on the interview. We reviewed the consent and started the interview. Emma leaned in with each question and reflected on her answers. This interview took 72 minutes. As this participant spoke there was noticeable anguish and discomfort at times. This interview was different because this participant wanted to take part in the research because they were interested in the subject based on an article, they read that was given to them from a separate source a few years ago. Although Emma was quick to note the article was not evidence-based.

Participant Fran requested that we meet in a local coffee shop for her interview. She bought a snack kit with veggies, cheese, and crackers to eat, and hot coffee and I purchased a hot coffee. We found a small two-person table in the corner of the shop to conduct the interview. The interview was scheduled for 8:30 on a Saturday morning and lasted 69 minutes.

Participant Ginny and I met at a coffee shop on a Sunday morning at 10 a.m. This interview lasted 42 minutes. We both had freshly brewed cups of coffee, on a warm sunny morning. We sat at a square black rod iron table, on black rod-iron chairs that matched the table across from each other sipping coffee. When answering the first few

questions Ginny was looking in my eyes as she shared her stories. As she continued to share, I noted that she started to look down, and was more reflective in how she answered and seemed to flip back and forth in time as the situation appeared internally harder to navigate.

The final participant interviewed was Hadley. We met at a local park, where we sat on the grass on a warm sunny Sunday afternoon at 2:00 p.m. This interview lasted 93 minutes, some of which was quiet time, during which Hadley was silently reflecting. The first few questions Hadley was relatively quick in answering, although thoughtful in her answers. When Hadley related narratives where she felt that she had failed a staff member on her team, her head was down, she was looking at the grass, playing with the grass blades between her fingers. She appeared to go back to the time where she felt less empowered and her voice had a sadness in it as she spoke. Hadley did not make eye contact as she spoke during this time. It appeared that she easily could have been living in the original moment right then with the level of pain that was noticeable in her body language: slouching shoulders, soft voice, lowered eyes and reflective thoughts that did not change.

Transcription

All the interviews were transcribed within 24 to 72 hours following the interviews. A second and sometimes third listen and verification of the transcription were completed during this time as well. Transcribed interviews were concurrently read and played back more than once. This was done to not only make sure the interviews were transcribed correctly, but to better understand each participants narrative. General themes

were identified throughout the interviews. A document with all the behaviors that I was looking for ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, inspiration, interdependence, observant, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability was created. Then under each of the behaviors I listed each of the participants names and any of the narratives from their specific story that was identified to belong under that behavior.

Data Analysis

I analyzed the data according to behaviors found in the literature, behaviors in the operational definition and new behaviors that emerged. I initially analyzed the data for the 15 behaviors identified in the literature on PD. These included the ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, inspiration, interdependence, observant, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. These 15 were found in the initial literature search to see if they would potentially be found in the interviews and if they existed in any or all of the participant interviews. Each of the behaviors were used as a header with each participant name underneath. I then reviewed the transcribed narratives and placed participant statements under each of their names and where I saw them align. Behaviors consistent with the preliminary operational definition of an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, or a combination of these attributes including a level

of risk were then examined. I analyzed the data using a similar process that was followed previously. Again, each of the behaviors was placed as a header, and each participants name was placed underneath. The transcribed narratives were reviewed in order to find the identified behaviors or elements of innovation, creativity, adaptability or any combination of these including a level of risk presented itself.

Of the original fifteen behaviors of PD looked for only 13 of them were found in the narratives of the participants. Those 13 were: Ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, interdependence, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. I was intrigued that not all 15 of the behaviors found in the literature were found in the narratives and I was curious to see what other behaviors might be found.

Ability to Flex with Adversity

The ability to flex with adversity was an important behavior for nurses because the day of the nurse rarely goes as planned. It was important to be able to read the situation and change the plan in the moment for what will work best and have the best outcome. The ability to flex with adversity was found in all eight narratives. Bailey had completed an evaluation in the birth center where the culture was focused on the mother/baby relationship, being baby friendly and on making the patients stay feel more like a home environment. Bailey noticed they had an isolation cart, although there was nothing in it. When Bailey asked the staff about the isolation cart and how they use it, she was told "...never used it because they didn't need it." The staff believed that they had

everything that they needed antibiotics for the baby's eyes, and everything to care for mom. Bailey was concerned and asked "What happens when a mom comes in with the flu, RSV, or something else? How do you protect yourself from passing from one mother to the another?" Bailey spent time talking with the staff letting them know that she understood that they were trying to protect the cohort or the mother/baby relationship, but that they needed to protect themselves, their other patients, and any spread of infection. The staff nurses replied that "that is not something that happens on their unit, and they don't have those kinds of patients." Bailey stated she,

> had a new manager and an infection preventionist that were open to discussing this situation. She made the point that even though they were a rural community hospital they needed to be using evidence-based practices on all units. I brought up the idea of standardization and creating a system where all the isolation carts were identical in what they carried. Together we brought together the right stakeholders and put together an isolation cart that was put together identically and with the same signage no matter what unit they were placed on.

Bailey educated the birth center on the isolation carts. At first, they said "no thank you, this is not needed." Approximately one week later almost to the day, Bailey received a phone call "We used the cart! We are so glad that we had it, because otherwise we would be running around trying to find all the equipment, but we had it all in one place!" Bailey said, this achievement was celebrated by the entire department, not only because they had the same safe practice as everyone else, they came to understand that they could have the special bond with the babies while protecting them from outside infections.

Hadley's narrative showed an ability to flex with adversity that was different than Bailey's. Hadley was a nurse for over 30 years and felt "she had a strong work ethic." While she was at work she talked about how:

> I wanted to get work done or work-related tasks completed. I noticed peers taking long breaks, not getting work done talking about things not related to work, and not getting their work done, this was frustrating. My way of handling this was to role model getting the work done, whether this was with patients or peers, and engaging in small amounts of talking with co-workers; however, I found that her work ethic wasn't shared by everyone.

Hadley stated "this was her way of flexing with adversity in work ethic in her environment." She said, "it was also a lonely way for her to work at times."

Accountability for Self and Peers

As a professional, nurses are culpable for their actions and words as part of the basic competencies that nurses are responsible to uphold (i.e. Standard 7 and Standard 9; ANA, 2015). Standard 7 (ANA, 2015) is Ethics and says that the RN practices ethically. This includes practicing with compassion, and respect and inherit dignity, worth, and unique attributes of all people (ANA, 2015, p. 67). Standard 9 is about communication, it states that the registered nurse communicates effectively in all aspects of practice (ANA, 2015, p. 71). This behavior was found in 8 of 8 narratives. Emma told the story of a faculty surgeon that came to the unit with the Residents he was over. When the team was doing post-surgery rounding at the bedside of the patient, the faculty surgeon consistently

showed inappropriate behavior toward the residents in front of the patients. Emma witnessed this situation several times until one day the faculty provider went too far:

> I did this wrote the email to the manager about the doctor's bad behavior for two reasons: a) to express that this was going on, that this had to change it was not right, b) [to] provide the documentation knowing that you cannot bring a case against someone unless the documentation is there.

When Emma described this situation she leaned forward, her voice became strained, and a bit higher in pitch. She took her glasses, off with her right hand and placed them on the table countertop. This showed as anxiety to me as she was speaking of the situation and the need to act. I identified this as what Westphal et al. (2015) described as interpersonal work-related conflict, identified as both a common and psychologically challenging stressor. As Emma spoke it was as if she did not have a choice but to act in the way she did.

Authenticity

When our truth is spoken, we come across as reliable and believable. Our peers and colleagues were much more likely to engage with us and help encourage those around to adopt similar behaviors. This behavior was significantly important for those that participated in a communicative space; because, when people presented on equal terms to discuss high-intensity, common issues or problems of any level and reached an agreement that may bring change or fear under different situations (Bevin, 2013) authenticity, or speaking ones truth allows for better understanding of each other. Authenticity was found in

only 4 of 8 narratives. This was apparent when Anne was confronted with the following situation:

> If you were on 1st and 3 weekends or 2nd and 4th and people, the 1st and 3rd all hung out together when they didn't work and there was drama among the group. This group wasn't stated to be specifically exclusive - I was identified as someone that could be part of the group if I wanted to be, but I made a conscience decision not to be part of the group because I did not want to be part of that drama. After working there for a few years, there was a major rift between a couple people that ended up a big thing. HR was involved and a bunch of people were put on work contracts including how they were supposed to behave. However, there was still this expectation that people were supposed to choose sides when they worked on the unit, and I hesitate to say, but it was like we were in middle school. I was friends with people on both sides, but people really split. They really wanted everyone to choose sides. It was emotionally challenging when I had to work with people that I had been friends with, and I was not any longer because of my choices [of how I wanted to behave].

Delaney was confronted with a situation where she was working with nurses in radiation oncology and talking with the medical director. The medical director was concerned that there was a "real problem with trust, distrust, respect, nastiness and institutionalized bullying." Delaney asked to complete a survey and included every staff in asking

questions about what made them happy and what made them unhappy about their jobs. Upon collating the information, she went back to the medical director and shared the data. During a meeting with the staff, the medical director was authentic and true regarding his part in the clinic issues:

> I want to start the change towards greater transparency, and I am starting it now. I am showing you that I saw my fault and my flaws [in the report] and how I hurt you now I am asking you to partner with me to get over it and work it through. I want you to call me on the carpet.

Delaney stated that "he is a remarkable man." At the meeting the staff discussed how they were living with resentment, isolating themselves, not a team. Delaney said with work they have started working as a team!"

Autonomy

All nurses had a level of autonomy within their practice that they used on a daily basis. It was important to have a foundation and understanding of the basic expectations of nursing practice in order to know a nurse's level of independent practice and autonomy (ANA, 2015). Autonomy was found in 6 of 8 of the participant narratives. Fran had been challenged by an education issue,

> This was a significant patient safety issue for many nurses in the pre-operative and holding area regarding intravenous fluids free flowing into the patients because they knew that the anesthesiologists would take the bag of intravenous fluids off the current tubing, replacing it with a different tubing that did not fit the pump. The danger was not when an anesthesiologist was with the patient at all times in the

> operating room and monitoring under their license; it was when the nurse was not with that patient 100% of the time in the holding area, under their license.

Fran educated the nurses to "follow the policy and set up the intravenous fluids and tubing on the pumps correctly." Nurses would get around the policy by having a provider write an order after the fact to cover them. Fran had a "court case regarding a pediatric patient that died from a fluid overload" that she shared with the nurses and said the "anesthesiologist is not going to up on the stand defending you against the policy." Fran was not seeing practice change and did not feel supported by the manager, or department director and went to the chief nursing officer (CNO) to get support. Fran stated, "people were aghast that I thought this was a big deal and went to the CNO!"

> This was not okay people being angry (that I went up the chain of command to report); however, they did not understand the safety issue. This was a huge patient safety issue and there had just been a big lawsuit down in California because they [staff] hung the wrong fluid in a 1000ml bag on a kid, and they [the kid] ended up with brain swelling and died. It was a huge deal!

Although, this conflict was difficult for the participant, she was an expert in (the specialty and) the culture, yet she wanted a positive patient outcome (Marsh et al., 2004) for the patient and the organization. Fran felt that it was important to continue to escalate this issue until it was heard.

Clarifying Information in a Professional Way

Since a significant amount of the staffs' work relied on effective communication with each other (see Duddle & Boughton, 2007), whenever there could be confusion or miscommunication clarifying information in a professional way should be the expectation. Standard 9, of the ANA Scope and Standards (2015) states that nurses expose care processes and decisions when they do not appear to be in the best interest of the healthcare consumer and maintains communication with interprofessional team and others to facilitate safe transitions and continuity in care delivery (p. 71) just to mention a few of the expectations. All 8 of the participant narratives included the behavior of clarifying information in a professional way.

Bailey overheard a nurse caring for a patient, where the family kept saying "my dad is in pain." The nurse understood that the patient was not really in pain but was "having agonal breathing and wet breathing and the family did not realize this was natural at this stage of dying." Bailey listened to the nurse as she educated the family while "consoling them and advocating for the patient and their (patient) wishes when they cannot is a gift and difficult on the nurse over time."

Casey modeled clarifying information in a professional way when (she) confronted a call by an angry physician yelling that "nurses were holding things up" and the physician wanted the nurses to "let the patients into the OR!" Casey told the physician that she "needed to talk to the nurses and would get back to him." Casey found out that the reason the patients were being held up, was because the consents were not signed. Casey told the nurse "if the consent was not completed it was the correct action to

hold up the case until it was completed." Casey called the physician back after talking with the nurse and said that "it was the right thing to do, holding up the whole thing due to the paperwork for the patient not being completed, the patient doesn't go in the room." Casey said that he continued to yell and make threats because he was not getting what he wanted. Both of these narratives demonstrate the need for a Culture of Safety. Staff RNs needed to feel safe speaking up when they saw processes that were not right, patients should always be kept in the center of what healthcare staff do (see Scott-Cawiezell et al., 2006).

Connectedness

Often times nurses would describe their units as a "second family" because they were present so much during their awake hours. Nurses had experienced new life, death and much of what happened in between the two, that had made it difficult for others outside the profession to understand in the same context. Ginny wanted to partner with the manager and the staff of the oncology clinic she was working with to make processes, procedures and the overall culture safer for both patients and staff. Ginny was concerned that RNs were not wearing personal protective equipment (PPE)to handle chemotherapy, there was not a double check with two RNs with chemotherapy, a single nurse was hanging chemotherapy. Ginny would advocate and try to partner with the manager for the staff to abide by the American Society of Chemotherapy standards and guidelines. The staff understood; however, they felt caught between the manager and doing the right thing. The manager response was "Ginny did not understand; this is the way we do this in the community." Ginny continued to work with her and explain that "the American

Society of Chemotherapy standards and guidelines were the same no matter what the setting." The manager continued to resist; Ginny finally advised that she was going to "escalate her concerns up the chain of command." The manager left the oncology clinic shortly after the escalation. The relationship had a lot of value to Ginny and it was difficult for her thinking that she had "made the manager leave, or made it look like she was failing." After the manager had gone, Ginny was "comforted that the staff nurses came together, and standardized care." The nurses understood where their standards and guidelines came from and took the lead with Ginny's help putting them into place. Building positive relationships with peers and colleagues was shown as an important component of these narratives not only for that single moment in time but for future interactions too.

Courage

Courage was shown in different ways throughout the narratives within the participants stories. All eight participants showed courage in their narratives. Anne showed courage in the narrative that she shared by "refusing to choose sides." She lost friendships with people over it because "people were not okay with my choices to not choose sides." Anne explained "I felt like the place I was/am is an okay place to go too and they need to be okay with that place for me."

In the narrative below the RNs felt so strongly about making sure that their patients were safe that they were courageous and continued to escalate their concerns until they felt that they had been listened too. The oncologists would come in the morning and sign off the orders. One of the newer charge nurses who was also Ginny's preceptor,

was in charge this particular day. As Ginny and the charge nurse watched the physician as he signed off the stack chemotherapy orders, "it didn't look like he was even reading those orders." The charge nurse spoke up and said, "Dr. XX I am getting scared; I am not sure that you are reading those orders." The physician replied, "I trust you nurses." The charge nurse and Ginny agreed at this time that they needed to go talk to the manager because "this was unsafe."

Interdependence

Interdependence is the state of being dependent upon one another or mutual dependence (Interdependence, 2019) with each other, which describes nursing within the teams as they collaborate with each other every day. Interdependence was found in 6 of 8 narratives. Hadley shared how the unit went from a unit of traditionalists and baby boomers (two generations) of nurses to adding in the Generation X and Generation Y (three or four generations). The third and fourth generations made a huge impact on getting people to work overtime. Before the third and fourth generations entered the unit, you would let the staff know the needs of the unit and people would just take turns offering to work overtime and it was pretty evenly split. Hadley stated that the "conflict became so intense that human resources became involved as well as a mediator to work with the staff."

RNs were interdependent on each other for many things in daily practice. Whether it was to assist each other in turning patients, trading shifts, or working for a culture of safety in completing two RN high-risk medication checks, or talking with each

other regarding who needed to take the next admission. RNs depend on each other for help, support and working to keep their patients safe.

Political Astuteness

It was important to be able to be aware and read the climate of the unit that you were assigned to. If a nurse was unable to read the unit, they were likely to be less than successful. As leaders if we were aware of what was happening, there was the potential to preempt some if not most of the conflict that could arise; if, we were not afraid to address the conflict. This can often be a delicate balance for some leaders, because they become the face that was associated with unwelcomed change, and all the negative feelings that can go with that for others (Jackson & Daly, 2011). Political astuteness was found in 5 of 8 eight narratives. Anne gave the example that there was a time that it was really challenging to come to work, she did not have it as bad as some people. Anne had a friend that became a scapegoat for some nurses on the unit to where she felt unsafe at work. If they “got stuck” working with those nurses, they “wouldn’t support her.” When she was charge, they “wouldn’t give her important information for patient safety.” Anne stated she “felt a little protected, because my manager liked me.” She also said that she felt that she was not treated that same way in part because she is “quietly confident, so people were like okay she is not a weak link.” To Anne it was important to be seen in this way, because she would not be treated like her friend.

By having the ability to manage or recognize work-based personal conflict, difficult situations involving human distress, and crisis management with little warning and few resources, potentially while providing support and assistance to traumatized and

distressed patients, families, and health professional staff, of which represent workplace adversity (Jackson & Daly, 2011, p. 21 & 22) nurses felt successful. RNs may rely on the relationships with their coworkers and the outcomes of everyday interactions to feel successful. The RNs ability to be successful may in part have some relation to their success with how political astute they are to their environment.

Speaking Up Even When It is Uncomfortable

It is a nurse's obligation to speak up, to create a culture of safety by speaking up and providing peer feedback to colleagues (Oregon State Board of Nursing, 2008; ANA, 2015). This could be uncomfortable because of the interdependence of the profession on each other, and often nurses felt that it was too risky. Essentially, it is important to maintain dialog that facilitates safer practices and not look for a culture of blame (see Scott-Cawiezell et al., 2006). This behavior was found in all eight of the narratives. Emma's example spoke about,

> How going from a staff nurse to a manager changed the way she felt about speaking up. As a manager I felt more responsible to speak up, to role model for staff in hopes staff saw how to professionally speak up. I believed I had become more self-empowered to do things like that (speaking up) especially being a nurse manager.

Ginny shared a story from 25 years ago when speaking up was not talked about as it is today. She thought that was really brave and courageous of her charge nurse, especially at that time:

> The oncologists would come in the morning and sign the orders. One of the charge nurses was younger than the others, and the charge nurse and I looked at each other and we were watching the Dr. sign the stack of chemo orders. It didn't look like he was even reading those orders. She was younger than the other charge nurses I had been precepted by. She spoke up and said Dr. XX I am getting scared; I am not sure that you are reading those orders. She said I think that we should go talk to the manager. This is unsafe.

This specific narrative was an example of the registered nurse voicing her concerns and getting validation from another registered nurse. Fackler et al., (2015) acknowledged that when nurses felt they were on the same page as other colleagues, or peers normally in a hierarchical level, they felt more in a collaborative decision-making model (p. 270).

The characteristics that were stated in the stories that helped the participants speak-up were abilities such as leadership qualities, confidence in self, confidence in professional skills, knowledge and independent scope of practice, communication skills, open minded, listen and continue to talk until you find someone that listened. Interestingly enough many of these items could be seen in the stories that the participants shared for their own example of doing what was right even if that meant going against unit culture. These same qualities were seen in the stories that they chose to share when they saw another nurse act in a way, he or she knew was correct, but went against unit culture. This led me to believe that these stories had an important alignment with the

belief system that these participants had. I am not sure if this was something that they were aware of.

Strong Relationships

Nurses tended to have strong relationships with at least some of their peers that they work with. Nurses were able to cultivate and create the environments that they worked in (see Fabian, 2013). Six of the 8 narratives had strong relationships as a behavior that was seen in the data. When Casey was confronted with the angry physician because the nurses were not moving the patients into the OR without signed consents, she stayed calm and checked the facts. Knowing that the physician was still angry, Casey called the chief of staff to let him know what had occurred and she asked for the chief of staff to call the nurses and let them know that they did the right thing. After the chief of staff listened to the physician when he called, he provided support for Casey and the nurses. He told the nurses and Casey how much he appreciated them for keeping the patient and the staff safe. Casey has never heard of the chief of staff doing this again.

In this narrative example, although the direct costs included time and energy from speaking up; the indirect costs of weakened public image, retaliation from those with opposing viewpoints, antagonistic relationships, or a wounded ego of reduced or ignored views did not occur (Premeaux & Bedeian, 2003). Casey and the chief of staff handled the situation in a professional manner, supporting the actions of the nurses following protocols for not sending patients into the OR without the appropriately signed consents. This was important because the indirect costs could have been significant, especially considering the physician and the nurse would continue to work together.

Vision

Vision was an important trait in nurses because they need to be able to look forward to the outcomes that were significant for forward movement. Ginny shared her vision with the manager of the oncology clinic when she saw that the nurses were practicing in a way that was not standardized with the American Society of Chemotherapy standards and guidelines. Ginny stated,

> Many of the RNs were not wearing PPE to handle chemotherapy. There was no double check when setting up or initially giving chemotherapy, a single nurse was hanging chemotherapy. RNs were putting in orders for physicians, and because of these errors had been made.

All of this culminated in "safety for staff and patients had been in jeopardy by not following the guidelines." The vision of making a decision regarding practice change in the above way was not only significant, imperative and had high stakes of communication, teamwork and very high decision making (see Pipe et al., 2011, p. 12) that ultimately affected the entire healthcare team, patients and the community.

Vulnerability

As a nurse, or a nurse leader, this was not looked at as a weakness, it gives others a role model to aspire after and may remove some of the fear of showing vulnerability.

Hadley discussed,

> What I would often do is just kind of work in my own little world and spend the time with patients or with other employees who I could help out that was just my work ethic and it isn't one that is shared by everyone obviously.

This also allowed the behavior of vulnerability to work against her at times as well as for her. For instance, when she "felt she did not have the support" needed, the vulnerability worked against her. When she did not feel she needed the support and still had the vulnerability it did not necessarily work against her and things were fine. All eight narratives showed this behavior.

Preliminary Operational Definition

I reviewed the current preliminary operational definition of PD: adaptability, creativity, innovation and containing a level of risk to see if it occurred in each of the interviews. A similar process was used where adaptability, creativity, and innovation were used as titles, interview participant names were placed under these, and supporting data from the corresponding narrative was placed under the corresponding name. By looking at each of the stories and what the intentional and moral behavior or "what made it so" or the correction of an RNs view of what is right and wrong. I was looking to see if any one of or a combination of adaptability, creativity and/or innovation while containing a level of risk were found within the stories the participants had shared. If the data supported summarizing the intentional and moral behavior norm for the group and

elements and of all of this information was found in most of the interviews, then definition would have been validated.

When reviewing the narratives, one of the biggest epiphanies came when reviewing adaptability, creativity, and innovation. This is where the behaviors were easiest to see in the stories that had been told. I noticed this to be especially true the more interviews I had completed and the more data there was to review.

Adaptability

Adaptability is the ability to adjust to new conditions (Adaptability, 2019). I have decided to define the ability to flex with adversity as the ability to activate your resilience in the face of adversity. In reading about the ability to flex with adversity, I found the term was often equated to resilience. Resilience was defined as the following: how the participant would adjust to what was happening and the other was how the participant would internally respond to what was happening externally (Resilience, 2019).

Ginny had been confronted with one manager who left from a multiple site clinical operation. Once this occurred the other two managers came onto the same page with her or they “adapted” to follow the American Society of Chemotherapy standards and guidelines. The other managers were “not willing to clean up the issues, but they were willing to partner” with Ginny after the one manager left.

Fran discussed a nurse that was hired from the IV team that was adept at central line dressings. In the post-operative area, there was an “expectation that the central line dressings were changed when soiled” prior to sending the patients to the floor. This was not getting done, primarily because the postoperative nurses had not been given the

education, and because they thought it would take too much time. The IV nurse was really good at central line changes, cleaning and putting a biopatch on them; the other nurses were “getting mad at her because they believed she was taking too long.” They thought she was “taking longer so she would not get another patient.” Fran decided to have the IV nurse do an “in-service for the other nurses, now understand what line infection days are, and she also wrote the Standing Operating Procedure (SOP).” After the in-service the “whole post-operative unit adapted to the SOP” and patients were safer.

Creativity

Being creative for the purpose of this study was to solve problems in a new way, perhaps looking at the issue through a new lens. Casey was confronted with this when she asked the physician to call the nurse to reinforce the action, she took to keep the patient safe. The chief of staff called the nurse and told her she “did the right thing stopping the patient from going into the OR, because there was not a signed consent available.” Casey stated that she “never heard of him doing that again.” “He was still my favorite chief of staff because we worked together so well for patient safety” Casey said multiple times during the interview.

Nurses are a key component in the healthcare organization as they have a unique advocacy role; patient care and safety can and will be significantly compromised if they do not speak up (see Garon, 2011; Sayer et al., 2011). These nurses had a unique perspective understanding the policies and knowing what was important to keep the patient safe. They also have a distinctive role bridging the gap between the patient and the physician.

Bailey was creative in her organization when talking with a group of nurses in the birth center about using an isolation cart and getting significant push-back. She reached out to her new manager and infection preventionist, which was “not part of the normal culture” to come up with a solution. This was an example of creativity because the lens that Bailey used to review the process had not been used before to bring the group together to help come up with a solution. She chose to problem solve in this new way and came up with a solution to keep patients and staff safer.

Since nurse’s work in interdisciplinary and intradisciplinary teams it was important to be creative in the way one approached situations in order to have the best outcomes. Not every peer or colleague interaction was going to be the same. If I am aware of how I generally respond to others, I may not have to think as much about this and will be able to focus on another to see how they are interacting (Patterson, 2002).

Innovation

Innovating is about making changes in something established, especially by introducing new methods, ideas, (Innovation, 2019). Delaney told this story of “shame and blame” from a unit where she was working and where physicians, RNs, and medical assistants wanted a better culture to work together in. This shows a way that conflict was addressed within the leadership or tiered leadership structure, to help create a culture of safety. Survey questions had been completed with all the staff because it was noted that there were issues with trust, mistrust, nastiness and institutional bullying. Delaney shared this statement of her physician co-worker:

> I want to start the change towards greater transparency, and I am starting it now. I am showing you that I saw my fault and my flaws and how I hurt you now I am asking you to partner with me to get over it and work it through. I want you to call me on the carpet.

This unit and leader specifically wanted to make significant changes to not only be patient focused, but to set the standard for everyone to hold themselves and others accountable (Lockett et al., 2015). Delaney stated was "very proud" of this partnership and teamwork to increase accountability for all. This leader was willing to partner to create a healthier culture in the unit for the staff, and therefore the patients.

When Fran was confronted with nurses running bags of fluids in the preoperative and holding areas without pumps the way she was able to get the nurses to listen was to flip the training/education. She went to the anesthesiologists as using the incorrect IV tubing, they were taught to use the pumps, to help the nurses and they followed the policy that way too. They knew what the expectations were. In the training/education they received they were shown the data, the risk by not following the policy, time studies were done to show the little time the nurse was in the holding area at the bedside of the pediatric patients. The anesthesiologists came to understand when a patient was in the holding area, if the IV was positional and the patient was to move, and the nurse was not there, "it could be a disastrous situation."

This was an example of an environment that was open to dialog facilitating safer practices or in other words a culture of safety (see Scott-Cawiezell et al., 2006). This was significant in the fact that they had multiple roles at the table including the physician

partners that were brought into the conversation. This was a successful example of what the IOM (2001) report was referencing in "highlighted risks to patient safety and offering strategies to improve patient safety through a tangible care delivery process, such as medication administration, ….and organizational struggles such as clinicians not speaking-up" (see Lockett et al., 2015, p, 558).

There were also some examples of combinations of the behaviors aligning with the preliminary operational definition. I found many of the behaviors occurring together in the same narrative. I found multiple behaviors occurring in the same narrative more than a single behavior.

Adaptability, Creativity, Innovation, Speaking Up

The narratives including components of adaptability, creativity, and innovation appeared to have one of the largest combining effects within this study.

Anne was innovative and creative in the way she chose to carry herself at work. All of the narrative statements below required the ability to bring all the components of adaptability, creativity, innovation and speaking-up. Anne had to adjust to new conditions, partially set by herself due to her statement. Although she chose to look at the current dynamics on the unit through a different lens and speak-up in a way that introduced a new way to address the current behaviors. Anne stated "I choose to work kindly and professionally with everyone, …. that was a conscience decision."

Delaney worked with an ambulatory nurse group that was to try to problem solve some clinical issues. When Delaney announced that she would be leaving the organization,

> the group decided that they were turning themselves into the Ambulatory Nursing Council, as a shared governance force that the organization had not been able to get going before. We wanted to have a group sort of like a brain trust, to pull the strengths out of it and make it work for what we needed. They are doing it! They have created the Ambulatory Nursing Council. They invited all ambulatory nurses to participate, and they were saying these would be the areas of focus to start: IT, and Coverage & Staffing. They believed if they could get those two things done, they were successful.

The temporary preliminary operation definition included the behaviors of adaptability, creativity, innovation, and speaking up. These narratives were examples of how the four components in the preliminary operational definition could be seen in the participant narratives. All of those interviewed showed or perceived a significant level of risk in their interactions.

In answering the question of the study What positive deviance behaviors, if any, are present in nurses' workplace stories? The participants shared in their stories why they themselves or other nurses would speak-up. Anne stated, "I am confident, people skills, rule and expectation follower, self-reflect, understand social obligation of role, and I read a lot." Bailey talked about how she is "a good listener, able to speak my mind, think out loud, have a great filter, and make sure it is an open conversation." Casey discussed that "It's about doing the right things. I don't think anybody is hierarchically better than another, [there are times you] keep talking to people until you find someone that will listen." For Delaney

it was important for her to let others know "I cannot do things that hurt people, and courage. If we do not do right things, we are all wasting our time."

For others it was as if they felt they did not have a choice but to act in the way they did. For example, Emma said "I have a hard time sitting back and seeing things that are totally wrong. I do feel speaking up is important. I have spoken up, to express my thinking." Fran stated,

> I am not intimidated easily, I do not fear things, I do not fear repercussions. I do not fear someone thinking badly of me. My patient is going to be safe. I believe in patient safety and patient advocacy. I was raised by an attorney.

Ginny discussed that,

> It feels too bad to not speak up. Nurses give each other the strength/courage to speak up. Confidence in their own and each other's nursing practice. Confidence in your own ability. Confidence in your communication ability to not hurt the relationship. Caring a lot about your professional relationships but not caring so much if everybody liked you.

Hadley shared when speaking up was comfortable and felt good to do.

> I think when I felt comfortable speaking up, a big one was having support and having respect that what I was saying was okay to say. Respect in myself and pride in myself… and time it helps to be older and experienced.

The participants shared characteristics in their narratives that did not help them speak up. Many of these responses came out in the interviews where the participants were not able to resolve some difficult time in their career. Such as when Hadley talked about her lack of support, the information below supported this thought process. Emma pointed out that she "has to be careful" at the time of the interviews and that she was "not as inclined to get into the conversations right now because she needed to be careful." This too aligned with the information that was given by the participant stories. Anne stated that "nurses are conflict averse," and they have a "fear of breaking" intact or perceived intact "relationships," as well as, have a "fear of giving feedback even though they say they want it."

Bailey had concerns for new nurses or those new to the profession. That they might be "too new" and do not know enough to speak-up or "not have the experience to realize what is normal." Her other concern was the nurses that have "been around for a long time" and were not able to see how change could be useful, the "we've always done it this way" or were fearful of change. Casey believed that some nurses come to work because it is "just a job." In her experience, most of the nurses "see themselves as subservient" or do not want to "push it for fear of looking stupid."

Emma believes that people have trouble being honest because they were "worried that others will judge them, or they are not secure with themselves." As an employee if you "say something that management does not like you could lose your job" even if it was accurate. It could be very risky. Ginny had fears of

disturbing the current relationship. She had heard of people that wanted everyone to like them so speaking-up was not in the "picture for them."

These responses gave insight as to why nurses may not always speak up. Another insight was why it was important to keep it safe "feeling" for RNs to continue to stay talking or in dialog in order to know what is happening in the unit community (see Gary, 2013). Even though nurses have honorable intentions, independent of the outcomes, these actions could be extremely risky for the person that is deviating both from a level of personal comfort and protecting their license and livelihood (Gary, 2013).

New Behaviors

Identifying new behaviors potentially allowed for a more complete definition to be created for the nursing profession; as well as, a more comprehensive behaviors list. It was important to maintain an open mind to any new behaviors that could emerge. The behaviors found in the narratives were: ability to flex with adversity (resilience), accountability for self and others, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, interdependence, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision and vulnerability; were found along with new behaviors including intentional, moral and self-empowerment, responsibility and not driven by a level of authority were identified.

After validating the existing behaviors, I thought were present, I looked for reoccurring behaviors that were new, such as reflective, self-reflection, understanding of ANA Scope and Standards, intentional in actions, and initiative or the ability to self-

empower. Some interesting behaviors that were found in the participant narratives were upbringing such as “this is my social obligation,” (Anne, Ginny) “I do a lot of self-reflection,” (Anne, Bailey, Delaney, Emma, Ginny, and Hadley); “strong work ethic,”(Hadley) “intentional,” (Bailey. Fran); “respect” (Hadley); “don’t stop until you accomplish your goal,” (Casey); “confident in skills and knowledge of Scope of Practice”(Anne, Fran); “I own my practice” (Ginny); “I say things out loud so people know what I am thinking” (Bailey).

Additional behaviors found were self-reflection, respect, transparency, action oriented, understanding of ANA Scope and Standards, Intentional in actions, and initiative or the ability to self-empower under risky circumstances. I believe that the ones that should be added to the list are self-reflection, understanding of ANA Scope and Standards, intentional in actions, and initiative or the ability to self-empower under risky circumstances as these were the ones that came up most often in the outcomes.

Discrepant Information

Some of the discrepant information that was found was nurses not choosing to speak-up for themselves. The narratives would seem to show that many of those interviewed had an internal need to speak up for others; however, it appears to be harder for themselves. When asked for characteristics that help the participants speak-up responses were “I am from New York” (Casey), “…People just go to work for a paycheck” (Anne) and then there are those that seem to be hurting a lot from speaking-up like the following example. Delaney when asked what helped her speak-up, said that she was a “big mouth, always in trouble and noncompliant.” She also said that she was

"probably one of the worst employees her boss ever had." Delaney said this was because she did not "play by their rules", and "could not do things to hurt others." She stated that because of this she was "hurting leadership by calling them out on it." Sadly, she looked at me and said that it was "also hurting her", because she was "leaving" the organization soon. Listening to Delaney talk about characteristics that helped her speak-up and to hear these statements was difficult. The body language that went with these statements was sad, her eyes were focused downward, voice lowered and a shrug of the shoulders.

The original preliminary operations definition appears to have been accurate in both the behaviors identified, and in this definition with the addition of self-empowerment, responsibility with the stories studied. The new proposed definition of PD for nursing should be an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, self-empowerment, responsibility or a combination of these attributes including a level of risk.

Evidence of Trustworthiness

Credibility

Validity strategies are a significant strength within qualitative research (Creswell, 2013). For this study, there were eight participant interviews conducted; thus, 8 of 10 sources of data in this study to review. Once the interviews were recorded with the Dragon Naturally Speaking, Recorder Edition Digital 13 issue, digital device, I listened to each interview to make sure that they translated correctly. I made sure to listen to them more than once and at least one of the times on a separate day. I did this to make sure that

I had "fresh ears" so I would not miss anything important and that I was focused. Another strategy was to spend "prolonged time" in the field (Creswell, 2013, p. 246). Although they were asked, none of the participants were interested in reviewing a portion of the transcript. They were interested in reading the whole paper once it was completed and said they would look for it.

Transferability

An important aspect of transferability is that the findings include "thick descriptions for the reader to assess potential transferability and appropriateness for their own settings" (Miles, Huberman, & Saldana, 2014, p. 214). This was why participant quotes were used from the narratives to help with the transporting of the readers to the setting of the shared experiences (Creswell, 2013). Prior to each of the interviews, my observation journal was out and ready to document in. Being prepared for the participant allowed for focused attention on the interview itself and to be present with the participant. Any of the observations written down in my journal also helps the readers share in the experience of the interviewee. Transferability of the interview participants experiences may resonate with the readers experiences in that they were able to make reasonable comparisons to their own information or other similarities (Miles et al., 2014).

Variation of participant selection was obtained by self-selection and snowball selection. Because the participant selection was done this way, a specific type of participant was not sought out. Thus, the sample of participants would be theoretically diverse enough to apply to a broader sample or have greater opportunity for transferability (see Miles et al., 2014).

Dependability

When bringing the themes together to review them, it was important to have someone not as familiar with the study to provide an objective assessment both during the and at the end (Creswell, 2013). This objective assessment was done by my committee chair. There was limited discussion prior to sharing the transcribed interviews with the committee chair, as we did not want to influence each other prior to reviewing the interviews for themes. We both reviewed 4 of 8 transcribed interviews independently and then placed them in the drop box for the other to review and see if our assessments were similar. The more data points there were the greater the trustworthiness there was in the results. We were able to come to similar conclusions regarding the data points that we read. Our findings were congruent with each other when we came back and read the review each of us had completed.

Confirmability

Confirmability was important because the researcher needed to acknowledge their own bias's, personal background and anything that could impact how they would interpret the study results (Creswell, 2013); as well as, any personal assumptions, values and or affective states that may have had an effect on an interview (Miles et al., 2014). After each interview I reflected not only on the interview, but also on the feelings following the interview. By completing this reflective exercise, and documenting the biases, assumptions, and any affective states that I left with would be visible. Therefore, less likely to allow the biases, assumptions and affective states to interfere without awareness, into the study results. Confirmability was also important in that the entire

picture of the study was clear enough that the procedures and methods are described explicitly (Miles et al., 2014, p. 311). These notes are reviewed often while composing the last two chapters.

Results

In this section the single research question asked by this study was addressed. This was done by summarizing my findings and conclusions from the data analysis. There was a total of one question "What positive deviance behaviors, if any, are present in nurses' workplace stories?" asked at the start of this study.

The behaviors that had been summarized for positive deviance in nursing were: the ability to flex with adversity, accountability for self and others, adaptability, authenticity, autonomy, clarifying information in a professional way, connectedness, creativity, courage, including a level of risk, innovation, inspiration, interdependence, intentional, not driven by a level of authority, moral empowerment, political astuteness, responsibility, self-empowerment, speaking up even when it is uncomfortable, strong relationships, vision and vulnerability. All of these were found in the individual narratives told by the participants in this study. There were some new behaviors that emerged in the narratives including intentional, moral empowerment and self-empowerment, responsibility, as well as, not driven by a level of authority. All of the behaviors appear to have had the underpinning of not being driven by a level of authority and were intentional acts.

Intentional, Moral-Empowerment, and Self-Empowerment

These new behaviors that had been added to the definition were seen throughout the eight participant narratives. Each participant had a clear statement of being intentional in their narratives. Empowerment is the process of becoming stronger and more confident (Empowerment, 2019). Moral: Is a principle that governs right and wrong (Moral, 2019). Self: who I am in my identity (Self, 2019). For the purpose of this study, self-empowerment will be defined as: who I am in my identity, and the process of becoming stronger and more confident (Self, 2019; Empowerment, 2019); and, moral empowerment: an individual is stronger and more confident in their principles of right and wrong as they are successful or perceive success (Moral, 2019; Empowerment, 2019). When Anne was confronted with losing some friendships with peers, she continued her choice to not take part. She did not want any part of the continued unit drama, because people were not okay with her choice over not taking sides, she was self-empowered to continue intentional decision.

Emma was,

> saddened that she did not approach the provider directly regarding his poor treatment of the residents. She intentionally reported the physician by email to her manager "for two reasons: a) to express that this was going on, that this had to change it was not right, b) provide the documentation knowing that you cannot bring a case against someone unless the documentation was there.

When asked Emma stated she "interpreted this to mean she was morally empowered and self-empowered to send the email." She said that she "could not watch the physician treat the residents poorly anymore in front of the patients!" This was very important to her in her story as she repeated it three times to make a point. These appear to be intentional, moral acts of behavior when speaking-up. All eight of the participants had examples of having been intentional, exhibited moral empowerment and self-empowerment behaviors.

When the participants were speaking up for another it also appeared it was easier to act in a way that was correct yet went against unit culture. All eight of the participants agreed that this was a true statement. Casey's example was when she called the chief of staff and let him know that he would be receiving a "phone call from an angry physician." The call would be about the nurse and herself because they "stopped him from going into the OR without the required consents signed in a non-urgent case."

This call does not appear driven by a level of authority, but by self-empowerment and intentionality. Again, this appears to show an intentional, moral act of behavior when speaking-up. In other words, a need to do the right thing, where it was harder to not do the right thing than it was to do the right thing (i.e. Standard 5A; ANA, 2015).

Fran shared an example of a safety issue where she felt it was so important that she kept escalating until she was able to get someone to listen even though this was a significant risk to herself. Fran had escalated an educational issue straight up to the CNO, related to the nurses using an IV tubing that would free flow bag fluids into pediatric patients. This was related to the anesthesiologists not using a pump in the OR to regulate

the fluids, they would manually regulate them. When the patient came back to the postoperative area the nurses were not 1:1 and mistakes could easily occur if the patient was not on a pump, especially pediatric patients. The manager and director were upset with Fran, even though she had shared the recent article on a lawsuit in California because a 1000ml of fluid had infused on a kid and they ended up with brain swelling and died. They did not understand the safety issue and that was the reason she went above them to the CNO.

Fran understood prior to making the education decision and escalating it up beyond the manager and director to the CNO that some would be upset. She was willing to accept this and take the "risk" in order to provide a safer atmosphere for patients. She too was self-empowered as she was not necessarily supported by those in authority in this endeavor.

Delaney reported a story regarding a physician sharing some unit cultural results in a staff meeting. The physician had noticed an issue with trust, distrust, respect and nastiness and institutionalized bullying within his clinic. He wanted to start changing the culture and asked for Delaney to gather data from all the staff. Once the results were back and he saw that he was part of the issue he held a staff meeting with Delaney at his side. He said, "I want to start the change towards greater transparency, and I am starting it now." He told the staff that he was showing them that he saw his "fault and flaws and how I hurt you." He told them that he wanted to partner with them to help him work through it. He also said that he wanted them to let him know when he fell into old ways. This was not only intentional, moral empowerment, and self-empowerment, it also

showed that other colleagues could potentially share in these behaviors with us if the relationships and the willingness to be vulnerable were there.

Although Fran understood that the central line dressing changes were time consuming; she also understood that wheeling a patient through the halls with a dressing that was weeping, or seeping was not safe for the patient and policy. The culture was to ignore doing the dressing changes prior to the patient leaving the post surgery area even if it was visibly soiled. The rationale was that it extended the period of time the patient was in the unit and backs up the post surgery area. An intravenous nurse was hired; she understood the procedure and she was doing making sure her patients had the central line dressing changed prior to leaving. The nurses she worked with were mad because they thought she was doing the dressing changes to avoid getting another patient. Her peers understanding was not at the same level that hers was. She was asked to do create a standard operating procedure (SOP) that would meet the policy requirements for the least amount of time and to train her peers to it. Her peers started completing the dressing changes prior to the patients leaving the post surgery area.

This was a risk for this nurse since this was not the culture. She was self-empowered to make the right thing happen even though her peers originally were not supportive her practice choices. This nurse continued to do what was right for the patient even though her peers were upset and thought that she was avoiding taking another patient or being slow. It was more important for this nurse to change the dressing and send the patient out safely than to worry about what her peers thought. This nurse understood what not changing that dressing could mean to the patient and what the

outcomes could be. This nurse also had an advocate in her educator, in that they understood the outcome for the patient if the correct process was not followed, and she was not supported.

Responsibility

The level of authority that someone had does not always appear to have played a significant role in how the person acted in a way that one knows is correct yet goes against unit culture. Ginny tried repeatedly to,

> partner with a manager to make things safer for patient care in an oncology unit; Although, the manager was unable to understand that even though they were a community clinic they needed to follow the American Society of Chemotherapy standards and guidelines. I eventually informed the manager that I needed to escalate the fact that chemotherapy was not checked by two nurses, and that the staff RNs were not using the proper PPE, up the chain of command, it was her social and ethical obligation.

Even as Ginny recounted this story there some pain in the words, as her eyes looked far off and her voice was softer. Ginny continued to say that "ultimately the manager left her position." The manager leaving was really hard for her. Ginny puts a huge value on relationships and felt like she "made her leave" or that she made the manager "look like she was failing." After a few minutes she continued her story saying, "over time the clinic is much safer for patients and staff." Ginny said in a thoughtful way that she had "reflected a lot on this even years later" and she "feels proud of this work." She ended this part of the story saying, "I understand that I did not own all of it, but it is still hard."

Hadley also described a story that I felt there was perceived pain in telling it. I asked if she still had "pain" when she thought about this. Hadley said she did, that it was the one situation she "still thinks of often" and "wishes she could have fixed." This participant is retired. While I listened and watched Hadley talk about this it was as if she was in this moment, experiencing it all over again:

> this [is a story] I think of frequently, I was a manager, during this time. I was on a unit we went from two generations (Traditionalists and Baby Boomers) to three or four generations (Generation X and Generation Y). The third and fourth generations were really making a huge impact on getting people to work overtime. Before that time, you would let the staff know the needs of the unit and people would just take turns offering to work overtime and it was pretty evenly split…. It was amazing how much damage they could do…. we had to have meetings on the floor we had to have a psychologist, who was brought in to talk to the staff to see if they could help things along, help the unit resolve some of the cultural issues work out.

In these last two stories there was a feeling of failure that came through, even as the participant continued to narrate their story, they believed what they had done was right, correct and even went along with their professional ethical obligations; it was evident they carried these moments even years following the original events. Still in all these stories the message of self-empowerment or initiative was heard. It would appear the desire or will from inside the participant was an instrumental component for success.

Failures, shame and blame these behaviors were not necessarily unexpected; what was unexpected was that these feelings can last years including into retirement. For some, they feel speaking up lost them their positions even when it was the right thing to do. Some of the participants when they reflect back on these times in their careers, have an intense feeling of loneliness. Especially if their managers, or supervisors were not "skilled" at speaking-up or comfortable with being in uncomfortable situations.

Summary

In summary, not all the initial behaviors from the literature search were found throughout the responses. However, 13 of the 15 behaviors were found in the participants narratives. Specifically, inspiration and observant were not found in the participants narratives. In the participants responses one or any combination of the these behaviors: ability to flex with adversity, accountability for self and others, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, interdependence, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision and vulnerability; were found along with new behaviors including intentional, moral and self-empowerment, responsibility and not driven by a level of authority were identified.

The key findings from Chapter 4 will be reviewed in the next Chapter. Additionally, I will summarize implications for the study including limitations, and recommendations. Lastly, conclusions will be discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This chapter begins with an interpretation of the study findings according to narrative inquiry combined with vocabularies of motive and symbolic interactionism. This is followed by limitations of the study, recommendations, and the implications. This section then ends with the conclusions.

The reason for embarking on this journey was to discover if, and what, behaviors of PD were exhibited within RN workplace stories. Then out of these findings I would develop an operational definition of PD for nursing. When I developed this study, I chose narrative inquiry combined with vocabularies of motive and symbolic interactionism. It was important to me to know whether RNs demonstrated behaviors of PD. If behaviors of PD could be established or revealed within the RN workplace stories, a new operational definition of PD could be identified specifically for the nursing profession. This new nursing specific definition of PD could, at a later time, be further explored and applied in future studies.

Interpretation of Findings

Implementing mechanisms for feedback and learning from error are imperative (IOM, 2001). Giving feedback and having the ability to receive feedback were important components to this IOM statement. Providing or receiving feedback when others were involved is not easy, especially if the results had been less than positive with previous attempts. I identified the term PD as being used in sociology, healthcare leadership, business, and with school nurses in leadership; however, I found there was a gap for the

term PD being used with nurses' everyday practice. Therefore, the research question I developed to guide this study was: What positive deviance behaviors, if any, are present in nurses' workplace stories?

Once the data had been analyzed, I refined the preliminary operational definition of PD as it applied to nursing. The original preliminary operational definition of PD was an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, and adaptability or a combination of these attributes, including a level of risk. In my literature search, I found that PD had components of innovation, creativity, and adaptability (see Gary, 2013) as well as a component of being intentional (see Lindberg & Clancy, 2010). The new definition of PD for nursing I developed was: an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, moral empowerment, self-empowerment, and responsibility or a combination of these attributes, including a level of risk.

Initially, the PD behaviors I was looking for were ability to flex with adversity, accountability for self and peers, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, inspiration, interdependence, observant, political astuteness, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability. Of these 15 original behaviors, 13 of them were identified in the narratives of the participants. The two behaviors that were not clearly identified in the participant narratives were inspiration and observant. New PD behaviors found were

intentional, moral and self-empowerment, responsibility, and not driven by a level of authority.

Using narrative inquiry helped me to capture the life story from the lens of the participant (see Merriam, 2009) while the use of symbolic interactionism helped to explain the meanings that the participants assigned to each narrative or story (see Charmaz, 2014). Finally, vocabularies of motive helped me understand if the participant answered the questions based on the person they were talking to ("Vocabularies of motive," n.d.). A concern was that the positive deviant could be misidentified as having had conflict behaviors by those that are uncomfortable with differences in desires, goals, needs, and wants (Almost, 2005; Boughton & Duddle, 2007). Although Delaney's boss saw conflict behaviors in her actions when Delaney was helping the medical director with the "real problem with trust, distrust, respect, nastiness and institutionalized bullying" data, the medical director was very happy with the results. Delaney showed moral empowerment in this story. She felt stronger and confident in her principles of right and wrong as well as her success. All eight of the participants struggled with conflict behaviors on some level to a greater or lesser degree because they influenced their perception of the work environment (Fackler et al., 2015; Higazee, 2015; Lees, 2016; Rosenstein et al., 2014). The level of these moral issues varied in the intensity that each participant felt related to the need to step into the environment to intervene.

When reviewing the narratives, one of my biggest epiphanies came when reviewing adaptability, creativity, and innovation. This was where the behaviors were easiest to see in the stories that had been told. Under adaptability, Anne stated "I was like

I am not going to take this bad behavior from others." It was clear in that she chose to adapt in such a way to take a risk and go against the established norm of the culture, which was to choose the same side as the nurses that worked your same weekend pattern and not the nurses that worked the opposite weekend pattern. One or any combination of adaptability, creativity, and innovation were found in the narratives from the interview participants. This appeared to be predominant in those that had an understanding of their independent scope of practice.

Nurses could have a high level of stress on a normal day, just by nature of the kind of work they do. It requires strong relationships to manage stressful days. The positive deviant was able to flex with adversity, show resilience, as the day goes on in order to decrease stress and stay resilient, not only for their own stress level but for the stress level of those around them including peers, colleagues, patients, and families. A commonly identified psychologically taxing stressor in healthcare work environment is interpersonal work-related conflict (see Westphal et al., 2015). It is a risk when nurses take actions against the current culture. When nurses were self-empowered to make the right thing happen even though their peers originally were not supportive of the practice choices patient and unit outcomes are better. This is shown in examples such as Fran's central line dressing changes happening prior to patients' leaving the post surgery area. The nurse in Fran's narrative continued to do what was right for the patient even though her peers were upset and thought that she was avoiding taking another patient or being slow. It was more important for this nurse to change the dressing and send the patient out safely than to worry about what her peers thought. This nurse understood what not

changing the dressing could mean to the patient and what the outcome could be. This nurse also had an advocate in her educator, in that they understood the outcome for the patient if the correct process was not followed and she was not supported.

Interestingly enough, many of these behaviors could be seen in the stories that the participants shared for their own example of doing what was right even if that meant going against unit culture. These same qualities were seen in the stories that they chose to share for seeing another nurse act in a way he or she knew was correct but went against unit culture. This led me to believe that these stories had an important alignment with the belief system that these participants had. I am not sure if this was something that they are aware of.

The participants in this study were willing to speak up when they saw things that were not correct for patients or others. They were also willing to speak up for processes that were broken. This appears to be an intentional, moral act of behavior when speaking up. In the stories, as the participants spoke, other peers could have exhibited these same behaviors and/or actions because they too had seen the same things and did not act on them. Nurses have an obligation to speak up to create a culture of safety for patients as well as provide peer feedback to collaborators and colleagues (see Oregon State Board of Nursing, 2008). Speaking up was foundational in giving and receiving feedback. Data from 2010, reported 82% of sentinel events were caused by poor communication (Joint Commission, 2012). Within this factor was the important ability to clarify information in a professional way to reduce the potential error in communication. It was also significant

for RNs because they have a unique advocacy role within the organizations they work in (Garon, 2011; Sayer et al., 2011).

Speaking up does not appear driven by a level of authority but by self-empowerment. Again, this appears to show an intentional, moral act of behavior when speaking up. In other words, a need to do the right thing, where it was harder to not do the right thing than it is do the right thing. In the interviews, some of the participants had suggestions for limitations or challenges for those who do not speak up. Some of the ideas were utilizing nursing school to help teach speaking up, "we need to learn to talk to each other, have courage, not feel like there was a hierarchy and that everyone is equal in being able to share their thoughts, and remember it's about patient-centered care." This was not only intentional, moral, self-empowerment, it also shows that other colleagues can potentially share in these behaviors if the relationships and the willingness to be vulnerable were there.

I also studied leadership in the literature review. There are many positive sides of leadership behaviors that were confirmed in this study, such as authenticity, courage, connectedness, vision, and political astuteness. It was noted in the review that it was the nurse leader's responsibility to create and sustain high-quality, safe, and effective patient-centered care (Jackson & Daly, 2011; Pipe et al., 2011). This does not necessarily mean the manager or other formal titled leader are the responsible individual. As professionals with a license, RNs are believed to be leaders (ANA, 2015). Leaders that were noted as resilient must be able to reconcile their own decisions and actions within the work environment. It was also noted in my study that when participants were in what was

considered a "leadership" position, two of the participants thought it was easier to act in a way that was correct, yet, went against unit culture.

In the narratives, when the positive deviant was managing difficult situations that involved human distress, work-related, interpersonal conflict, crisis management usually presenting itself with little warning, some that involved traumatized patients, families, and healthcare staff provided the biggest challenge (see Jackson & Daly, 2011). When leading people through change, challenging their beliefs, including but not limited to, daily routines, tools, loyalties, and their way of thinking, individuals become the face of the unwelcome change (Jackson & Daly, 2011; Rosenstein et al., 2014; Strutton & Knouse, 1997). This was found to be true in the narratives told by the participants. In Delaney's story with the medical director where her boss did not understand the need to resolve the "issues with trust, mistrust, nastiness and institutional bullying," Delaney challenged her boss's beliefs and worked with the medical director for positive outcomes. There was also Ginny's example of the manager that left the oncology clinic because she had a difficult time making the changes to align with the American Society of Chemotherapy standards and guidelines.

Moral empowerment was shown in the data by participants stating "I had to do…" or "I could not just stand by…" There was a clear moral need and desire to take action. This is why I think there were some participants that carried some of the situations they were not able to resolve in a way they felt good about with them, sometimes past retirement. In two participant stories, there was a feeling of failure that came through, and even as the interviewee continued to narrate her story, she believed what she had done

was right, correct, and even went along with her professional, ethical obligations. It was evident they carried these moments even years following the original events. Still, in all these stories the message of self-empowerment or initiative could be heard. It would appear the desire or will from inside the interviewee is an instrumental component for success.

For example, Hadley had retired, and she still reflected on the story with the multiple generations and how she had not been successful with that situation. There was some internal force that drove them or empowered them to take action and “do the right thing,” knowing that there would be consequences of some type. Some of the consequences were lower in acuity, such as having a conversation that had no conflict, to high acuity of a person losing their job. In all the participants’ narratives, they showed that they were not driven by a level of authority, meaning they did not wait for someone to tell them to do what needed to be done. They saw something in their community that needed to be done and they took action to get it done. Participants that shared narratives with strong relationships believed they had more successful outcomes than those that did not have the stories with the strong relationships.

The findings of this study supported that there are PD behaviors that existed in nurses’ workplace stories. The behaviors found were as follows: Ability to flex with adversity, accountability for self and others, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, intentional, interdependence, moral empowerment, not driven by a level of authority, political astuteness, responsibility, self-empowerment, speaking up even when it is uncomfortable, strong

relationships, vision and vulnerability were identified. The newly identified definition of PD for nursing is an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, moral empowerment, self-empowerment, responsibility or a combination of these attributes including a level of risk.

Limitations of the Study

Limitations of the study consisted of (a) conceptual limitations, (b) situational limitations, and (c) methodological limitations. My concern in regard to the conceptual limitations was that the participant would tell me what they thought I wanted to hear, instead of what their real truth was, because they might see a level of authority difference ("Vocabularies of motive," n.d.). In my observations of the participants, and follow-up dialog this did not appear to be an issue; however, I believe it is still a good consideration for a limitation.

Situational limitations were the participant selecting to be in the study and they also selected location of the interview. When the participant selected both partaking in the study and then they chose the location of the interview this made the opportunity safer for them and less awkward. I was successful in meeting all participants that the location of their choice.

Methodological limitations of this qualitative study with vocabularies of motive positioned in the conceptual foundation of narrative inquiry in conjunction with symbolic interactionism allowed me to observe and build from the data found in the participant interviews. This approach allowed me to develop a complex picture of the what the PD

behaviors were that existed in the nurse's workplace stories (Creswell, 2009). Semi structured and unstructured interviews allowed me to ask clarifying questions as needed or to expand on questions to get a better understanding of the participants information that was being shared (see Merriam, 2009). Interviews were the best way to access the information as I was trying to ascertain what was on the participants mind (Patton, 2015). The data collection method gave a first-hand account of the situation under study; where the participant observation maximized advantages of the human being as an instrument. As such I needed to be careful to keep any biases that I might bring to the situation to a minimum. When bias was noted, it was recorded and interpreted. I noticed that the bias noted was in my writing as I would read over my chapters this was easy to fix and if I did not catch it someone on my committee did. I was the sole interviewer for this study, I was also the only transcriber for the recorded interviews. I also had eight participants which is a limited number from the western United States that may not have represented the East Coast or the Midwest as well as it could have.

Recommendations

One or any combination of adaptability, creativity, and innovation were found in the narratives from the interview participants. This appeared to be predominant in those that have an understanding of their independent scope of practice. Since this was not specifically addressed in this study, questions may need to be addressed regarding this in upcoming studies. Perhaps outline leadership qualities, confidence in self, confidence in professional skills, knowledge and independent scope of practice, communication skills, open minded, listen and continue to talk until you find someone that will listen.

Interestingly enough many of these items can be seen in the stories that the participants shared for their own example of doing what was right even if that meant going against unit culture. These same qualities are seen in the stories that they chose to share for seeing another nurse act in a way he or she knew was correct but went against unit culture. Perhaps, focusing on symbolic interactionism to see how participants attribute meanings to things derived from, or arises out of, social interactions, and in turn actions are based on idiosyncratic meanings (Blumer, 1986).

Listening to each participants narrative, I wonder if the stories each participant shared had an important alignment with their belief system. That perhaps, the PD behaviors are through the lens they inherently have and are not learned. I would like to see if PD behaviors are something that could be taught to other RNs. This could be something to look at in a future study.

Many of these responses came out in the interviews where the participants were not able to resolve some difficult time in their career. Such as when Hadley talks about her lack of support, the information below supports this thought process. Emma points out that she “has to be careful” at the time of the interviews and that she was “not as inclined to get into the conversations right now because she needed to be careful” (see Almost, 2006). This too aligns with the information that was given by the participant stories. This would be a great opportunity in the future for continued research in this area. If these behaviors can be taught as a practice methodology, Marsh et al., (2004) discussed that PD is a low-cost method to identify both strategies used, and roles needed to encourage the remainder of the community to adopt the behaviors. I did not need to apply

for any grants to conduct this study. If a curriculum can be created to educate staff on competency of these behaviors this could potentially taught, and we increase our number of high reliability organizations. These would be my recommendations for future study ideas. I would also try to get a larger sample size across a more diverse group.

Implications

The findings from this study have impact to positive social change at the individual, organizational and societal/policy levels. With PD behaviors now identified and a nursing operational definition of positive deviance for nursing of an intentional and moral behavior that departs or differs from the established norm, containing elements of innovation, creativity, adaptability, moral empowerment, self-empowerment, responsibility or a combination of these attributes including a level of risk. Nursing now has its own definition to use. The individual has a way to define and back their actions in a safe way or that could be used as an expectation as a professional nurse. At the organizational level, the identified PD behaviors and definition can be used as an expectation of how to express oneself in a professional, honest, and direct manner in the right time and place. At the organizational level those identified as positive deviants could be recognized as organizational change agents, valuable in not only finding innovative approaches in healthcare issues and as a problem-solving technique (Gary, 2013; Ladd, 2009). At the societal/policy level this could in time set expectations for the professional nurse. Since behaviors had been identified these could be written into job descriptions, and/or competency-based orientation checklists. As leaders, preceptors, or nurses' themselves identify the behaviors on their own or a peer's annual review they

could be acknowledged for attaining the competency of the behavior or skill. For example, Anne showed PD behaviors when she chose to "work kindly with everyone and not choose sides with the incivility that was occurring on her unit." In this model, utilizing PD behaviors would be celebrated and Anne would be encouraged to mentor others using these behaviors and skills. Positive deviants are found within the unit, they understand the work as well as what the challenges are using an intentional and moral behavior that departs or differs from the established norm. Positive deviants are recognized as organizational change agents, valuable in finding innovative approaches to health care issues, and as a problem-solving technique (see Gary, 2013; Ladd, 2009). As more nurses are identified as a positive deviant, they will be in a place to use the PD behaviors to engage not only themselves but to teach others to resolve issues in a productive and proactive way.

Conclusions

RNs are professionals and leaders. As such RNs have a unique position on the healthcare team as advocates and mentors. RNs need to use their PD behaviors: ability to flex with adversity, accountability for self and others, authenticity, autonomy, clarifying information in a professional way, connectedness, courage, intentional, interdependence, moral empowerment, not driven by a level of authority, political astuteness, responsibility, self-empowerment, speaking up even when it is uncomfortable, strong relationships, vision, and vulnerability, not only to create a better culture for patients, colleagues, and themselves, but because it is the right thing to do. The new definition of PD for nursing: an intentional and moral behavior that departs or differs from the

established norm, containing elements of innovation, creativity, adaptability, moral-empowerment, self-empowerment, responsibility or a combination of these attributes including a level of risk, allows nurses to speak up, model, and apply the behaviors that they believe are so important. The more successful the individual was the more they tended to continue the behaviors that they had positive feelings about the outcomes. The nurses that had good feeling about themselves and their actions appeared to continue as the outcomes are positive. Perhaps the two of these processes that result in positive outcomes become reinforcing; almost as if they are a self-fulfilling prophecy. This new identified definition has extended the knowledge of nursing in that is has added a definition for nursing.

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Appendix A:

Semi structured

Interview Guide

Semi-Structured Interview Guide

Demographic Data

Age: ____ Gender: ____ Race: ______________________

ADN___ DN___ BSN ___ MSN___ DNP___ PhD___ Other___

How long have you been a Registered Nurse? ______ years _____ months

Employment Since Graduation from Nursing School

Department	Kind of Unit	Length of Time On Unit
Department	Kind of Unit	Length of Time On Unit
Department	Kind of Unit	Length of Time On Unit
Department	Kind of Unit	Length of Time On Unit
Department	Kind of Unit	Length of Time On Unit
Department	Kind of Unit	Length of Time On Unit

Interview Guide

Leading question: "Tell me what you think this interview is about?"

Prompts may include:

- Tell me about a time that you acted in a way you knew was correct, but went against unit culture.
    - What was the outcome?

- Tell me about a time that you saw another nurse act in a way he or she knew was correct, but went against unit culture.
    - What was the outcome?
- What characteristic do you have that helps you speak-up?
    - Perhaps a characteristic that other nurses who don't speak-up lack?

Follow-up probes and questions will be used depending on the participant's responses.

Upon apparent completion of the interview participants will be asked "Is there anything else you would like to tell me?"