EMERGING LEADERS: THE EXPERIENCES OF NEW NURSE MANAGERS IN AN ORGANIZATION UNDERGOING CHANGE

by

Joan T. Mueller

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

DOCTOR OF HEALTH ADMINISTRATION

UNIVERSITY OF PHOENIX

November 2009

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November 2009

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ABSTRACT

A call for the development of quality environments in healthcare focused on leadership in healthcare organizations. The purpose of this qualitative case study was to determine how healthcare leadership developed in a changing organization. Purposeful sampling selected one organization that changed the primary leadership role at the practice level to nurse manager. Two in-depth interviews, researcher notes, and document review discovered the experiences of four participants. Manual and computer-assisted coding used pattern matching revealing 6 themes and 22 key words. The themes, defining a leader; to become a leader; searching for balance; the influence of others; make a difference; and building the practice environment, took the study audience through the leadership development process of the participants.

DEDICATION

This dissertation is dedicated to my Nana, Lottie Leocadia Soboczinska Siehien (1901-1991) and to those other strong women in my family, Frances Rita Lyons Boro (1904-1965), Barbara Ann Boro Hordeski (1934-2002), and Carolyn Frances Boro McLaughlin (1933-2004), who have gone before me. May they be remembered with love.

ACKNOWLEDGMENTS

I thank the four particiapants in this research study. Your valuable insights, perspectives, and experiences have contributed to the knowledge base of healthcare leadership. I look forward to seeing the full expansion of your leadership as you grow in knowledge.

Challenges in life are put there so that we can grow stronger in faith and love. I appreciated the support and guidance of my mentor, Dr. Barbara Shambaugh. My committee members, Dr. Leonard Kelpsh and Dr. Mervyn Caldwallader, provided complementary insights to the dissertation process. Thank you for your patience, support, and guidance.

My coworkers, Betsy and Jane, offered support, encourangement, and understanding. Thank you for listening. Dr. Marion Conti-O'Hare provided invaluable guidance and support. Thank you for reliving the doctoral journey with me. To those other organizational members who kept inquiring if I was done yet. Thank you for your interest and support even when I saw your eyes glazing over during my explanations of theoretical connections and leadership in healthcare.

University of Phoenix cohort members, Janet, Raja, Kim, and Linda, shared this journey with me by contributing their perspectives, advice, and insights. I valued our friendship. I connected with Don in third year residency. I valued our collaboration and friendship across cultures. Thank you all for your continuous support and encouragement thoughout the challenges of the past few years.

My family, Ronnie, Crystal, and Brian, supplied the reason for achieving a doctorial degree that would contribute to my inner identity as a caring individual. I thank

you for your love and support and I cherish each moment that brought us closer together. I look forward to sharing this accomplishment with you as we move along life's journey. Thank you all for being in my life.

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CHAPTER 1: INTRODUCTION

Stakeholders have determined that, as an industry, healthcare lags behind other industries in the provision of quality service (Institute of Medicine [IOM], 2001). In searching for solutions to the problem of quality in the provision of healthcare, researchers (Brewer, Lim, & Cross, 2008; Frankel, Leonard, & Denham, 2006; Mallak, Lyth, Olsen, Ulshafer, & Sardone, 2003; Morgan & Ogbonna, 2008; Rondeau & Wagar, 1999; Stewart & Kringas, 2003) have examined relationships between organizational environments and organizational cultures. Leaders in the healthcare industry have realized the significance of customer service in maintaining and expanding a customer base (Anderson, Amarasingham, & Pickens, 2007; Green, Zick, & Makoul, 2009; Thomas, 2003; Yasin, Zimmerer, Miller, & Zimmerer, 2002) and have understood the need to follow other service industries in the development of quality service environments (Frankel et al., 2006; Natarajan, 2006; Ruchlin, Dubbs, Callahan, & Fosina, 2004; Savolainen, 2000; Scotti, Driscoll, Harmon, & Behson, 2007). Leaders in healthcare have responded to the challenge with a commitment to developing practice environments that support excellence in service delivery (Goonan, 2007; Hilburn, McNulty, Jewett, & Wainwright, 2006; Smetzer & Navarra, 2007).

A first step in changing the healthcare environment consists of increasing customer satisfaction (Grieves & Mathews, 1997; Howard, 1999; Scotti et al., 2007; Smith, 2003). A second step pertains to aligning the performance of the individuals in the organization with the provision of quality service (Anderson et al., 2007; Baker, Walsh, & Marjerison, 2000; Fuller, 2007; Manring & Brailsford, 2001; Naquin & Holton, 2006; Naude & McCabe, 2005; Sarros, Gray, & Densten, 2002; Savolainen, 2000). A third step

concerns promoting leadership development (Block & Manning, 2007; Brown, 1998; Cook, 2001; Ferguson et al., 2007; Force, 2005; Hawkins, Carter, & Nugent, 2009; Sherman, 2005; Shirey, 2006; Waters, 2004) as a conduit to energizing the practice environment. Developing leaders at the practice level and engaging staff in creating and sustaining change efforts have become priorities for quality service delivery in healthcare organizations (Aronson, Mastorovich, & Arsht, 2002; Frankel et al., 2006; Haase-Herrick, 2005; Litwin, Beauchesne, & Rabinowitz, 1997; Lukas et al., 2007; Smith, 2003; Walmsley & Miller, 2007; Wilkinson, Rushmer, & Davies, 2004).

Chapter 1 includes the framework for the current qualitative case study. The chapter contains an overview of leadership in healthcare, background information and statement of the problem, and details about the purpose, significance, and nature of the study. The conceptual framework provides a connection between the research study and theory. The chapter summary follows operational definitions, assumptions, scope, limitations, and delimitations.

Background of the Problem

Previous approaches to healthcare leadership stemmed from a hierarchical model in which the physician is the primary decision maker (Cody, 2003; Frankel et al., 2006; Green et al., 2009; Hertting, Nilsson, Theorell, & Larsson, 2004; Mantzoukas & Jasper, 2004; Porter-O'Grady, 1994; Seago, 2006; Wiggins, 2006). The realization that the traditional approach restricted the growth of quality environments for care slowly emerged in the last decade of the 20th century (Frankel et al., 2006; Martin, O'Brien, Heyworth, & Meyer, 2005; McAlearney, 2006; Ogbonna & Harris, 2000; Thyer, 2003). Hierarchical leadership produces a separation between administrative and nursing

leadership in healthcare organizations (Carney, 2004b; Higgs & Rowland, 2005; IOM, 2001, 2004; Rosengren, Engstrom, & Axelsson, 1999). In identifying quality (Appelbaum & Wohl, 2000; Covey & Gulledge, 1992; Fen-Chuan & Chi-Shan, 2004; Goonan, 2007; Lageson, 2004; Lukas et al., 2007) as the determining factor in the provision of service, researchers (Doyle & Turkie, 2006; Frankel et al., 2006; Hayhurst, Saylor, & Stuenkel, 2005; IOM, 2000, 2001, 2004; McAlearney, 2006; Waldman, Smith, & Hood, 2003) stipulated leadership was the starting point in approaches to service delivery change.

Task-oriented individuals in the clinical setting are comfortable with the hierarchical approach to leadership (Bolton, 2005; Mantzoukas & Jasper, 2004; Thyer, 2003). Carney (2004b) determined a divide existed between clinical and nonclinical leadership, with clinical leaders taking a task-oriented role (Kalisch, Weaver, & Salas, 2009). Hierarchical leaders (Beeson & Davis, 2000; Frankel et al., 2006; Ogbonna & Harris, 2000; Plsek & Wilson, 2001) respond poorly to environments requiring continual change. Carney (2004a) and Tilley (1999) noted the maintenance of hierarchical leadership for clinical nursing leaders restricted the ability of nurses to contribute to organizational change efforts.

Changes in funding healthcare delivery (Anderson et al., 2007; Bolton, 2005; Haase-Herrick, 2005; LeBrasseur, Whissell, & Ojha, 2002; Marlin, Huonker, & Hasbrouck, 2004) have altered structures for executive leadership toward alignment with business models. The business model is characterized by a participative leadership approach, providing the impetus for change for healthcare leaders (Beil-Hildebrand, 2002; Frankel et al., 2006; Johnson, 2005; Morgan & Ogbonna, 2008; Scoble & Russell,

2003; Waldman et al., 2003). A diverse range of skill sets and competencies exist in the healthcare industry, with a clear separation (Bolton, 2005; Bondas, 2006; Carney, 2004b; Kakabadse, 2000; Lin, Wu, Huang, Tseng, & Lawler, 2007; Oshagbemi & Gill, 2004; Seago, 2006) between the administrative and practice levels. The separation limits the potential for developing a cohesive organizational leadership structure (Block & Manning, 2007; Morgan & Ogbonna, 2008).

The complexity of defining an effective leadership approach in healthcare organizations stems from the competing demands of clinical judgment at the unit level and corporate business practices at the administrative level (Bondas, 2006; Carney, 2004b; Fitzgerald et al., 2007; Johnson, 2005; Morgan & Ogbonna, 2008; Purcell & Milner, 2005; Scoble & Russell, 2003). In many healthcare institutions, the organizational structure is not conducive to encouraging and nurturing nurses as potential leaders (Block & Manning, 2007; Johansson, Pörn, Theorell, & Gustafsson, 2007; Millward & Bryan, 2005; Tilley, 1999; Wiggins, 2006). Leadership choice at the practice level consists of promoting expert clinicians based on organizational and unit longevity (Alarcon, Astudillo, Barrios, & Rivas, 2002; Bolton, 2005; Ernst, 1995; Hancock, Campbell, Bignell, & Kilgour, 2005; Heller et al., 2004; Stanley, 2006; Upenieks, 2003) rather than leadership capacity. Researchers (Alimo-Metcalfe & Alban-Metcalfe, 2005; Avolio, 2007; Dawson, Aebersold, Mamolen, Goldberg, & Frank, 2005; Kramer et al., 2007; Lageson, 2004; Lindholm, Sivberg, & Udén, 2000; Sanders, Davidson, & Price, 1996; Spinelli, 2006; Wieck, Prydun, & Walsh, 2002) have identified the attributes, qualities, concepts, and standards of leadership practice and have established leadership

capacity without defining an effective leadership approach specifically for the practice environment (Shirey, 2006; Wallin, Ewald, Wikblad, Scott-Findlay, & Arnetz, 2006).

Statement of the Problem

Habermas (1981/1984, 1981/1987) theorized the mixture of culture and environment created a need for continual change. Organizational culture in healthcare developed from the fragmented practice culture of individual units (Duffield, 2005; Kammerlind, Dahlgaard, & Rutberg, 2004; Mantzoukas & Jasper, 2004). Individual units have functioned as separate environments with separate loyalties and obligations (Brown, 1998; Brown & Duguid, 2001; Manring & Brailsford, 2001). With the new focus of healthcare change (IOM, 2001, 2004) on the practice environment, previous models of leadership and leadership development lacked alignment with the needs of the 21st century healthcare environment. Change efforts added to the diverse educational and practice experiences of nursing leaders have complicated the ability of organizations to develop effective leaders (Block & Manning, 2007; Bolton, 2005; Bondas, 2006; Johns, 2003; Lichtenstein, Alexander, Jinnett, & Ullman, 1997; McAlearney, 2006; Stanley, 2006; Ulrich, Buerhaus, Donelan, Normal, & Dittus, 2005).

The specific problem is the development of leadership at the practice level during change initiatives in healthcare organizations. Organizational leaders view the development of nursing leadership at the unit level as essential to successful cultural change (Block & Manning, 2007; Cain, 2005; Hawkins et al., 2009; Kim, Dluhy, & Lauzon-Clabo, 2008; Manojlovich, 2005; Morgan, 2005; Pipe, 2007; Ponte et al., 2007; Sherman, 2005; Sundkvist & Zingmark, 2003). Nurse managers (Collinson, 2006; Laschinger, Wong, McMahon, & Kaufmann, 1999; McGuire & Kennerly, 2006; Shirey,

2006; Tilley, 1999) are key components in the development of practice environments that reflect quality in service provision (Kim, Dansereau, Kim, & Kim, 2004; Litwin et al., 1997; Sherman, 2005). First-tier leadership change efforts offer a perspective rarely studied (Cook, 2001; Mathena, 2002; Patrick & Laschinger, 2006). The lack of previous research supports the need and significance of the current study.

The case study was based on one healthcare organization involved in role change to study leadership development during change. In the participating organization, head nurses became nurse managers. The role change coincided with an initiative to advance service excellence and increase quality in the organization.

Leadership development processes can emerge from healthcare research (IOM, 2001). A qualitative case study (Patton, 2002; Yin, 2003) was an appropriate choice to research a topic with limited available past data. The current research study contributed to the knowledge base for healthcare leadership development.

Purpose of the Study

The purpose of the qualitative case study was to determine how healthcare leadership develops in a changing organization. Frankel et al. (2006), M. E. Smith (2003), Sherman (2005), and R. J. Anderson et al. (2007) purported that organizational change efforts depended on a two-fold approach including the development of effective leadership and changes in the practice environment to reflect a commitment to service excellence and quality (Berger, 1992; Fuller, 2007; Goonan, 2007; Grieves & Mathews, 1997; Litwin et al., 1997; McAlearney, 2006). The organization participating in the study was a community hospital undergoing change to create an organizational environment with an emphasis on service excellence. The organization initiated the change effort with

the introduction of the nurse manager as a new leadership role, providing a unique opportunity to study first-tier leadership development. The qualitative case study consisted of eliciting the experiences of four nurse managers in a community hospital in Long Island, New York, United States of America.

The qualitative case study included examining the practice environment through the experiences of new nurse managers. Data collection included audio-recorded repeated in-depth interviews, director/nurse manager meeting minutes, and researcher notes comprising an inclusive (Yin, 2003) depiction of the nurse manager role. The use of an interview guide (Hesse-Biber & Leavy, 2004; Rubin & Rubin, 2005) promoted the free flow of dialogue based on emerging interview contents.

A qualitative inquiry approach allowed significance to derive from the perspective of the nurse managers (Patton, 2002). The inclusion of confirmatory information occurred after the completion of the interviews through a review of director/nurse manager meeting minutes. Descriptive and reflective research notes provided a third perspective.

Significance of the Study

Healthcare restructuring efforts reflect the need to develop quality processes and standardize service provision (Beil-Hildebrand, 2002; Burnhope & Edmonstone, 2003; Frankel et al., 2006; IOM, 2000, 2001, 2004; Lukas et al., 2007; McAlearney, 2006; Natarajan, 2006). Stakeholders have influenced change in healthcare organizations (Billett, 2002a; Fitzgerald et al., 2007; Green et al., 2009; Litwin et al., 1997; Naude & McCabe, 2005). Waldersee (1997) and P. I. Morgan and Ogbonna (2008) determined that employees at the service level of the organization lacked a clear understanding of change.

The research study consisted of examining the development of nurse managers' leadership practices during change.

Healthcare efforts to increase quality are based on a relationship between the organizational environment and the organizational culture (Anderson et al., 2007; Frankel et al., 2006; Naude & McCabe, 2005). Standardization of service delivery in healthcare organizations contributed to creating cultures of quality (Goonan, 2007; Longo, Hewett, Ge, Schubert, & Kiely, 2007; Lukas et al., 2007). Previous researchers (Casida & Pinto-Zipp, 2008; Currie, Harvey, West, McKenna, & Keeney, 2005; Lageson, 2004; Lincoln & Johnson, 2009; Litwin et al., 1997; Meraviglia et al., 2009; Rundall et al., 2007; Stewart & Kringas, 2003; Yemm, 2007) believed that a direct connection existed between the culture of the organization and the ability to deliver quality service. The findings in the current study provided data on the influence of the new role of the nurse manager on the service culture of the unit.

Significance of the Study to Leadership

The findings provided insight about the impact of leadership development at the practice level of the organization during change on the development of service quality. Knowledge development in the workplace pertains to the development of structural, affective, and cognitive domains in individuals (Billett, 2002a; Care & Udod, 2003; Kang, Morris, & Snell, 2007; Naude & McCabe, 2005; Ponte et al., 2007). The ability of individuals to adapt to organizational change depends on the development of leadership capacity (Avolio, 2007; Frankel et al., 2006; Higgs & Rowland, 2005; McAlearney, 2006; Montesino, 2002; Sherman, 2005; Vitala, 2004; Yemm, 2007).

Divergent perspectives with regard to the nurse manager role (Gould, Kelly, Goldstone, & Maidwell, 2001; Hales, 2005; Litwin et al., 1997; Sherman, 2007; Wong, 1998) have hampered the development of a leadership model in the healthcare environment. Role determination from the perspective of the nurse manager facilitated determining the significance of the essential role of nurse managers to organizational functioning (Hawkins et al., 2009; Kalisch et al., 2009; Kramer et al., 2007; Naude & McCabe, 2005; Sanders et al., 1996; Sherman, 2005; Shirey, 2006). Manring and Brailsford (2001) and Sundkvist and Zingmark (2003) submitted that improving quality in the workplace environment depended on the effectiveness of first-tier leaders. A study of first-tier leadership in a changing organization produced data of significance to leadership and healthcare.

Nature of the Study

The current study was conducted with a qualitative case study design. In contrast to the qualitative approach, quantitative research is based on research questions and hypotheses concerning the presence or influence of specific variables previously identified (Creswell, 2005; Meadows, 2003). The exploration of leadership development in healthcare at the first-tier leadership level necessitated an approach unrestricted by preconceived variables and scaled number responses (Jean Lee, 1992; Pelit & Huault, 2008). The qualitative approach supported the need to determine how the leadership role of nurse manager developed during change (Meadows, 2003).

A qualitative research approach (DiCicco-Bloom & Crabtree, 2006; Hesse-Biber & Leavy, 2004; Patton, 2002; Rubin & Rubin, 2005) was appropriate to explore the understanding, reasons, and meanings underlying the participants' responses. The

visualization of the topic and research direction helped determine the research method (Hesse-Biber & Leavy, 2004). A qualitative case study approach facilitated the emergence of connections, perceptions, impressions, and understandings from the interview process, providing rich, thorough, and credible descriptive data (DiCicco-Bloom & Crabtree, 2006; Patton, 2002; Yin, 2003).

The use of one organization and a unique group of individuals provided an opportunity for a case study design (Patton, 2002; Yin, 2003). The application of case study methodology (Meadows, 2003; Patton, 2002; Singleton, Straits, & Straits, 1993; Yin, 2003) helped understand a contemporary social phenomenon in the context of the role of the nurse manager. In the current case study, the contemporary issue involved how first-tier leadership development influenced service delivery in a changing healthcare organization.

The study was an exploration of the connection of four nurse managers to the workplace, the individual perspectives filtered through learned experiences, and the shared meanings developed as a group. The use of an in-depth interview format (DiCicco-Bloom & Crabtree, 2006; Patton, 2002) supported a qualitative approach (Anderson, Crabtree, Steele, & McDaniel, 2005). A semistructured approach to question development and the use of active listening techniques including probes and prompts encouraged the flow of information (Neuman, 2003; Rubin & Rubin, 2005; Seidman, 2006). Quantitative researchers (Creswell, 2005) select a few specific variables before the interview process and structure the interview question to elicit information concerning the specific variables. The qualitative approach was suited to an in-depth exploration of

meanings through interviewing and to understanding leadership development in the participating organization.

Essential to the in-depth interview process (Miller & Crabtree, 2004; Rubin & Rubin, 2005; Seidman, 2006) was the understanding that the process consists of more than one session with each participant. The study included two interviews, director/nurse manager meeting records, and descriptive and reflective notes as sources of data collection. Preliminary data analysis consisted of manual coding to formulate additional interview questions. An interval of two weeks between each in-depth interview for each participant allowed the selection of topics for further exploration and determined which topics remain significant.

Accurate vocalization through data representation created internal validity (Hesse-Biber & Leavy, 2004; Patton, 2002; Rubin & Rubin, 2005; Seidman, 2006; Yin, 2003). The participants verified their individual transcripts after the second in-depth interview and before data entry into Qualrus computer software. The computer software package has the capability of systematically processing data and providing structure with data categories. Internal validity of the findings occurred when the themes, concepts, and patterns emerging from data analysis aligned with the conceptual framework and literature review from the research proposal (Patton, 2002; Priest, Roberts, & Woods, 2002; Yin, 2003).

The research study provided a snapshot of the organization through the eyes of the nurse managers. The case study design included multiple sources of data, a clear connection between the data and the source, and verification of accuracy by the data source (Bachor, 2002; Maxwell, 1992; Patton, 2002; Savin-Baden, 2004; Yin, 2003). A

case study protocol (Yin, 2003) and an interview guide (Miller & Crabtree, 2004; Patton, 2002; Rubin & Rubin, 2005) provided structure for the research study and helped demonstrate validity and rigor through theoretical connections and a sense of completeness (Meyrick, 2006; Whittemore, Chase, & Mandle, 2001). The completed case study aligned with the qualitative conceptual perspective.

Research Questions

The purpose of the qualitative case study was to determine how healthcare leadership developed in a changing organization. Previous researchers have shown leadership capacity (Frankel et al., 2006; Gullo & Gerstle, 2004; Harshman & Harshman, 1999; IOM, 2001, 2004; McAlearney, 2006; Morgan & Ogbonna, 2008; Naude & McCabe, 2005; Nelson & Coxhead, 1997; Rundall et al., 2007; Yemm, 2007) to be essential to the development of healthcare environments supporting excellence in service provision. The following research question guided the study: How does leadership develop in a changing organization? Two subquestions targeting the leadership development of the nurse managers were as follows:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

The qualitative research questions facilitated the emergence of complex data based on a broad spectrum of possibilities during in-depth interviews to explore connections, perceptions, differences, and similarities in the phenomenon under study (Creswell, 2005). Building on the general topics of leadership, change, and leadership development, the in-depth interview process brought forth questions specific to each

participant. Qualitative questions offer a wider scope of inquiry than quantitative questions and facilitate obtaining rich data that contribute to the understanding of complex interactions and situations (Patton, 2002; Pelit & Huault, 2008; Rubin & Rubin, 2005; Yin, 2003).

Conceptual Framework

The topic for the current research originated from a broad subject base (Miller & Crabtree, 2004; Rubin & Rubin, 2005; Yin, 2003). Previous research is a source of conceptual frameworks (Sofaer, 1999). The conceptual framework selected for the current study (see Appendix A) connected the research questions, the literature review, and the research methodology (Smyth, 2004). The conceptual framework provided research guidance, theoretical direction, and a starting point for data analysis and interpretation (Oliver, 2004).

The research conceptual framework included the constructs of identity, culture, and organization and supported the use of Wenger's (1998) book, *Communities of Practice: Learning, Meaning, and Identity*, Porter-O'Grady and Finnigan's (1984) book, *Shared Governance for Nursing: A Creative Approach to Professional Accountability*, and Habermas' books, *The Theory of Communicative Action: Reason and the Rationalization of Society* (1981/1984), and *The Theory of Communicative Action: Lifeworld and System: A Critique of Functionalist Reason* (1981/1987).

The visualization of the organization as a community is aligned with perspectives of nursing as a helping profession. A sense of community (i.e., belongingness) is crucial in connecting organizations to individual stakeholders (Lincoln & Johnson, 2009; Manion & Bartholomew, 2004; Rowe & Hogarth, 2005; Smith, 2005). Cousin and

Deepwell (2005) and Robinson and Cottrell (2005) suggested that learning strengthened the bonds between organizations and individuals with participation, reification, identification, and engagement as necessary factors in developing relationships. The commonality of experiences in the practice environment contributes to formulating cooperative communities and organizational cultures (Morgan & Ogbonna, 2008; Thompson, 2005; Wenger, 1998).

Social learning theory promotes the bonding of group members by integrating personal and professional experiences and creating shared experiences in the workplace (Davis & Luthans, 1980; Wood & Bandura, 1989). The practice environment exists as construction of a relationship between individual and collective perspectives (Billett, 2002a; Manion & Bartholomew, 2004). Social, political, personal, and cultural identities merge in organizations when coordinated mechanisms exist that engage individuals in learning processes (Illeris, 2004). Successful construction of a community-of-practice depends on levels of participation in the development of shared knowledge and learning, the degree of connection to the group, and the formation of individual identity (Wenger, 1998).

Defining community in the organization consists of determining elements that reflect a community-of-practice perspective (Kramer et al., 2007; Lesser & Storck, 2001; Naude & McCabe, 2005). Individuals interact in the practice environment to develop a sense of "mutual engagement, a joint enterprise, and a shared repertoire" (Wenger, 1998, p. 73). Such patterns of interaction create a sense of belongingness in ideal organizational environments (Elving, 2005; Lincoln & Johnson, 2009; Smith, 2005). Learning, negotiation, understanding, and accountability emerged as key factors in communities of

practice that demonstrate a shared excellence in providing service (Meraviglia et al., 2009; Wenger, 1998).

Shared Governance

A significant gap (Brown, 1998; Heller et al., 2004; Rundall et al., 2007) exists between the structured clinical mastery novice nurses need and the autonomous professional practice expected in expert nurses. Shared governance provides a model for leadership development in the practice environment through learning, negotiation, understanding, and accountability (Frith & Montgomery, 2006; Ireson & McGillis, 1998; McGoldrick, Menschner, & Pollock, 2001; Porter-O'Grady, 1994; Porter-O'Grady & Finnigan, 1984; Williamson, 2005). In shared governance models, the decision-making process occurs no longer at the senior leadership level but at the practice level of the organization. A call for autonomy, participative practices, communication, and commitment are characteristics of shared governance as a vehicle for workplace empowerment and leadership development (Burnhope & Edmonstone, 2003; Dunbar et al., 2007; Kramer et al., 2007; McGoldrick et al., 2001; Moore & Hutchison, 2007; Morgan & Ogbonna, 2008; Schryer, 2004; Styer, 2007).

Anthony (2004), Duffin (2009), Frith and Montgomery (2006), and Styer (2007) affirmed collaboration was important in the development of cohesive and effective practice environments. The development of relationships between professional disciplines in healthcare organizations depends on the use of cooperative, collaborative strategies (Green et al., 2009; Kalisch et al., 2009; Kramer et al., 2007; Tagliaventi & Mattarelli, 2006). Flexible structuring facilitates the development of shared governance councils based on the needs and expectations of organizations. Governance frameworks

emerge from existing cultures of organizations (Carroll & Arneson, 2003; Dunbar et al., 2007; Hilburn et al., 2006; Styer, 2007; Thompson et al., 2004).

In some organizations, nurse managers guide staff nurse participatory councils through effective communication strategies (Anthony, 2004; Caramanica, 2004; Dunbar et al., 2007; McGoldrick et al., 2001; Styer, 2007; Williamson, 2005). In other organizations, a predominance of leadership and educator involvement limits staff nurse participation (Hilburn et al., 2006; Thompson et al., 2004). Expanding council participation to other professional groups increases the functionality of practice initiatives (Ireson & McGillis, 1998; Jackson, 2000; Schryer, 2004; Williamson, 2005). Councils that separate second-tier leadership from practice nurses foster autonomy through increasing decision-making capacity (Carroll & Arneson, 2003; Ireson & McGillis, 1998; Moore & Hutchison, 2007).

Evidence-based problem solving enhances clarity, improves functionality, and facilitates the development of lasting solutions (Moore & Hutchison, 2007; Williamson, 2005). The focus of projects is on policy and educational development as well as on streamlining paperwork (Styer, 2007; Thompson et al., 2004). Staff and patient satisfaction increases when team processes center on patient-related issues, problem solving, and standardized initiative development (Green et al., 2009; Ireson & McGillis, 1998; Schryer, 2004). Basing practice initiatives on evidence instead of past practice supports globalization (Amitay, Popper, & Lipshitz, 2005; Kramer et al., 2007; Wallin et al., 2006; Zuzelo, McGoldrick, Seminara, & Karbach, 2006).

Theory of Communicative Action

The interactions of individuals produce reasoning, culture, and society to organizations. Meaning in the practice environment emerges within the cultural context with objective, social, and subjective qualities combining to alter the relationship of individuals. The active participation of individuals in determining understandings generates a common approach, aligning worldviews. The creation of community norms, patterns, and expectations reflects individuality by mediating knowledge, brokering communication, and exploring meaning in the practice environment (Habermas, 1981/1984, 1981/1987; Horton, Tschudin, & Forget, 2007; Lincoln & Johnson, 2009; Morgan & Ogbonna, 2008; Niemi, 2005; Parkin, 1996).

Knowledge increases from individuals' cognition mediated by communicative action and developed from the “rationalization of the lifeworld” (Habermas, 1981/1987, p. 148). Professional practice develops from the norms and boundaries of moral and ethical principles (Fagerberg, 2004; Ponte et al., 2007; Sumner, 2006). The communications of individuals in the practice environment supply specific meanings centered on professional practice and demonstrate communicative patterns learned from past and present life experiences (Green et al., 2009). Decision making in healthcare organizations occurs based on the learned responses of individuals drawing relevance from normative, objective, and subjective worlds (Blaug, 1997; Morgan & Ogbonna, 2008; Tan & Sjoberg, 2005).

The intermingling of life worlds generates understandings from the interactions of individuals and produce organizational norms. Communicative patterns change based on the level and type of interaction in the practice environment. The culture of practice

environments influences the interactions of stakeholders (Billett, 2002a; Crowe, 1998; Elving, 2005; Green et al., 2009; Horton et al., 2007; Lincoln & Johnson, 2009; Yemm, 2007). The focus of change in healthcare environments is the development of leadership and interactions aligned with standards of service excellence (Frankel et al., 2006; Lukas et al., 2007; Tan & Sjoberg, 2005).

Leadership Development

The conceptual framework in the current study consists of leadership development and the interrelated concepts of identity, culture, and organization. S. Brown (1998) and Campbell, Dardis, and Campbell (2003) asserted leadership development required interpersonal qualities as well as interpersonal, cognitive, communication, and task-specific skills. In healthcare, service to challenging populations (Garman, Fitz, & Fraser, 2006; Magyary & Brandt, 2005; Mullen & Asher, 2007; Wiggins, 2006) requires leaders who integrate competencies related to cultural diversity, family-centered care modalities, and partnership models of care delivery with evidence as a basis for leadership development (Litwin et al., 1997; Rundall et al., 2007; Wiggins, 2006; Yemm, 2007). Curtis et al. (2004) and Block and Manning (2007) supported a professional approach to learning using personal development plans and skill evaluation for the development of successful healthcare teams.

Macfarlane and Lomas (1994) believed the use of competencies restricted leadership growth and decreased professional autonomy. Effective leadership at the practice level necessitates technical and skill-based competencies (Stanley, 2006). Structured leadership education (Elmuti, Minnis, & Abebe, 2005) isolates professionals by discipline and limits the development of a global perspective, generating ethical silos.

Heller et al. (2004), Spencer and Jordan (2001), and Donaher, Russell, Scoble, and Chen (2007) submitted that the development of competencies created higher performing nurse leaders as opposed to nurses without exposure to structured leadership education.

A changing healthcare environment supports the concept of life-long leadership development for professionals (Block & Manning, 2007; Horton et al., 2007; McAlearney, 2006; Naquin & Holton, 2006; Russell & Scoble, 2003). Perez and Ordóñez de Pablos (2003) demonstrated the efficacy of leadership development for all members of the organization in furthering strategic and competitive advantage. High performing healthcare organizations provide a three-pronged approach to leadership development with emphasis on the individual, the culture, and the organization (Casida & Pinto-Zipp, 2008; Frankel et al., 2006; Naude & McCabe, 2005; Walmsley & Miller, 2007; Yemm, 2007).

The conceptual framework selected for the current study guided the development of semistructured questions and topics essential to the in-depth interview process. The framework was appropriate for the qualitative exploration of connections, perceptions, differences, and similarities between individual nurse managers. A focus on identity, culture, and organization targeted elements essential for the development of leadership. The conceptual framework provided direction for the literature review and the analysis of data.

Definition of Terms

The definitions section provides meaning, clarity, and understanding of terms and concepts used with a meaning specific to the current research study (Cooper & Schindler, 2003; Neuman, 2003).

Belongingness. Belongingness is connectedness and affiliation with the group. Belongingness enhances the ability of individuals to develop a sense of self (Lee & Robbins, 1995). A sense of belongingness emerges when the culture of the organization stimulates the formation of a professional identity consistent with creating a commonality of experiences (Benson & Dundis, 2003; Estiénne, 1997).

Community-of-practice. Community-of-practice refers to the melding of individuals into a cohesive team occurring with the use of participation, negotiation, and engagement. Practice patterns develop when individual competencies are used in cooperative communities, transforming learning and knowledge into a commonality of experiences and creating group expectations (De Cremer & Alberts, 2004; Wenger, 1998). Organizational environments supporting the development of cooperative partnerships between care practitioners, patients, and involved significant others support the transformation of a workplace into a practice community (IOM, 2004; Ponte et al., 2007).

First-tier leadership. First-tier leadership consists of leadership positions at the practice level of the organization. First-tier leaders have direct daily contact with internal and external organizational stakeholders. These individuals have the ability to create change and guide staff members toward excellence in practice and service (Kim et al., 2004; Popper & Lipshitz, 1993; Yemm, 2007).

Head nurse. The head nurse is a management role in a hierarchical hospital culture at the unit level. Communication takes place in one direction from senior management to head nurse to staff members. Directive role responsibilities are aligned

with transactional leadership styles and hamper the adaptation of the environment to the needs of the stakeholders (Boumans & Landeweerd, 1993; Ernst, 1995).

Hierarchical culture. A hierarchical culture is characterized by the adherence to rules and regulations and lack of innovation, creativity, and independent decision making by individuals and groups. In a hierarchical organizational culture, roles, responsibilities, and functions are categorized without allowance for deviation, change, and initiative. A hierarchical culture is a rigid structure consisting of existing patterns of behavior, norms, and values that decrease autonomy and reinforce resistance to change (Apker, Propp, & Ford, 2005; Wood & Bandura, 1989).

Nurse manager. The nurse manager has 24-hour accountability for decisions at the practice level of the organization (Kelley, Weber, & Sprengel, 2005). A primary part of the leadership role for nurse managers concerns engaging staff members in aligning service provision standards that promote excellence in care with the development of staff members toward effective leadership practice (Hawkins et al., 2009; Sanders et al., 1996; Yemm, 2007).

Organizational culture. Culture is a pattern of shared interactions. Unique cultures develop, shaped by the patterns of organizational behavior, norms, and values of individuals in organizations and mediated by adaptation to the internal and external environments (Deaux & Martin, 2003; Morgan & Ogbonna, 2008; Waters, 2004; Wood & Bandura, 1989).

Participation. Participation is an active process of connecting individuals to the social and personal spheres in communities of practice. Participation can be negative or positive. In using participation, individuals allow the connection to alter their perceptions

and experiences and to reflect involvement in the process. “[Participation] places the negotiation of meaning in the context of our forms of membership in various communities. It is a constituent of our identities” (Wenger, 1998, p. 57). Participation is the “daily, situated interactions and shared experiences of members of the community working towards common goals” (Robinson & Cottrell, 2005, ¶ 5).

Practice environment. The practice environment is the internal environment of a healthcare organization in which direct patient care services are provided at the unit level. The practice environment of the organization supports the interaction of professionals, leaders, and staff members with patients and members of the community (Green et al., 2009; Shirey, 2006; Weymes, 2005).

Professional identity. The personal and professional spheres provide experiences that aid in the development of individuals as professionals. A professional identity in nursing stems from nurses' perspective based on moral, ethical, educational, and relationship expectations and learned experiences (Cook, Gilmer, & Bess, 2003; Harkness, Smith, Waxman, & Hix, 2003).

Reification. Reification concerns the objectification of ideas, concepts, aspects, and phenomena connected to life and humanity (Pitkin, 1987). Reification occurs in organizations when tensions from unanticipated consequences challenge the existing social framework of individuals in the workplace. Reification minimizes the ability of practitioners to control the environment, increasing instability, limiting rationality, and decreasing functionality and adaptability (Colignon, 1989).

Second-tier leadership. The leadership ladder in healthcare includes a gradual increase in responsibilities and separation from direct care provision. Second-tier leaders

provide direction, oversight, and resources to the practice level of the healthcare organization through connecting strategic vision to care modalities (Carroll, 2005; Currie, 2006).

Assumptions

The first assumption for the current study was that a purposeful sampling strategy would produce a unique group of participants. The choice of case study design was based on the assumption that the phenomenon under study was unique (Yin, 2003). A third assumption was the leadership development of the participating particular nurse manager group reflected the fact that the participating organization was in a period of change. It was further assumed the study of first-tier leadership in a changing organization would produce data significant to role determination.

Another assumption of the current research study was the participating community hospital was representative of other suburban mid-sized community hospitals in the United States of America. An assumption concerned the investigator's organizational role as assistant director at the hospital and the belief such role would not introduce bias in the development of a relationship with the participants. The ability of the participants to reflect on questions, develop inner meanings, and express individualized response is crucial to the development of a dialog and essential to case study research (Anderson, Armitage, Jack, & Wittner, 2004; Yin, 2003).

Limitations

Limitations define the boundaries of a study. Purposeful sampling techniques (Devers & Frankel, 2000; Patton, 2002; Seidman, 2006) targeted the selection of individuals who could provide in-depth information concerning the study topic. The

number of nurse managers was limited to individuals who were comfortable with participating and who met the criteria for inclusion in the research study. The criteria limited the sample of nurse managers to 10. Four nurse managers agreed to participate.

Interview data limitations and restrictions originated from the organizational relationship of the investigator and the nurse managers. The in-depth interview became dialog through shared cultural knowledge, and the participants constructed new knowledge and meaning (Miller & Crabtree, 2004). A comprehensive consent process defining confidentiality and anonymity (Patton, 2002; Rubin & Rubin, 2005; Yin, 2003) generated an atmosphere of openness, candor, and responsiveness. Through notes, the investigator engaged in reflexivity (Chiu, 2006; Creswell & Miller, 2000; Hand, 2003) in order to capture personal bias, assumptions, perspectives, and viewpoints.

A limitation of the current study pertained to external validity. The topic choice of leadership development during change applied to a specific healthcare organization. Generalizability (i.e., transferability) was based on the use of existing theory and concepts in the data analysis stage of the study. A qualitative approach to case study research encourages the use of theoretical foundations with analytic generation (Hesse-Biber & Leavy, 2004; Yin, 2003) during pattern matching. Theoretical foundations supported connections between the results and theory, increasing the transferability of the findings to other research studies.

Delimitations

A delimitation of the study consisted of surveying new nurse managers at one community hospital on Long Island, New York. The focus of the study was leadership development during a change effort in the healthcare organization selected only. Nurse

managers with no experience in the position of nurse manager but with 1 year of tenure in the managerial position were included in the study. No other healthcare personnel were included.

Scope of the Study

The IOM (2000, 2001, 2004) determined the healthcare environment required substantial change and transformation to provide quality care in America. Evaluating medical error in 2000, calling for quality in 2001, and advocating for healthy work environments in 2004, the IOM specified that change at the practice level required effective leadership (Block & Manning, 2007; IOM, 2000, 2001, 2004; Sherman, 2005; Stanley, 2006; Yemm, 2007). M. J. Cook (2001), Mathena (2002), and Patrick and Laschinger (2006) pointed to a lack of research on first-tier leadership development during change. The current qualitative research study was an exploration of one organization's effort to develop leadership at the practice level during change.

Leadership is a primary consideration in successful change. The choice of nurse managers as study participants was central to the research study. Previous researchers (Force, 2005; Kleinman, 2004; McGuire & Kennerly, 2006; Sellgren, Ekvall, & Tomson, 2006) have chosen the staff member and the nurse manager as units of comparison for leadership abilities. The approach in previous research was to study leadership in terms of specific leadership styles, qualities, and models. Radical change (IOM, 2000, 2001, 2004) is needed to reconfigure the healthcare environment. The current research was an exploration of leadership at the practice level. The goal was to contribute the knowledge necessary to build effective healthcare environments that sustain change.

The specific intent of the current research was to elicit information about the development of leadership during change when leaders are new to a leadership role. Staff members might be able to identify qualities and abilities of effective nurse managers, but only the leaders involved in the change effort can identify the rationale supporting the use or rejection of specific qualities, abilities, and strategies. The scope of the study was limited to participants with at least 1 year of tenure in the nurse manager role and no previous experience in the nurse manager role.

Summary

The intent of chapter 1 was to provide the structural framework for the current research study. The purpose of the qualitative case study aligned with the premise that leadership development is an essential quality in changing the American healthcare delivery process (IOM, 2000, 2001, 2004). In developing their leadership skills, nurses experience a lack of a clear leadership path reflecting a mixture of approaches to professional practice (Block & Manning, 2007; Bolton, 2005; Bondas, 2006; Johns, 2003; Lichtenstein et al., 1997; Stanley, 2006; Ulrich et al., 2005). The conceptual framework for the case study included community-of-practice, shared governance, and the theory of communicative action to demonstrate how leadership development requires a connection between the individual, the culture, and the environment in the healthcare organization.

Defining the healthcare organization as a community-of-practice, Wenger (1998) theorized that relationships in organizations individualize the practice environment. The interactions of individuals in unit-based communities-of-practice form the organizational environment and exist concurrently with global cultural organizational attributes (Brewer

et al., 2008; Duffin, 2009). The organizational culture becomes a key factor in the ability of stakeholders to participate cooperatively in change efforts (Berger, 1992; Casida & Pinto-Zipp, 2008; Fuller, 2007; Graham, 2003; Higgs & Rowland, 2005; Morgan & Ogbonna, 2008). Shared governance in the practice environment is necessary to design, implement, and sustain change efforts (Bate, Khan, & Pye, 2000; Narine & Persaud, 2003; Sully de Luque & Sommer, 2000). The research study consisted of following the experiences of four nurse managers during a change effort in one mid-size community hospital.

Chapter 1 began with an introduction and background information about the current case study, followed by statements of the problem, purpose, and significance of the study of leadership development in a changing healthcare organization. Included in chapter 1 was a discussion of the nature of the study and of the conceptual framework bridging practice with theory. The chapter concluded with operational definitions, assumptions, limitations, and delimitation delineating potential structural problems.

Chapter 2 is an in-depth review of previous literature. Subsequent chapters include the qualitative case study methodology, the analysis of data, and the conclusions, recommendations, and future research directions for a comprehensive description of how leadership developed during change in the participating organization.

CHAPTER 2: REVIEW OF THE LITERATURE

Chapter 1 included a framework for the current qualitative case study. The purpose of the study was to determine how first-tier healthcare leadership developed in a changing organization. Chapter 2 is a review of previous literature on the topic of interest. The purpose of the literature section is to explore and critically analyze previous research in leadership, leadership development, organizational change, organizational culture, and organizational environments. Finding a paucity of literature dedicated to healthcare leadership development led to broadening the literature review to include research studies, theories, and substantive research-based literature from other fields and disciplines.

Throughout history, individuals have exhibited various patterns of leadership behavior. Each era produced leaders who influenced others toward adopting specific leadership styles (Doyle & Turkie, 2006; Johnson, 2005; Popper, 2004; Sarros, Gray et al., 2002). In the healthcare industry, models used for the first wave of change attempts originated from developments in the military, transportation, and manufacturing in which the risk to human life and the potential for error exist as in healthcare. Borrowed models were based on hierarchical and transactional leadership, creating a divide between the administrative and practice levels of healthcare (Beil-Hildebrand, 2002; Cody, 2003; Frankel et al., 2006; Rice, 1980; Savolainen, 2000; Weymes, 2005; Young & Dulewicz, 2006).

The second wave of change connected healthcare with other service industries and generated discussions on changing leadership approaches to accommodate a customer service perspective (Anderson et al., 2007; Frankel et al., 2006; Goonan, 2007;

Green et al., 2009; Kammerlind et al., 2004). The focus of new leadership models (Elenkov & Manev, 2005; Gullo & Gerstle, 2004; Morrison, Jones, & Fuller, 1997; Österberg, 2004; Yukl, Gordon, & Taber, 2002) was on connecting leaders to followers through management approaches to leadership leading to the development of the transformational, charismatic, and servant leadership styles. Originally crafted for executives outside the healthcare industry, the models aligned with second-tier leadership (Anderson et al., 2007; Elenkov & Manev, 2005; Spinelli, 2006), not with the unique leadership qualities needed for first-tier leadership (McCormack et al., 2002; Sarros, Gray et al., 2002). Nurse managers are key individuals in the first-tier leadership structure and serve as the conduit between second-tier leadership and staff members (Aronson et al., 2002; Collinson, 2006; Laschinger et al., 1999; Shirey, 2006; Tilley, 1999).

The Institute of Medicine (IOM) (2000) led the third wave of change and stipulates in 2001 that the ability to understand and facilitate team approaches across organizational environments and disciplines required the ability of first-tier leadership to utilize systems thinking. In the first decade of the 21st century, the third wave of change involves all stakeholders of the healthcare organization and requires leadership modalities that address the challenges to leadership development particular to the healthcare field.

The literature review includes research studies, theories, and substantive research-based literature from healthcare and other fields contributing to the data analysis, conclusion, and recommendations of this research study. The focus of chapter 2 is the exploration of literature pertinent to the research study topic of leadership development in a changing healthcare organization. The chapter concludes with an overview of significant key points and an analysis of the literature reviewed.

Documentation

A cumulative approach to research during a 5-year period elicited peer-reviewed literature for the review. Leadership, theory, organization, environment, and change in the healthcare environment qualified as significant topics. Approximately 5,000 peer-reviewed articles, books, and studies were examined for inclusion, and 465 were used. A key word search table (see Appendix B) included categories for peer-reviewed articles, germinal works, books, and studies. Table categories provided a framework for the literature review with some data and information repeated in more than one category because of overlapping content.

Access to electronic libraries at the University of Phoenix, Bellevue University, and North Shore-Long Island Jewish Health System provided the majority of peer-reviewed literature. The use of Internet search engines such as Yahoo and Google provided the connection to Web sites offering an array of information pertinent to leadership, organizations, and healthcare and allowed access to peer-reviewed literature and books. Nursing Web sites such as Medscape, Association of Critical Care Nurses, and the Eastern Nursing Research Society supplied peer-reviewed articles and studies, content books, and germinal works. A comprehensive array of peer-reviewed articles, studies, and books were used for the literature review of healthcare organizations, leadership, and change.

Literature Review

Successful organizational development depends on the degree of stakeholder engagement in the organization (Berger, 1992; Frankel et al., 2006; Fuller, 2007; Lacey, Teasley, & Cox, 2009; Naude & McCabe, 2005; Nelson, 2003; Piccolo & Colquitt,

2006). Leadership efforts to change the organizational environment necessitate acceptance of change efforts (Leslie, Loch, & Schaninger, 2006; Malloch & Lussier, 2000; Morgan & Ogbonna, 2008; Rowe & Hogarth, 2005; Savolainen, 2000; Stewart & Kringas, 2003; Waldersee, 1997). The IOM (2004) called for the development of healthcare practice environments reflecting the needs and expectations of a global society. Recommending that initiatives incorporate quality and service excellence, the IOM promoted the development of effective leadership at the practice level of the organization to drive change efforts. The focus of the literature review is on foundations supporting the development of leadership in healthcare.

Theoretical Foundations

Mirvis (1996) posited that concepts in theoretical development align with the processing, interpreting, and inquiring functions of individuals. Individual theorists from varied disciplines brought forth conceptual frameworks applying to organizational development (Kang et al., 2007; Leppitt, 2006; Lynham, Chermack, & Noggle, 2004). Evidence-based approaches for the development of healthcare environments (Alarcon et al., 2002; Waldman et al., 2003; Zuzelo et al., 2006) pertain to gaining insight from past theory and developing new theory from research specific to healthcare (Wallin et al., 2006). Theoretical foundations include exploring existing theory to obtain insight about the development of organizations and individuals.

Social Cognitive Learning Theory

The functioning of complex workplace environments depends on individuals' perceptions of their abilities and on the expectation that the tools necessary for survival exist in the workplace environment (Åmo, 2006; Appelbaum, St-Pierre, & Glavas, 1998;

Billett, 2002a; Duffin, 2009; Fagerberg, 2004; Kalisch et al., 2009; McNamara, Luce, &Tompson, 2002; Naude & McCabe, 2005; Stanley, 2006). Individuals' belief in their abilities stimulates self-efficacy and the cognitive processing of information (Popper & Lipshitz, 1993; Smollan, 2006). Believing that the process of learning is continuous allows individuals to set increasingly complex goals in response to a changing workplace environment. Leaders stimulate individuals by setting goals and expectations that enhance the learning experience while increasing leadership ability through analytic processing and development of social and leadership capacity (Koberg, Boss, Senjem, & Goodman, 1999; McCormick & Martinko, 2004; Wood & Bandura, 1989).

The examination of relationship building in the workplace (Wenger, 1998) derives from concepts of social learning. Cognitive processes enable individuals to evaluate the workplace (Mantzoukas & Jasper, 2004). A decision-making process (Gibson, 2004) motivates individuals to learn how to adapt and align with organizational practice models (Chatman, 1991). Wood and Bandura (1989) and Barbuto (2005) asserted individual development includes a combination of factors from internal mechanisms of the individual and external mechanisms of the organizational culture.

A workplace persona incorporates cognitive, self-regulatory, and self-reflective processes to align with the organizational environment (Campbell et al., 2003; Shirey, 2006; Stewart, Stansfield, & Tapp, 2004). Carney (2004b) asserted that dissonance between clinical and nonclinical leadership hampered the success of initiatives and limited organizational success. The ability to fit into the workplace depends on the ability to adapt to the culture of the organizational unit (Argyris, 1954; Lincoln & Johnson,

2009). Wood and Bandura (1989) developed a practice model of the connection between performance, personal goals, self-efficacy, and analytic strategies.

Performance. The tendency to rely on past practice (Graham & Jahani, 1977; Green et al., 2009) decreases the competency achievement of managers in the workplace. In previous management practices, problems are identified as separate issues, limiting the ability of the manager to gain diverse experiences. Complex work environments create a need to adapt and grow by increasing decision-making capacity (Britt, Davison, Bliese, & Castro, 2004; Stewart & Kringas, 2003; Wallin et al., 2006). Decision-making capacity increases with the segmentation of performance into levels (Naquin & Holton, 2006; Wood & Bandura, 1989).

Performance improves when shared knowledge in teams influences the setting of goals (Baker et al., 2000; Lincoln & Johnson, 2009; Quigley, Tesluk, Locke, & Bartol, 2007; Savolainen, 2000). Knowledge development spurs innovation and increases performance in organizations by stimulating cognition through learning (de Jong & Den Hartog, 2007; Kang et al., 2007; Naquin & Holton, 2006; Yeo, 2003). Changing organizational environments influence stakeholder development, altering individual and group performance (Green et al., 2009; Lukas et al., 2007; Lynham et al., 2004; Narine & Persaud, 2003; Ogbonna & Harris, 2000). Performance goals align with the development of quality initiatives through the stewardship of leaders (Anderson et al., 2007; Block & Manning, 2007).

E. A. Smith (2005) discussed the relationship of productivity and satisfaction in team formation. Performance improves when team members demonstrate self-efficacy, achievement motivation, productivity, and emotional intelligence. Higher levels of leader

empowerment correlate with decreased levels of work-related tension, supporting perceived effectiveness and greater performance (Davies, Laschinger, & Andrusyszyn, 2006; Laschinger et al., 1999). Low power relationships influence innovation capacity when cultural and social factors decrease the ability of followers to meet performance goals (Elenkov & Manev, 2005; Kalisch et al., 2009).

Personal goals. Mastery modeling guides the development of personal goals. Behavioral cues influence the formation of personal goals by utilizing the interaction between internal standards and self-evaluation to support goal formation. The interaction between self-efficacy and analytic strategies moves personal goals to a higher level of mastery by positioning personal goals as reflective of past performance. Positive reinforcement motivates the development of personal goals, reflecting increased cognitive abilities (Block & Manning, 2007; Chiaburu & Marinova, 2005; Senge, 1990/1994; Shirey, 2006; Wood & Bandura, 1989).

Leaders of changing organizations have discovered that communication barriers limit supervisors' mastery of skills (Mathena, 2002; May & Kahnweiler, 2000). Cognitive processing improves role mastery goals when supervisors value innovation in followers (Janssen & Van Yperen, 2004). Successful goal implementation benefits from a framework approach to support and facilitate leadership roles (Higgs & Rowland, 2005) during organizational change. J. Fuller (2007), Geisler (2005), and Malloch and Lussier (2000) found that employee engagement strengthened professional practice and increased productivity and satisfaction (Green et al., 2009; Illeris, 2004; Lacey et al., 2009).

Self-efficacy. Confidence in problem solving develops resilience, leading to improved skill adaptation and perceived control over adverse circumstances in the

workplace (Shirey, 2006; Tucker & Edmondson, 2003). The use of mastery experiences, modeling, and social persuasion enables individuals to reach and exceed personal and professional goals (Wood & Bandura, 1989). The development of a strong sense of self-efficacy strengthens the performance of individuals who use career achievements, motivational ability, ability to function under stress, and resiliency under adversity (Bouffard, Bouchard, Goulet, Denoncourt, & Couture, 2005; Chiaburu & Marinova, 2005; Schwoerer, May, Hallensbe, & Mencl, 2005; Senge, 1990/1994; Wood & Bandura, 1989). Peers with higher levels of self-efficacy, locus of control, and optimism fail to reach full leadership capacity when designated as natural leaders (Popper, Amit, Gal, Miskhkal-Sinai, & Lisak, 2004).

Analytic strategies. Wood and Bandura (1989) found a connection between lower self-efficacy, lack of personal goal complexity, and limited realization of personal responsibility for decision making. According to Davis and Luthans (1980), previous researchers focused more on the individual and behavior than the organizational environment as an equal contributor in learning processes. Stimuli, consequences, cognition, and behavior become essential components in utilizing social learning theory to study organizational behavior (Davis & Luthans, 1980). Wood and Bandura advocated using complex analytic strategies to evaluate decision-making processes and develop performance goals.

James, Hater, Gent, and Bruni (1978) used cognitive mapping to separate organizational culture into situational factors (i.e., organization) and psychological factors (i.e., individual). Apker (2001) and Ravasi and Schultz (2006) put forth the concept of sensemaking as a component of cognitive processing in individuals.

Sensemaking provides a construct for organizational advancement, aligning individuals with changes in the internal and external environments (Bowerman, 2003). Assimilation of individuals into an organizational culture depends on the perception that nurses are professionals with high moral and ethical values (Brown, 1998; Horton et al., 2007).

Managerial cognition (Hackman & Wageman, 2007; O'Loughlin & McFadzean, 1999; Petraf & Shanley, 1997; Wood & Bandura, 1989) represents one aspect of decision making. Communicative action in organizations includes the influence of followers on managers' leadership capacity as essential to productivity and innovation (Kim et al., 2004; Thompson, 2002). Hackman and Wageman and Avolio (2007) supported the viewpoint that interactive leadership models develop cognitive processes in leaders and followers. Nursing leaders with high levels of structural empowerment and self-efficacy develop professional practice models to mentor staff members toward increased leadership capacity (Kalisch et al., 2009; Manojlovich, 2005; Wallin et al., 2006).

Identity Theory

Habermas (1981/1984) submitted that identity formation occurred across the rationalization of worldviews with learning and the synthesis of knowledge developing from the socialization of the individual through cognition and language. The complexity of the relationship between social norms, societal expectations, and individual behavior has prompted attempts to understand, define, develop, and mold identities. In identity theory, the place of the individual in society and in the workplace represents an interrelationship between the narrower concepts of public and private selves (Deaux & Martin, 2003; Illeris, 2004; Stryker & Burke, 2000). The differences between individual, organizational, and cultural expectations, values, and perspectives challenge the

development of cohesive workplaces (Cody, 2003; Green et al., 2009; Horton et al., 2007).

Restrictive hierarchical environments (Brown & Duguid, 2001; Carney, 2004b; Edmonstone & Western, 2002; Mantzoukas & Jasper, 2004; Sarros, Tanewski, Winter, Santora, & Densten, 2002) help develop identity within a group conformity process. Beil-Hildebrand (2002) and Seago (2006) theorized the role of the nurse in an organization developed from a perspective of feminist repression with individuals other than nurses having decision capacity. Social norms and expectations eliminate the voice of the nurse by restricting identity development, autonomy, and professional practice (Stewart et al., 2004). Hierarchical cultures generate less trust in leadership by followers than more equalitarian cultures (Brown, 1998; Casimir, Waldman, Bartam, & Yang, 2006).

In innovative organizations, job standardization and role clarity help focus individuals on the development of cohesive organizational units (Leslie et al., 2006; Lukas et al., 2007; Tung Ling Hsiung & An Tien Hsieh, 2003). Identification with team members supports collaborative team development (DiMeglio et al., 2005; Duffin, 2009; Kvarnström & Cedersund, 2006; Lincoln & Johnson, 2009). The inability to personalize organizational leadership goals limits the engagement of subordinates in a change effort (Sveningsson & Larsson, 2006). Participation in organizational decision processes increases the connection to the organization (Fuller, 2007; Savolainen, 2000; Thompson, 2002).

Cohesive communities-of-practice show that the degree of socialization relates positively to the level of organizational connection experienced (Brickson, 2005; Chatman, 1991; Letkemann, 2002). Group cohesion stems from an increase in self-

esteem and self-efficacy, creating a greater sense of belongingness in individuals and supporting the formation of group norms (De Cremer, 2001; Rountree & Porter, 2009; Stets & Burke, 2000). J. B. Fuller, Marler, Hester, Frey, and Relyea (2006) found that low self-esteem limited cognitive attachment and decreased organizational connection.

M. A. Thompson (2002) discovered that participation in decisions regarding work and organization was more important than participating in decisions concerning coworkers. Ravasi and Schultz (2006) and Billett and Somerville (2004) theorized that the cultural transformation of individuals' understandings develop from a common goal of improving the workplace. Reflective practices reveal facets of identity significant to reconstructing workplace identities through collective leadership modeling (Raelin, 2006; Rowe & Hogarth, 2005). A sense of family emerges as significant to organizational functioning (Lennon & Wollin, 2001; Letkemann, 2002).

Bono and Judge (2003) and Amitay et al. (2005) found the degree of transformational leadership in organizations negatively correlated with the degree of individual goal attainment and sense of self-worth or self-concordance. Access to transformational leaders through social networks shows a linkage between positional power, social capital development, and leadership development (Bono & Anderson, 2005). Hierarchical and gendered expectations target specific leaders as pivotal to behavioral modeling, knowledge adaptation, and identity formation (Godkin & Godkin, 2004). Leadership strategies focused on increasing decision-making capacity can empower staff members to develop effective work practices, decreasing job tension (Kalisch et al., 2009; Laschinger et al., 1999; Naude & McCabe, 2005).

Positive work practices (Harkness et al., 2003) require accessible knowledge. Learning experiences geared to improve organizational practices and develop organizational identity motivate individuals toward collaboration in professional practice (DiMeglio et al., 2005; Wallin et al., 2006). Work group tenure mediates individual attitude dissimilarity, increasing group cohesion but not decreasing degree of dissimilarity (Van der Vegt, 2002). Workplace group diversity, cohesion, and performance influence the development of initiatives and patient satisfaction (Chang, Hughes, & Mark, 2006).

Argyris (1954) maintained that personal identity formation depended on the ability of the individual to connect to the workplace through the socialization processes of the group. Individuals with a complex social identity show more ability to adjust to group membership variation when compared to individuals with less complex social identity patterns. Organizational identity development supports individuals' ability to adjust to changing group memberships. Individuals with a greater connection to the organization show a propensity to visualize the needs of the group above the needs of the individual (Lincoln & Johnson, 2009; Madsen, Miller, & John, 2005; Ruvolo, 2004).

Nario-Redmond, Biernat, Eidelman, and Palenske (2004) found that individuals rated personal identity higher than social identity when workplace cohesion occurred. Organizational fit occurs when organizational values and beliefs are congruent with the values and beliefs of the individual (Barbuto, 2005; Kim et al., 2004; Nario-Redmond et al., 2004). Chatman (1991) failed to connect socialization, mentoring, and formal training to successful cultural integration of the individual into the organization. Beyer and

Hannah (2002) found that individuals with more work experiences integrated more easily into new workplaces than individuals with fewer work experiences.

Sluss and Ashforth (2007) discussed a model of workplace identity that combined the personal self and the role-based self in a continually changing environment. The formation of relationships between coworkers deepens the connection of the individual to the workplace, creating a group identity. In healthcare, the development of mutual meanings (Lincoln & Johnson, 2009; Petraf & Shanley, 1997) emerges from the formation of relationships between coworkers, advancing novice nurses to expert practitioners. The inclusive nature of a community-of-practice perspective (Wenger, 1998) transcends organizational boundaries by equalizing the concept of identity.

Theory of Communicative Action

Reasoning (Blaug, 1997) expands individuals' worldview with the development of critical thinking. Critical thinking is significant for the enculturation of individuals in organizations through the mediation of social norms and personal identity (Brookfield, 2005; O'Donnell, 1999). Changing societal norms (Brown, 1998; Montesino, 2002) encourage the use of critical thinking in followers who develop workplace goals and expectations based on participative leadership instead of past authoritarian leadership practices (Naquin & Holton, 2006). Critical theory is a useful tool to examine the differences between individual and group perceptions of cultural norms through "achieving understanding in language" (Habermas, 1981/1984, p. 75).

In negotiating meaning, individuals use a common language to reach a mutual understanding and restructure worldviews through rationalization (Habermas, 1981/1984). Scharp (2003) argued that communication between individuals lacked

common understanding because of differences in perception and divergent worldviews. Habermas assessed the degree of agreement with individual worldviews as defined by a separation of dialog, discourse, and critique. Cognition brings rationality within the context of language and communication, moving individuals toward a consideration of opposing worldviews by determining the degree of meaning inherent in dialog, discourse, and critique.

The expert knowledge that individuals produce creates tension when conflicting societal and cultural influences limit organizational alignment (DiMeglio et al., 2005; Habermas, 1981/1984). Wallin et al. (2006) and Gilbert and Rasche (2007) presented the concept of professional practice as vital to healthcare organizations because of an association between societal and cultural norms and ethics and social accountability. Moral and ethical values perceived by society as inherent to the role of the nurse reflect globalization in organizations and show a lack of congruence between generations of nurses (Horton et al., 2007). Organizational norms derived from the rationalization of validity emerge from individuals' interaction within the embedded concepts of the worldview of the organization (Habermas, 1981/1984, 1981/1987).

Tension resulting from conflicts of action positions the healthcare professional as accountable for ethical behavior dependent on the understanding of the individual. Job tension in nursing occurs because of perceived lack of access to resources and support in the workplace (Davies et al., 2006; DiMeglio et al., 2005; Morgan & Ogbonna, 2008). Conflict based on individuals' worldview requires negotiating meaning to produce consensus “as a rationalization of means for ends that are selected in accord with particular values” (Habermas, 1981/1984, p. 253). Effective communication strategies

and the negotiation of power relationships influence perceptions of autonomy in nursing (Carney, 2004b; Cody, 2003; Kalisch et al., 2009; Rowe & Hogarth, 2005; Stewart et al., 2004).

Societal integration integrates concepts of action theory and systems theory into lifeworlds changing goal-directed action to communicative action (Habermas, 1981/1984). Communicative action enables individuals to reach understanding, using the structural components of the lifeworld manifested by culture, society, and personality. Reaching understanding through the interpretive action of coordinating lifeworlds, individuals secure the integration of culture and society in the organization. Cultural expectations target the ability of individuals to negotiate lifeworld experiences toward commonality in participation (Brookfield, 2005; Cousin & Deepwell, 2005; Habermas, 1981/1987; Martins & Terblanche, 2003; O'Donnell, 1999; Rountree & Porter, 2009).

Chriss (1995) emphasized the role of the normative, objective, and subjective worlds in determining validity or truthfulness in communicative action. "Subjects acting communicatively always come to an understanding in the horizon of a lifeworld" (Habermas, 1981/1984, p. 70). The ability to mediate communication rests on the belief the negotiation of mutual understandings stems from individuals' need to obtain mutual understanding (Wenger, 1998). "Reaching an understanding functions as a mechanism for coordinating actions only through the participants in interaction coming to an agreement concerning the claimed validity of their utterances" (Wenger, 1998, p. 99).

Habermas (1981/1987) defined the lifeworld as the beginning of communicative action. As moral conflicts, ethical dilemmas become a communicative tool to develop institutional frameworks. Kelly (2000) stated communication agreement requires the

consent of individuals. Recognizing the role of norms and action, Habermas (1981/1984, 1981/1987) theorized that consensus occurred during linguistic discourse through communicative action. Individuals' cognitive processes highlight the benefit of objectification over an emphasis on values that negates the effects of communication and choice (Habermas, 1981/1984).

"A pathological de-formation of the communicative infrastructure of the lifeworld" (Habermas, 1981/1987, p. 375) characterizes the concept of reification. A lack of connection to the lifeworld develops from the influence of power, media, and money, limiting cultural and dialogic balance. Fleming and Spicer (2005) demonstrated that reification detached the individual from the worldview. Mason and Chandley (1992) noted the objectification of a nursing model of care created reification because practitioners rely on the model as a guide for documentation instead of a tool for professional interaction.

The moral and ethical standpoints of leaders inform acceptable behavior in organizations (Cody, 2003; Habermas, 1981/1987; Storr, 2004). Discourse ethics (Meisenbach, 2006) in organizations require clearly understandable concepts to guide the process of determining ethical certainty. Strategies include validating the needs of society, stakeholder determination, dialogue between individual and collective lifeworlds, and alignment between stakeholders and organizations (Green et al., 2009; Meisenbach, 2006; Ravasi & Schultz, 2006). The application of objective, normative, and subjective lifeworlds occurs with the development of decision-making capacity of all stakeholders by using rationalization, acceptability of opposing viewpoints, and the creation of dialog (Foster & Jonker, 2005).

Rustin (1999) argued the emphasis on democracy and the ideals of western society limits the application of Habermas' theoretical discourse to other societies. Changing social norms (Tan & Sjoberg, 2005) determine the degree of benefit obtained from the restructuring of Habermas' worlds. The globalization of society has brought new approaches to organizational operations with a need for increased knowledge concerning normative, objective, and subjective worlds (Illeris, 2003; Tan & Sjoberg, 2005). An increased integration of women into society challenges existing social norms centered on formal and informal power structures, allowing adaptation to a global perspective by negotiating new organizational frameworks (Godkin & Godkin, 2004; Tan & Sjoberg, 2005). With new perspectives, individuals reach understanding about the lifeworld through the actions of socialization and the reconstruction of knowledge through learning (Habermas, 1981/1984).

Organizational Foundations

Internal and external stakeholders of organizations interact at the practice level. The influence of an organization on the stakeholders determines the functioning of the practice environment of the organization (Billett, 2002a; Godkin & Godkin, 2004; Lincoln & Johnson, 2009; Meraviglia et al., 2009; Savolainen, 2000; Stanley, 2006). Based on recommendations for radical change by the IOM (2000, 2001, 2004), the definition of specific organizational cultures and environments becomes significant to change efforts (Lacey et al., 2009; Yasin et al., 2002). Change in healthcare requires an understanding of the various organizational stakeholders, cultures, and environments (Apker et al., 2005; Appelbaum & Wohl, 2000; Billett, 2002b; Brewer et al., 2008; Green et al., 2009; McKenna, 1992). The rapidly changing healthcare environment generates

opportunities for healthcare organizations to evolve (Higgs & Rowland, 2005; Länsisalmi, Kivimäki, Aalto, & Ruoranen, 2006; Narine & Persaud, 2003; Rundall et al., 2007).

Culture and Change

Healthcare organizations consist of individuals placed in workplace communities based on skill sets, practice patterns, and perceived fit with the existing workplace culture (Brewer et al., 2008; Schraeder, 2004; Tung Ling Hsiung & An Tien Hsieh, 2003; Wenger, 1998). The organizational culture provides the medium for the interactions of the individuals in the workplace, leading to the development and maintenance of patterns in practices (DiMeglio et al., 2005; Lincoln & Johnson, 2009; Ogbonna & Harris, 2000; Savolainen, 2000; Wenger, 1998; Westerman & Cyr, 2004). Professional practice identities merge with personal identities and form a multidisciplinary organizational platform providing the basis for organizational cultures. The changing healthcare climate challenges the connectivity of individuals to the organization, the specific workplace, and the organizational service delivery process (Cummings, 2006; Fuller, 2007; Länsisalmi et al., 2006; Laschinger et al., 1999; Meraviglia et al., 2009; Morgan & Ogbonna, 2008; Natarajan, 2006; Peltier, Schibrowsky, & Nill, 2004; Rountree & Porter, 2009; Shirey, 2006; Wenger, 1998).

Hierarchy. Traditional relationships determine the connection of employees to management in workplaces (Gabris & Ihrke, 2007; Savolainen, 2000). Hierarchical structures remain a consistent part of work processes and accountability despite attempts to restructure the workplace (Åmo, 2006; Cody, 2003; Hales, 2005; Kalisch et al., 2009; Leslie et al., 2006; Mantzoukas & Jasper, 2004; McAlearney, 2006). Pillay, Boulton-

Lewis, Wilss, and Lankshear (2003) established that hierarchical work processes corresponded with a lack of openness to adaptation and inhibited innovation in practice patterns. The perception of work as a job limits growth, challenge, and achievement (Duffin, 2009).

Institutionalism in organizations tightens the connection of hierarchy to the practice environment (Wenger, 1998). Beil-Hildebrand (2002), Cody (2003), and Allen (2004) discussed boundaries and hierarchical constructs as significant barriers to changing nursing practice. Hertting et al. (2004) theorized that lack of collaboration in hierarchical organizational structures decreased staff member morale and limited the effectiveness of change. Mentoring, leadership development, and knowledge advancement change power dynamics from hierarchical to collaborative (Godkin & Godkin, 2004; Ponte et al., 2007; Rafferty & Griffin, 2006).

Organizational change (Bate et al., 2000; Wiggins, 2006) supports the development of a collaborative partnership model, eliminating the hierarchical model of leadership. The development of organizational assets (i.e., people) helps integrate healthy relationships in the organizational design, creating a sense of belongingness in the organization. Augier and Knudsen (2004) theorized the organizational design derived from a perspective of individuals as agents who set the boundaries of the organization. Placing the employee at the center of the workflow and decision-making process generates empowerment (Apker et al., 2005; Aronson et al., 2002; Fuller, 2007; Lincoln & Johnson, 2009; Sarros, Gray et al., 2002; Sharkey, 2006).

Cultural shift. Change in organizations is successful when the people in the organization have the ability to comprehend, acknowledge, and accept the change process

(Åmo, 2006; Appelbaum, Berke, Taylor, & Vazquez, 2008; Buchanan, 2003; Morgan & Ogbonna, 2008; Nelson, 2003; Sharkey, 2006; Waldersee, 1997). M. E. Smith (2003), Cowley (2007), and Fitzgerald et al. (2007) identified that failure to change results mostly from limited leadership capability and inability to overcome cultural resistance. Understanding the existing culture is essential in developing approaches for employee engagement in the change process (Duffin, 2009; Lacey et al., 2009; McKenna, 1992; Rondeau & Wagar, 1999; Savolainen, 2000; Sharkey, 2006; Waters, 2004; Yasin et al., 2002; Yemm, 2007). Harmony exists when organizational cultures fit the expectations of individuals, increasing adaptation to change and retention (Appelbaum & Wohl, 2000; Westerman & Cyr, 2004).

Engagement depends on the cognitive capacity of individuals, the extent of individual participation in the change effort, and a sense of community in the workplace (Berger, 1992; Billett, Smith, & Barker, 2005; Morgan & Ogbonna, 2008; Peltier et al., 2004). Public acknowledgement, small manageable steps, and a dedicated core group who supports and tracks progress enable employees to develop connections to the workplace during cultural shifts (King & Wright, 2007; Ravasi & Schultz, 2006; Smith, 2003). A focused second-tier leadership creates a culture of commitment and coaching by using influence tactics to align leadership with cooperation and service quality (Savolainen, 2000; Stewart & Kringas, 2003). Unit cultures that exhibit increased staff member support connect the use of professional practice to patient-centered care delivery, clarifying nursing roles (Boumans, Landeweerd, & Visser, 2004; Kalisch et al., 2009; Lincoln & Johnson, 2009; Rowe & Hogarth, 2005).

Organizational change affects the systemic flow of information by changing response times (Wenger, 1998). Available knowledge (Augier & Knudsen, 2004; Goodman & Truss, 2004; Meyer & Stensaker, 2006) is the source of direction for the information flow between the employees in the organization. The effective processing of information is based on communication techniques and empowerment to improve productivity during organizational change (Fuller, 2007; Grieves & Mathews, 1997; Meynell, 2005; Yemm, 2007). A successful organizational merger (Sharkey, 2006) targets the development of effective communication strategies, leadership engagement in defining and developing processes, peer mentoring, cultural linkages to performance and compensation structures, and a team approach to planning and workplace practice (Naquin & Holton, 2006).

Rundall et al. (2007) and R. Sanchez and Heene (1997) stressed the abilities of managers in determining the adaptability of the organization to market forces. Members in the organization interact with the internal and external environment, using competitive advantage (Perez & Ordóñez de Pablos, 2003; Porter, 1991) to increase profitability. Reflective practitioners contribute to change models applicable to specific organizational needs (Rogers, 2006; Rowe & Hogarth, 2005). New strategies emerge when leaders recognize a need to change direction. Successful change efforts provide a flexible framework to generate meaning (Higgs & Rowland, 2005).

Supportive leaders mitigate stress development in complex environments by introducing structure with relationship building, performance indicators, and work engagement (Britt et al., 2004; Koberg et al., 1999; Naude & McCabe, 2005; Piccolo & Colquitt, 2006). Carney (2004b) found clinical leaders who were not involved in strategic

planning stymied the implementation of change processes. Alignment with business strategy, employee engagement, discretionary effort, and transparency supports successful cultural change as an indicator of leadership development, performance, and capacity (Appelbaum et al., 2008; Olesen, White, & Lemmer, 2007). Limited leadership buy-in contributes to the failure of intra-organizational change, decreasing productivity and connectivity (Proehl, 1997).

B. L. Porter and Parker (1992) mentioned the following six essential ingredients for successful change: "Felt need, management commitment, shared mindset, employee involvement, focused training, and accountability" (¶ 9-16). The learning capacity of managers influences the coordination of resources and the profitability of the organization. Decision-making processes cycle the flow of information from internal to external to internal (Meyer & Stensaker, 2006). Olesen et al. (2007) connected career success with leadership assessments and competencies.

In a participatory change model approach (Berger, 1992; Wiggins, 2006), executive engagement, collaboration, and adequate resource allocation support employee development. Project failure occurs because of inadequate communication and lack of executive support, limiting employee decision-making capacity (Cowley, 2007; Meyer & Stensaker, 2006; Porter & Parker, 1992; Smith, 2003). Team processes fail because of assumptions that employees will actively engage in the change process, engagement will result in a higher level of acceptance of the change effort, and engagement will provide a higher quality change effort (Berger, 1992; Pillay et al., 2003). The use of evidence-based practice (Alarcon et al., 2002; Hilburn et al., 2006; Lincoln & Johnson, 2009) heightens

the strengths of the leadership team and provides a focus for an organizational culture that supports excellence in professional practice and quality in service provision.

Organization reformation. Malloch and Lussier (2000) presented wellness as a core component of organization formation. The model is based on "supervisor support, clarity of expectations, employee involvement, peer cohesion, and innovation" (¶ 14) by using communication modalities to structure and develop the cultural environment. Garrett and McDaniel (2001) and Cummings (2006) found that insufficient supervisor support and peer cohesion challenged social network development and limited the ability of individuals to cope with change. Organizational involvement, identification, and loyalty positively influenced commitment to change when formal and informal (i.e., social) networks support a feeling of belongingness (Madsen et al., 2005).

A model can stimulate stakeholder growth by developing a culture that embraces belongingness (Lincoln & Johnson, 2009; Malloch & Lussier, 2000). Susnienė and Vanagas (2006) demonstrated that relationship building depended on the formation of collaborative decision-making processes. According to Leppitt (2006), a reliance on hierarchical mechanisms reveals a lack of flexibility, contributing to the failure of change efforts. Social sensitivity (Khatri, Ng, & Lee, 2001) positively influences satisfaction levels and enhances the ability of leaders to develop relationships with followers.

In rapid change efforts, the organization must keep pace with the change effort (Morgan & Ogbonna, 2008; Nelson, 2003). Organizational learning guides a rapid change effort through a three-level process of looped, adaptive, and behavioral learning (Lim & Chan, 2004). Mastery of skills and competencies contributes to adaptation of change strategies (Baker et al., 2000; Wenger, 1998; Woodward & Hendry, 2004).

Stakeholder development of skills and competencies for effective leadership involves the ability of the organization to provide resources during change efforts (Bligh & Carsten, 2005; Mathena, 2002; Wallin et al., 2006).

Successful integration of change into organizational cultures depends on the degree and type of resource allocation, first-tier leadership support, and communication strategies (Martins & Terblanche, 2003; Stewart & Kringas, 2003). Resource allocation, clear communication, alignment of mission and vision to strategic change, and cultures with a clear connection to service quality provide support to changing organizations (Cowley, 2007; Godkin & Godkin, 2004; Lukas et al., 2007; McAlearney, 2006). Tucker and Edmondson (2003) found that a predominant reliance on fixing immediate problems limited problem resolving capacity. Active conflict between first-tier and second-tier leadership emphasize differences in adaptation to change (Liedtka, Whitten, & Sorrells-Jones, 1998).

Successful stakeholder negotiation (Susnienė & Vanagas, 2006; Wenger, 1998) through change efforts depends on organizations developing a common language, shared cognitions, and effective communication (Bligh & Carsten, 2005; Green et al., 2009; Lincoln & Johnson, 2009; Schraeder, 2004). Such strategies must be flexible (Leppitt, 2006) in order to adapt to the needs of specific organizations. Neves and Caetano (2006) found the existence of supervisor support helped develop trust and enhanced engagement during change despite perceived low levels of empowerment. A key strategy is to use senior leadership to engage staff in formal and informal change efforts (Cowley, 2007).

Environment and Change

The experiences, perceptions, cognitions, and interactions of staff members supply a perspective often overlooked in the determination of functional practice environments (Cummings, 2006; Kalisch et al., 2009; Morrison et al., 1997; Scotti et al., 2007; Smollan, 2006). The focus of change efforts divides the healthcare organization into the four areas of "management practices, workforce deployment practices, work design, and organizational culture" (IOM, 2004, p. 3). Organizational change efforts (DiMeglio et al., 2005; Fuller, 2007; Ponte, Kruger, DeMarco, Hanley, & Conlin, 2004) present opportunities for recognizing, evaluating, and changing staff perceptions of the work environment. Leaders of effective organizations develop an environment of accountability with clear role delineation, identifiable mission, goals, and vision, and a culture of trust, responsiveness, and quality performance (Leslie et al., 2006; Rowe & Hogarth, 2005).

A lack of inclusive behavior and professional respect permeates staff member interactions, increasing new graduate turnover. Shared governance by team members restricts the flow of information between the committee members and other staff members (DiMeglio et al., 2005). Atencio, Cohen, and Gorenberg (2003) found that nurses with less seniority perceived a higher degree of autonomy and task orientation in the workplace when compared to nurses with higher seniority. Hayhurst et al. (2005) and Kalisch et al. (2009) targeted measures of peer cohesion, supervisor support, autonomy, and work pressure as factors influencing retention.

Gifford, Zammuto, Goodman, and Hill (2002) and Gullo and Gerstle (2004) found organizational commitment, empowerment, job satisfaction, and participatory

culture decreased intent to turnover. Perceptions (Mallak et al., 2003) that hierarchical methods of leadership provide a stable work environment slow organizational change. According to Chiaburu and Marinova (2005), the ability of individuals to learn changed in proportion to the level of peer support. Increased work demands, decreased resources, and hierarchical relationships challenge the ability of nurses to work cooperatively with other disciplines in a downsized environment (Hertting et al., 2004; Rountree & Porter, 2009).

Autonomy, supervisor support, peer cohesion, and clarity of purpose contribute to inclusive work environments and job commitment (Duffin, 2009; Koberg et al., 1999; Kotzer, Koepping, & LeDuc, 2006; Slater, 2006; Stuenkel, Nguyen, & Cohen, 2007). Ulrich et al. (2005) found leaders needed to reconnect with staff members. A change process (Rosengren et al., 1999) in which the input of practice-level professionals is ignored damages preexisting cooperative relationships with organizational leadership. Professional practice environments evolve from effective communication between disciplines and the inclusion of all voices in the determination of care modalities (Green et al., 2009; Morgan & Ogbonna, 2008; Stewart et al., 2004).

The use of control by leadership (Alarcon et al., 2002; Davies et al., 2006; Staten, Mangalindan, Saylor, & Stuenkel, 2003) influences the degree of autonomy in the workplace. Nurse managers emerge as central to the social atmosphere, span of control, and openness of the unit in participatory environments and progressive cultures (Khowaja, Merchant, & Hirani, 2005; Staten et al., 2003). Empowered environments support the use of a nursing model that produces effective leadership, encourages staff self-governance, and enables relationship building between professional disciplines. A

nursing model mediates the effects of burnout by empowering nurses to change workplace practices and develop a professional practice environment (Armstrong & Laschinger, 2006; Laschinger & Leiter, 2006; Wallin et al., 2006).

Mangold et al. (2006) revealed empowered nurses positively influenced practice patterns, using autonomy and professionalism. Leipzig et al. (2002) found hierarchical perceptions of the physician as a natural leader and final decision maker limited the development of effective interdisciplinary teams. A participative and supportive work environment targets the involvement of nurse managers in leadership development and mentoring programs as significant in creating a sense of belongingness and enhancing staff satisfaction (Block & Manning, 2007; Weir et al., 1997). Leadership styles that engage and involve all members in changing organizational environments increase performance and quality (Malloch & Lussier, 2000; Scotti et al., 2007; Young & Dulewicz, 2006).

Understanding strategic direction helps in sharing experiences and creating a participatory learning environment (Bowerman, 2003; Larson, 2007). Naude and McCabe (2005) spotlighted job and workplace flexibility as essential to the development of supportive learning environments. Senge (1990/1994) indicated the building of personal mastery, mental models, shared vision, and team learning moved organizations from gradual decline to "seeing through the complexity to the underlying structures generating change" (p. 128). Workplace communities-of-practice use "negotiation of meanings", "preservation and creation of knowledge," "spreading of information," and a "home for identities" (Wenger, 1998, pp. 251-252) as constructs for developing change in organizations (Rowe & Hogarth, 2005).

Knights and Willmott (1992) submitted dominant theological structures built on the hierarchical construction of social norms and eliminated the significance of cognition, reflexivity, and variability. Systems thinking provides tools enhancing the use of participative and reflective openness to develop leaders (Senge, 1990/1994). Checkland and Haynes (1994) proposed that systems thinking required "making the process of inquiry into an organized system" (¶ 19). Merging theoretical constructs into the culture of the organization places practice environments on a global perspective creating leadership capable of change management (Checkland & Haynes, 1994; Senge, 1990/1994).

Garrett and McDaniel (2001) demonstrated that unit social support overcame variations in work intensity, achieving workplace satisfaction. Challenging work environments contribute positively to the degree of staff member connectedness. Supportive relationships, professional practice, and advancement opportunities decrease stress and limit the formation of hostile work environments (DiMeglio et al., 2005; Hendel, Fish, & Galon, 2005; Hoffman, Hoelscher, & Sherif, 2005; Lincoln & Johnson, 2009; Williams, 2006). Collegial relationships with nurse mangers, doctors, and other disciplines enhance the ability of the nurse to advocate, participate, and change processes and practices in the workplace (Green et al., 2009; Ulrich et al., 2005).

Organizations and Groups

A cognitive approach to organizations and groups supports the use of social interaction as the basis for group formation (Kang et al., 2007; Wenger, 1998). Managers add a strategic component to organizational groups (Carney, 2004a, 2004b; O'Loughlin & McFadzean, 1999; Tang & Thomas, 1992). Healthcare managers describe

membership, leadership, and mutual respect as essential components for developing effective team environments (Kalisch et al., 2009; Mickan & Rodger, 2005). Practice environments supporting professional collaboration exhibit a commonality of practice that creates a sense of community (Green et al., 2009; Kvarnström & Cedersund, 2006; Lincoln & Johnson, 2009).

Leadership group synergy supports competitive advantage (Mehra, 1994; Ng, 2004; Perez & Ordóñez de Pablos, 2003; Porter, 1991) and increases the probability of developing and maintaining successful organizations. Group cohesion (Ensley & Pearce, 2001; Lincoln & Johnson, 2009; Rountree & Porter, 2009) uses synergy to incorporate a sense of belongingness, shared cognition, and lack of affective conflict as a positive factor in profitability (Smith, 2005). Synergy supports the building of relationships through experiences, using bonding in a community-of-practice environment (Ensley & Pearce, 2001; Wenger, 1998). Social integration (Billett et al., 2005; Petraf & Shanley, 1997; Van der Vegt, 2002) in the workplace empowers individuals to develop a sense of belongingness confirming organizational fit, group potency, and workgroup cohesion.

McNamara et al. (2002) determined that familiarity with a competitor's characteristics and fewer broad-based business strategies produced a more effective set of mental models. Knowledge accumulation enables expert practitioners to form advanced mental models and provides strategic benefits for management groups (Mehra, 1994; Schwaninger, 2001). Senge (1990/1994) determined that the effectiveness of complex mental models existed only when the cognitive processing of the involved individuals was synchronized. Cyclic cognitive development supports the continual accumulation of knowledge and the development of more advanced mental models as a strategic

advantage for organizations (Banks & Millward, 2000; Mehra, 1994; Rowe & Hogarth, 2005; Schwaninger, 2001).

Churchman and Woodard (2004) considered a healthcare strategic group as an executive forum for quality innovation. Membership aligns organizations with similar missions and visions (Appelbaum et al., 1998; Petraf & Shanley, 1997). Senior leadership in one healthcare organization consists of professional groups, limiting strategic planning (Carney, 2004a; De Cremer, 2001). Carney (2004b) found that clinical professionals stymied the advancement of strategic initiatives when executives excluded the clinician from full involvement in the strategic planning process.

Hierarchical structuring (Brown & Duguid, 2001; Carney, 2004a) limits the development of a cohesive strategic group and restricts the organizational ability to develop multidisciplinary approaches to organizational planning. Cognitive development in a community-of-practice evolves from the negotiation of meaning and the development of shared practices instead of models for knowledge accumulation (Billett, 2006; Habermas, 1981/1987; Wenger, 1998). Brokering a common language, increasing involvement in strategic planning, and expanding the autonomy of nurse managers are components of a framework for group functionality (Carney, 2004b; Litwin et al., 1997). Leadership development (Buchanan, 2003; Petraf & Shanley, 1997) supports the advancement of all leaders toward strategic group alignment, using mutual experiences and practices to create a sense of belongingness in organizations.

Kalisch et al. (2009), Mickan and Rodger (2005), and Meraviglia et al. (2009) found that healthcare teams categorized mutual respect, goals, leadership, communication, cohesion, and purpose as qualities essential to effective team

functioning. Job standardization, task mastery, and role clarity (Lave & Wenger, 1991; Lichtenstein et al., 1997; Slater, 2006; Tung Ling Hsiung & An Tien Hsieh, 2003) strengthen the acclimation of the individual to the organization and workplace community. Work satisfaction occurs when individual, group, and organizational values are congruent (Kammerlind et al., 2004; Lincoln & Johnson, 2009; Peltier et al., 2004; Rountree & Porter, 2009; Westerman & Cyr, 2004). Assimilation results from the ability of individuals to fit into a particular unit or work group (Mickan & Rodger, 2005). The process of assimilation into the group structure predicts the degree of cohesion through developing a communicative action that reflects ability to fit (Habermas, 1981/1984).

Gil, Rico, Alcover, and Barrasa (2005) maintained that high degrees of group potency correlated positively with group satisfaction. Performance ability improves when change-oriented leaders create an environment of innovation. Work group cohesion and initiative (Chang et al., 2006; Sánchez & Yurrebaso, 2009) become integral to developing inclusive environments. Work group members lack the ability to develop innovation behavior without the support of leadership (Åmo, 2006; Kalisch et al., 2009; Länsisalmi et al., 2006).

Organizational teams with effective leadership increase service quality (Alarcon et al., 2002; Hui, Chiu, Yu, Cheng, & Tse, 2007). Stimulating work group cohesion and initiative produce an atmosphere of inclusion (Martin et al., 2005; Slater, 2006). Stakeholder buy-in is based on leadership credibility, a significant factor in achieving successful change (Denis, Lamothe, & Langley, 2001). Patient satisfaction increases proportionally to the degree of work group cohesion (Chang et al., 2006; Ensley & Pearce, 2001).

Intragroup conflict influences the development of group cohesion. Relationship conflicts decrease cohesion in groups while positive resolution of task conflicts increases group cohesion (Jehn, 1997; Kalisch et al., 2009). The exclusion of individuals from in-groups occurs because of a lack of inclusion by in-group members (Labianca & Brass, 2006), a lack of connection with in-group members (Argyris, 1954), and lack of similarity with in-group members (De Cremer, 2001, Van der Vegt, 2002). Higher self-efficacy in individuals demonstrated by a feeling of belongingness predicts an increased ability to manage group conflict (Desivilya & Eizen, 2005).

A sense of belongingness emerges from social and professional inclusion in work groups (Cousin & Deepwell, 2005; Wenger, 1998). Chang et al. (2006) found that an ethnically diverse work group composition did not affect group performance or cohesion. Lichtenstein et al. (1997) determined that increased team diversity decreased the cohesive functioning of healthcare teams. The traditional hierarchical perception of the physician as the final determinant of care delivery decisions restricts the identification of the team process as an acceptable mode of care delivery (Martin et al., 2005; Morgan & Ogbonna, 2008).

Community-of-Practice

"A community of practice is a set of relations among persons, activity, and world over time and in relation with other tangential and overlapping communities of practice" (Lave & Wenger, 1991, p. 98). The healthcare organization consists of multiple levels of practice patterns, leadership categories, skill categories, and employee types forming a complex environment (IOM, 2004). Lesser and Storck (2001) connected the performance of the individual to categorization as an organizational asset (i.e., social capital). Mutual

goals, objectives, and interests create a shared understanding that merge the collective expertise of individuals through targeting the achievement of organizational objectives and increasing the performance capacity of the individual (Hughes, 2003; Smith, 2005).

Knowledge advancement occurs when developing a community-of-practice approach creates benefit for all stakeholders (Cousin & Deepwell, 2005; Soekijad, Huis in ‘t Veld, & Enserink, 2004). Innovation occurs with actively evolving communities-of-practice (Brown & Duguid, 2001). Lesser and Storck (2001) found the benefits of a community-of-practice perspective included “decreasing the learning curve of new employees; responding more rapidly to customer needs and inquiries; and reducing rework and preventing reinvention of the wheel” (¶ 22). Conflict between established team members and newcomers reduces the possibility of full participation (Handley, Sturdy, Fincham, & Clarke, 2006).

Leaders use rational persuasion, consultation, and coalition to influence long-term employees and form safety cultures in organizations (Clarke & Ward, 2006). Formal and informal influence (Billett, 2002b, 2006) shapes the functioning of the community-of-practice. Formal influence develops from interaction with internal and external stakeholders of the organization. Informal influence develops from the interaction of peers in a particular community-of-practice. Social (i.e., informal) and professional (i.e., formal) networks of interaction build relationships that influence communities-of-practice (Campbell et al., 2003; IOM, 2004; Letkemann, 2002; Wenger, 1998).

The growth (Habermas, 1981/1984) of individuals with norms formed from past and present experiences consists of interaction with the expected norms of the workplace. The similarity of experiences within a professional discipline predisposes individuals to

develop organizational relationships that strengthen cultural linkages (Billett, 2002b; Letkemann, 2002; Soekijad et al., 2004). The similarity transcends generational boundaries to stimulate a sense of belongingness with the strengthening of common bonds that integrate the individual into the community-of-practice and allow the formation of relationships. The relationships depend on the ability of the leader to motivate each individual to excel, confirming organizational allegiance (Billett, 2002b; Godkin & Godkin, 2004; Letkemann, 2002).

Boundaries (Illeris, 2004; Letkemann, 2002; Mackoff & Triolo, 2008; McAlearney, 2006; Tagliaventi & Mattarelli, 2006; Thompson, 2005; Thyer, 2003; Tucker & Edmondson, 2003) influence the development of individuals in the workplace and provide structure for organizational functioning. Letkemann proposed the concept of a hierarchical community-of-practice as anchoring employees to the organization. Tagliaventi and Mattarelli acknowledged that professional boundaries in healthcare affected the development of communities-of-practice. The use of language and knowledge specific to individual professions creates a hierarchical divide that restricts the formation of a cohesive community (Green et al., 2009; Mantzoukas & Jasper, 2004).

The advancement of society challenges existing professional norms and structures (McAlearney, 2006; Shewchuk, O'Connor, Fine, & Tyler, 2005). Healthcare change efforts require flexible communities-of-practice (Brown & Duguid, 1991; Zimitat, 2007). Flexibility in professional practice targets job categories that support research and learning along with clinical responsibilities (Naude & McCabe, 2005). Zimitat demonstrated that educational innovation could capture the unique growth potential of professionals and advance practice patterns from novice to expert.

Lave and Wenger (1991) asserted, “Participation at multiple levels is entailed in membership in a community of practice” (p. 98). The social processes in the community-of-practice support the development of leadership (Ogbonna & Harris, 2000). Wenger’s (1998) model of community-of-practice is based on identification and negotiation to shape individuals' interactions. The model describes engagement, imagination, and alignment as three levels of belonging, moving individuals through phases of identification and negotiation and defining membership in each community-of-practice.

Engagement. Wenger (1998) defined engagement as “the ongoing negotiation of meaning,” “the formation of trajectories,” and “the unfolding of histories of practice” (p. 174). Group formation, alignment, and functioning affirm the engagement of individuals in the workplace (Madsen et al., 2005). Engagement occurs despite divergent outcomes when individuals' voices are part of formal and informal group processes (Tyler & Blader, 2003). Professional practice environments produce a model of engagement that encourages the development of adaptive systems using reflection, participation, and negotiation to redefine and reframe mental models (Rowe & Hogarth, 2005).

Fox (2000) argued the inclusive nature of the community-of-practice lacked the ability to manage unequal power relationships and conflict. Negative relationships with an individual higher in the organizational structure limit engagement and inhibit career advancement (Labianca & Brass, 2006). Ogbonna and Harris (2000) and Madsen et al. (2005) found organizational success depended on leaders who acknowledge the value of employees. The development of new meanings in organizations reflects the commitment of individuals to reforming the practice environment (Lincoln & Johnson, 2009; Rowe &

Hogarth, 2005). Insularism decreases the viability of the group when a changing economic market requires more cost-effective work practices (Thompson, 2005).

Schaufeli and Bakker (2004) stated, "Engagement as a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (¶ 5). Engagement (Billett, 2002b; Billett et al., 2005; Lincoln & Johnson, 2009; Scotti et al., 2007) connects individuals to workplace communities-of-practice, increasing the probability that the workplace will develop and grow in response to a changing healthcare environment. An engaged community-of-practice becomes fragmented when organizational change emphasizes individual accountability instead of group innovation (Thompson, 2005). Authentic leaders challenge followers to extend identity formation and incorporate the needs of the unit and the organization (Shirey, 2006). Juriado and Gustafsson (2007) found that event stability allowed participants to form a bond of community, motivating members to ensure the negotiation of common goals and objectives results in common understanding.

Imagination. Wenger (1998) described imagination as the ability to see beyond perceptions, expectations, and experiences by connecting to the mutuality in the community-of-practice. Imagination increases the cognitive processing of individuals and expands understanding beyond the boundaries of the self by bringing innovation into rationality and limiting the influence of hierarchy (Cousin & Deepwell, 2005; Loasby, 2001). With communicative action, the subjective world is the holder of imagination. Natural language draws common understandings of the social world through the relationship between the subjective world and the objective world chosen by the individual (Habermas, 1981/1984). Carlsen (2006) presented imagination as a common

understanding derived from reframing, negotiating, and forming workplace meanings in the practice environment.

Alignment. Understanding and meaning issue from a common perception of a specific lifeworld (Habermas, 1981/1984). Alignment allows individuals to come to a common understanding of the community-of-practice. Common understanding incorporates how the community-of-practice relates to a wider worldview (Gill, 2003; Wenger, 1998). Flexibility and adaptability guide the development of all individuals as leaders in the workplace (Gill, 2003). A sense of synergy and relationship interdependence (Manion & Bartholomew, 2004) develops when community-of-practice experiences are aligned.

Creating a sense of belongingness in the community-of-practice, engagement, imagination, and alignment constitute a mutual construct of the community-of-practice by individuals and groups. Participation and reification facilitate access to positive and negative aspects of engagement, imagination, and alignment, stimulating learning. Insightful communities-of-practice use the management of engagement, imagination, and alignment to balance strengths and weaknesses against the framework of participation and reification. Functional communities-of-practice continually foster the ability to learn and grow with the use of mutual engagement, joint enterprise, and shared repertoire (Billett, 2006; Manion & Bartholomew, 2004; Wenger, 1998).

A focus on task completion and lack of social integration limits the formation of a community-of-practice (Woodward & Hendry, 2004). Learning, dialogue, and critical thinking connect transparency and accountability to trustworthiness and concreteness in decision-making processes (Snell, 2001). Despite the best efforts of a leader, negative

relationships (Labianca & Brass, 2006; Lichtenstein et al., 1997) exist in communities-of-practice. Strategies to foster a sense of connection target individual strengths and attributes supporting the development of a community and allowing a framework of inclusiveness that integrates separate disciplines (Manion & Bartholomew, 2004).

Team building strategies (Lincoln & Johnson, 2009; Loewen & Loo, 2004; Robinson & Cottrell, 2005) include increasing communication transparency, setting clear goals and objectives, and creating a shared language. Individuals in a team environment develop a sense of belongingness with respect, inclusiveness, and consideration as primary interactive elements of team behavior (Letkemann, 2002; Peltier et al., 2004). Liedtka et al. (1998) discovered that professional practice expectations limited collaborative team structures. Hierarchical practice patterns challenge the growth of professional knowledge and the advancement of evidence-based practice (Green et al., 2009; Mantzoukas & Jasper, 2004).

Hierarchical structures with centralize organizational processes at the management level set strict boundaries for the organization as a system (Habermas, 1981/1987). The multigenerational workplace, globalization, complex organizational structures, and diverse cultural perspectives produce complex environments requiring new approaches. The belief that modern organizations will experience continual change requiring environments supportive of change and that people will accept continual balancing of processes guides organizational structuring. The organization becomes an interactive system guided by leadership, interpreted by all stakeholders, and aligned by the development of a cohesive community-of-practice (Beeson & Davis, 2000; Horton et al., 2007; Wenger, 1998).

Leadership Foundations

Hierarchy forms leadership models focused on workplace performance goals instead of service excellence goals (Baack, Carr-Ruffino, & Pelletier, 1994; Grieves & Mathews, 1997; Hughes, 2003; Tilley, 1999; Yukl et al., 2002). New expectations specific to healthcare organizations derive from a need to change leadership approaches in healthcare (IOM, 2001, 2004; O'Connor, 2008; Parsons, 2004; Shirey, 2006; Stanley, 2006). The influence of hierarchy (Bate et al., 2000; Mantzoukas & Jasper, 2004; McKenna, 1992) hinders the development of new cultures based on the provision of quality service, complicating the development of new leadership modalities in healthcare (Fulmer & Graham, 1993; IOM, 2001, 2004).

Leadership Models

Moiden (2003) and K. Kim et al. (2004) recommended structuring leadership approaches based on followership. Leaders build a social support system that encourages positive interaction and promotes employee development (Hayhurst et al., 2005; Popper, 2004). Performance goals provide standards and motivate staff members to achieve excellence in service provision through empowerment. Effective leaders develop shared vision, strategy, and language that motivate and inspire employees to achieve excellence (Alarcon et al., 2002; Gill, 2003; Groves, 2006).

A formalized mentoring program supports the professional growth of registered nurses by improving relationship building and communication (Latham, Hogan, & Ringl, 2008). Stanley (2006) determined that clinical leadership depended on effective communication, decision capacity, and clinical competence. A continual evaluation of leadership style (Boumans & Landeweerd, 1993) creates environments in which social

support and communication are important elements in positive relationships between leaders and followers (Hooijberg, Hunt, & Dodge, 1997; Sanders et al., 1996). Communication based on emotional intelligence and relationship building guide the development of a cohesive community-of-practice during change (Holmes, Schnurr, Chan, & Chiles, 2003; Wenger, 1998).

Relationship building (Boyd & Taylor, 1998; Piccolo & Colquitt, 2006; Stuenkel et al., 2007) is crucial in the development and effective use of leadership. Delegating and mentoring deepens relationships and contributes to the formation of a participative organizational culture (Stuenkel et al., 2007). Relationship development, reflective and conceptual self-development, and risk taking are less important to leaders than the ability to carry out specific goals and objectives (Johnson, 2005). Conversely, Peltier et al. (2004) and Garman et al. (2006) presented communication and relationship building as leadership qualities essential to the development of trust in followers.

Perceptions of leadership capacity show that male managers focus on service goals while female managers need improvement in professional behavior skills (Baack et al., 1994). Role modeling aligns with strong nursing care principles instead of leadership capacity (Stanley, 2006). S. W. Johnson (2005) found that perceptions of technical skill achievement provided leadership with trust from followers. Hierarchical viewpoints (Sundkvist & Zingmark, 2003) separate first-level leadership into gender-specific roles, limiting leadership engagement, satisfaction, and effectiveness.

Leadership engagement in the workplace (Gullo & Gerstle, 2004; Stordeur, D'Hoore, & Vandenberghe, 2001) decreases work stressors for followers and supports the use of transformational leadership styles. A disconnect between leadership and

follower perception rates transformational leaders as more transactional when motivated by intrinsic process work behaviors (Barbuto, 2005). Harris and Ogbonna (2001) found that directive leadership limited organizational orientation toward service excellence. A change effort (Edmonstone & Western, 2002) focused on second-tier leadership fails to engage leaders at the practice level.

Fairholm (2004) found that senior managers used a broader spectrum of leadership qualities when compared to less experienced hierarchical managers. Self-rating by leaders produces higher perceptions of transformational leadership when compared to followers (Manning, 2002; Sellgren et al., 2006). Socialization and familiarity with leadership style (Felfe & Schyns, 2004) improves the acceptance of transformational leaders by followers. Subordinate satisfaction with effective leaders produces extra effort, improving performance when senior leaders show transformational leadership qualities (Spinelli, 2006).

Followers rate younger leaders highest in transformational leadership qualities (Manning, 2002). Levels of leadership confidence and follower truthfulness influence the ability to build relationships (Bjugstad, Thach, Thompson, & Morris, 2006; Neves & Caetano, 2006). The degree of friendship between leaders and followers influence relationship building (Bjugstad et al., 2006). Participative environments depend on leadership respect for follower autonomy and critical thinking skills (Block & Manning, 2007; Montesino, 2002).

Previous researchers (Kim et al., 2004; Lindholm et al., 2000) have suggested that the acceptance of specific leadership styles depended on the existing culture of the organization. Relationship management (Millward & Bryan, 2005; Moiden, 2003)

consists of connecting the depth of relationship with employees to specific leadership styles and traits. Power and control in the workplace determine the degree of followership. A disconnect exists between the autocratic leadership style and followers' need for autonomy, decreasing relationship building capacity (Montesino, 2002).

Wasonga and Murphy (2007) targeted the concepts of collaboration, active listening, cultural anthropology, egalitarianism, patience, humbleness, trust, and trustworthiness as aspects essential for the development of leadership capacity. Structured leadership development (Bowles & Bowles, 2000; DiMeglio et al., 2005) increases the leadership capacity of individuals and elicit more effective followership from subordinates. Leadership programs (Pintar, Capuano, & Rosser, 2007) for staff members can demonstrate the value of connecting performance to leadership capacity with the use of mentoring, goals, and coaching. Rowe and Hogarth (2005) and Rafferty and Griffin (2006) discovered that job satisfaction, organizational engagement, and role mastery aligned with leadership strategies showing mentoring and leadership development of followers as essential to the development of cohesive workplaces.

M. J. Cook (2001) and Dawson et al. (2005) examined the development of leadership capacity at the practice level where nurses can grow from novice to expert. Edmonstone and Western (2002) found that limited knowledge concerning the benefit of practice level leadership decreased staff satisfaction. Units with a higher leadership appraisal of professional practice lack staff member perception of autonomy in practice, input into decisions, and a learning environment (Anthony, Brennan, O'Brien, & Suwannaroop, 2004; Kramer et al., 2007). Evaluation of a professional practice model

(Anthony et al., 2004) shows low congruence between quality performance indicators and professional practice indicators.

Kramer et al. (2007) found that limited autonomy, decreased team cohesiveness, lack of professional respect and trust, and lack of nurse manager support challenged the growth of professional practice in staff nurses. A need for collaboration and coordination classifies the healthcare organization as a complex environment requiring the use of teams (Marks, Mathieu, & Zaccaro, 2001; McAlearney, 2006). Clinical nurse managers who engage other disciplines in innovative practice improvement initiatives increase leadership capacity (Ferguson et al., 2007). Collaboration between educators and leaders promotes growth in leadership skills and clinical excellence through varied perspectives, leadership styles, and practice roles (Dawson et al., 2005).

Newhouse and Mills (2002) and Ponte et al. (2007) found that nursing administrators perceived a connection between collaborative, professional, and leadership practice. Dionne, Yammarino, Atwater, and Spangler (2004) theorized that a shared vision would connect the team environment with transformational leadership. Raelin (2006) developed a leadership model with collaborative leaders as concurrent by sharing power, as collective by working toward a commonality of purpose, as mutual by appreciating the strengths of dialoging, and as compassionate by valuing participation of all stakeholders. The cognitive and rational processing capacity of individuals works toward aligning change with leadership styles (Gill, 2003; McCormick & Martinko, 2004; Naquin & Holton, 2006).

Sherman, Bishop, Eggenberger, and Karden (2007) elicited themes detailing leadership competencies that included personal mastery, interpersonal effectiveness,

human resource management, financial management, caring for self, staff, and patients, and systems thinking. Idealism, happenstance, temporary solutions, and career describe reasons why individuals chose nursing leadership (Bondas, 2006). The effective utilization of organizational resources occurs with the use of leadership development models to improve leadership practice (Block & Manning, 2007; Newhouse & Mills, 2002). Empowerment and competence development requires a model emphasizing cohesion, communication, and conflict management (Dionne et al., 2004; McAlearney, 2006).

Bondas (2006) stated that healthcare leaders sometimes took the path of least resistance. A leadership development model (Walmsley & Miller, 2007) generates limited success when involving connections between quality standards and work processes. Ferguson et al. (2007) found that observation, reflection, and critical thinking stimulated discussion concerning quality improvement in the workplace. Critical thinking (Hancock et al., 2005) and reflection (Grieves & Mathews, 1997; Raelin, 2006; Yemm, 2007) influence the development of leadership competencies.

A lack of structured education for leadership development (Hawkins et al., 2009; Johns, 2003) limits the ability of novice nurse managers to develop leadership capacity. Higgs and Rowland (2005) and Wallin et al. (2006) found the development of leadership capacity during change required expansion beyond techniques focused exclusively on individuals. Leadership programs (Herrin & Spears, 2007) that stress coaching trigger the expansion of leadership capacity and facilitate the creation of professional practice environments. A professional development model must incorporate reflection to develop critical thinking in nursing leadership (Gustafsson & Fagerberg, 2004; Johns, 2003).

The development of leadership capacity during change requires the use of additional approaches to build organizational-level capacity (Higgs & Rowland, 2005). The use of behavioral cues that combine thinking, meaning, feeling, and doing can develop a shared vision (Alimo-Metcalfe & Alban-Metcalfe, 2005; Senge, 1990/1994). Motivated, empowered, and inspired individuals with leadership capacity engage organizational members as change agents (Alimo-Metcalfe & Alban-Metcalfe, 2005; Rowe & Hogarth, 2005). A leadership model that accentuates the culture and environment of the organization becomes a priority for survival in healthcare (Latham et al., 2008; Parsons, 2004; Wiggins, 2006).

Nurse Managers

A redesign of the nurse manager role (Bolton, 2003; Duffield, 1994; Litwin et al., 1997; Miller, 1999; Rowe & Hogarth, 2005; Wong, 1998) expands the scope of oversight and responsibility and leads to change in perceptions. A range of transactional to transformational leadership characteristics based on role expectations and specific job requirements develops from the perceptions of individual nurse managers (Lindholm et al., 2000; Shivers-Blackwell, 2004; Yemm, 2007). The majority of managers perceive themselves as nurses rather than leaders, lack alignment with a career path in leadership, and believe that a vast divide separates leadership and nursing values. Such perceptions lead to conflict in role determination (Bolton, 2003, 2005; Sanders et al., 1996). Sherman et al. (2007) found few nurse managers chose to apply for the managerial position and expected second-tier leadership and staff members to assume the role of manager.

The effectiveness (Collinson, 2006; Lageson, 2004; Tilley, 1999) of the nurse manager role emerges as significant to the development of practice environments that

support excellence in service provision. The ability to adjust to increased role responsibilities and to manage time efficiently as well as adequate human resource management skills determines the effectiveness of nurse managers (Laschinger et al., 1999; Wilson, 2005). Staff members prefer nurse managers with a relationship orientation to a change and production orientation (Bligh & Carsten, 2005; Naude & McCabe, 2005; Sellgren et al., 2006). Leadership skills become significant to developing environments that demonstrate excellence in service and autonomy in practice (Hales, 2005; Kleinman, 2003; Sherman, 2005).

A characteristic of participative practice cultures is more initiatives for improvement using empowerment, autonomy, partnership, and flexibility than hierarchical cultures (Hayhurst et al., 2005; Stewart et al., 2004; Whitehead, 2006). Leaders who change their style from directive to facilitative prioritize the accountability of nurse managers for the practice environment (Aronson et al., 2002; Porter-O'Grady & Finnigan, 1984). Kramer et al. (2007) and Stewart et al. stressed the importance of autonomy and accountability in the development of leadership capacity in the practice environment. Nurse managers value effective communication by displaying leadership practices that emphasize accountability, visibility, and accessibility (Bligh & Carsten, 2005; Force, 2005).

Shared workplace goals are crucial in developing a caring environment and a sense of community (Hodson, 2004; Manfredi, 1996; Yemm, 2007). Communication mismatch and management by exception contribute to decreased staff morale, challenging the ability of nurse managers to form a cohesive community-of-practice (Kleinman, 2004). Lageson (2004) found that nurse managers who focused on quality of

service generated increased job satisfaction in registered nurses. Supportive supervisor and subordinate relationships develop with collective efficacy, correlate positively with job satisfaction, and support leadership approaches that built cohesive workplaces (Hall, 2007; Koberg et al., 1999; Neves & Caetano, 2006).

Anthony et al. (2005) and Latham et al. (2008) discovered that coaching and mentoring engaged individuals, stimulated a sense of belongingness and community, and developed a team approach to practice. Learning experiences emphasizing clinical practice instead of leadership competencies limit the ability of nurse managers to develop leadership capacity, engage staff members, and create cohesive environments (Johansson et al., 2007). Negative behavior and conflict in the workplace erode job satisfaction and a feeling of community (Hodson, 2004). Organizations that provided a supportive work environment with mentoring, training, and development programs rank highest in the ability to retain effective nurse managers (Loo & Thorpe, 2004; Parsons & Stonestreet, 2003).

Skills and tasks (Lin et al., 2007) represent areas of differences in leadership between nurse managers who focus on unit operations and second-tier leadership who focus on strategic planning, economics, and policy. A combination of available learning experiences and mentoring supports the development of effective leadership skills (Mathena, 2002; Sullivan, Bretschneider, & McCausland, 2003). A leadership development program (Morgan, 2005; Wolf, Bradle, & Greenhouse, 2006) can standardize performance indicators for advancing nurse managers from novice to expert. In one organization, Purcell and Milner (2005) found that lack of support hampered nurse managers in their attempt to attend leadership development courses.

Limited understanding and knowledge of the nurse manager role, policy involvement and knowledge, and overall understanding of the healthcare system challenge the ability to develop competencies for effective leadership (Care & Udod, 2003; Hancock et al., 2005). Laschinger et al. (1999) found an inverse relationship between staff perceptions of empowerment and participative leadership. Role confidence and positional power (Upenieks, 2003) increase the ability of nurse leaders to sustain professional practice environments. A focus on clinical expertise instead of the development of leadership capacity hinders engagement and leads to fragmentation in leadership practice (Purcell & Milner, 2005; Wenger, 1998).

The perception of staff members that strong leadership increases structural empowerment lacks relevance when survey results show no connection between type of leadership and professional practice (Manojlovich, 2005). Cohesive team environments depend on mutual respect exhibited by leaders and professionalism in managers (Hodson, 2005; Mickan & Rodger, 2005). Leadership and professional development opportunities support the commitment of nurses to professional practice (Mrayyan & Al-Faouri, 2008). Manfredi (1996) found that nurse managers identified credibility, visibility, education, and role modeling as effective strategies in developing environments that empowered staff members.

Changing organizational environments require continual learning (Block & Manning, 2007; Duffield, 2005; Wolf et al., 2006). Johnson and D'Argenio (1991) found short-term learning interventions showed minimal changes in leadership effectiveness 1 year after program completion. Kleinman (2003) and Scoble and Russell (2003) determined graduate education fulfilled the needs of nurse managers when programs

combined business competencies and clinical expertise. Wicks and St. Clair (2007) used the competencies of competition, financial control, collaboration, and development (i.e., growth and innovation) to evaluate nurse managers' performance.

Wilson (2005) theorized that completion of a leadership development program would increase retention in nurse managers. McGuire and Kennerly (2006) found no connection between leadership behavior and organizational commitment. The ability of nurse managers to inspire participation and innovation depends on knowledge of governance practices and experience in negotiating leadership structures (McMurray & Williams, 2004). Mentoring (Sullivan et al., 2003; Waters, Clarke, Ingall, & Dean-Jones, 2003; Weir et al., 1997) integrates leadership skills into the practice patterns of nurse managers.

According to Casida and Pinto-Zipp (2008), nurse managers with transformational leadership characteristics develop adaptive practice environments. Leadership behaviors that display attributes of the transformational leadership style promote autonomous and cooperative practice, strengthening the cohesion of staff members and formulating an inclusive and supportive community-of-practice (Bowles & Bowles, 2000; Force, 2005; Gullo & Gerstle, 2004; Murphy, 2005; Yemm, 2007). Transformational leaders with a long organizational tenure utilize collaborative conflict management with more frequency than transactional leaders with a short tenure (Hendel et al., 2005).

The focus of nurse managers' leadership skills is on managing human resources (Donaher et al., 2007; Lin et al., 2007). Effective communication (Care & Udod, 2003; Sherman et al., 2007) ranks highest in selected competencies. Nurse managers require

ongoing structured educational experiences for effective professional practice skills, including an increased need for computer literacy, human resource management, and evidence-based practice (Gould et al., 2001; Russell & Scoble, 2003; Sullivan et al., 2003; Wolf et al., 2006). Effective leadership practices maximize staff satisfaction, stimulate a sense of belongingness, and reflect a participative unit culture and a supportive work environment (Shirey, 2006; Wenger, 1998).

Shared Governance

Providing a platform for professional practice, shared governance (Porter-O'Grady & Finnigan, 1984) expands the decision capacity of staff members in healthcare organizations (Golanowski, Beaudry, Kurz, Laffery, & Hook, 2007; Prince, 1997). Organizational efforts to provide a fully functional governance structure depend on the ability to expand knowledge concerning how a process works (Edmonstone, 2000; Frith & Montgomery, 2006; Hess, 2004; Hilburn et al., 2006; Styer, 2007). Clinical governance requires leadership to guide professional practice (Wilkinson et al., 2004). The common elements of participation, accountability, and collaboration constitute a flexible framework that adjusts to the needs of a particular organization and supports accepted domains of professional practice (Hess, 1998; Porter-O'Grady & Finnigan, 1984).

Participation. Structural processes based on theory challenge the understanding of shared governance and limit the follow-up of projects (Williamson, 2005). Using directors to facilitate cooperative team processes decreases the involvement of staff members in governance decisions (Ireson & McGillis, 1998). Conflicting conceptualizations of autonomy limit the effectiveness of shared governance and

decrease participation and leadership buy-in (Apker, 2001). DiMeglio et al. (2005) and Styer (2007) found that the reworking of goals and objectives allowed educational topics to increase understanding and participation.

Member participation in unit councils lacks validity when processes not aligned with senior leadership strategy and nurse manager authority are eliminated (Carroll & Arneson, 2003). Latham et al. (2008) showed the efficacy of semiannual governance meetings. Limited participation in a multidisciplinary council limits the voice of nonclinical members (Scott & Caress, 2005). Restructuring of the shared governance process must reflect the need to prioritize education, mentoring, and facilitation (Bartunek, Rousseau, Rudolph, & DePalma, 2006; Moore & Hutchison, 2007). Shared governance initiatives include alignment with performance objectives, professional practice standards, and quality service goals, using approaches that balance supportive educational mechanisms, workplace empowerment, and collaborative partnerships (Hilburn et al., 2006; Moore & Hutchison, 2007).

In a study by Zuzelo et al. (2006), findings indicated an effort to reorganize a shared council structure to include evidence-based practice failed because of lack of cohesive interaction and staff support for council membership. The development of shared governance deteriorates when limited resource allocation and leadership support create disillusionment and apathy (Burnhope & Edmonstone, 2003). Workplace autonomy lacks momentum because of a lack of progression in shared governance initiatives (Kennerly, 1996). Frith and Montgomery (2006) found that individuals who participated in shared governance endeavors had more knowledge of the process than individuals who had not participated.

Accountability. Understandings of clinical governance help standardize system objectives and improve clinical practice, increasing accountability (Golanowski et al., 2007; Hackett, 1999). Attree (2005) discussed a clinical governance model highlighting accountability in nursing practice, autonomous decision making, and standardization of practice. Problem solving helps shift governance oversight from management to staff members, streamline council membership, and emphasize accountability (Caramanica, 2004). McGoldrick et al. (2001) and Frith and Montgomery (2006) stated a supportive learning environment created an environment of accountability that developed leadership skills.

The introduction of shared governance decreases staff turnover and increases nursing knowledge by advancing practice through encouraging advanced degrees and involvement in research projects (Bamford & Porter-O'Grady, 2000). Leaders work with staff members using accountability and research-based evidence to develop workplace practices that decrease turnover and vacancy rates (Parsons, 2004). Downsizing creates a negative perception of shared governance (Bartunek et al., 2006). A government reform movement using a standardized approach to shared governance produced dissonance between personal practice beliefs and government-formulated practice standards (Attree, 2005).

P. I. Morgan and Ogbonna (2008) found that divergent professional practice beliefs between physicians and nurses limited the successful application of shared governance. Designation of magnet status for one hospital stimulated dialogue on professional practice (Barney, 2002). Inconsistent implementation across organizational units limits understanding of accountability and decision-making processes (DiMeglio et

al., 2005; Jackson, 2000). Shared governance creates a collaborative work environment that increases the leadership ability of staff members while forming a cohesive community-of-practice that supports the growth and empowerment of all members (Moore & Hutchison, 2007; Parsons, 2004).

Collaboration. A partnership model engages staff members in changing processes by increasing autonomy and supporting the development of practice initiatives (Schryer, 2004; Thompson et al., 2004). The integration of new unit members based on communicative processes encourages knowledge acquisition, stabilizing team approaches to care delivery (Prince, 1997). New team members, educational challenges, and process problems trigger the development of a transition team (Dunbar et al., 2007). Coordination of processes allows standardization of professional practice and research-based initiatives to guide successful governance (Miller & Anderson, 2007).

Shared governance structures at one organization lacked consistent communication processes because of different levels of participation (Golanowski et al., 2007). Prince (1997) and Brooks et al. (2007) determined that increased participation in workplace decisions increased nurse satisfaction. Armstrong and Laschinger (2006) found that nurse/physician collaboration lacked significance when ranking the relationship between structural empowerment, magnet characteristics, and the existence of a patient safety culture. A transition from a nursing to an interdisciplinary model duplicates committees, limiting effectiveness (Golanowski et al., 2007).

Schryer (2004) and Brooks et al. (2007) showed that the rollout of a new leadership model and shared governance increased intent to stay. Decreases in work satisfaction resulting from organizational change limit buy-in (Martin, Gustin, Uddin, &

Risner, 2004). Team efforts target education and communication in the evaluation and support of council processes (Dunbar et al., 2007). Professional practice, demonstrated by commitment, autonomy, socialization, involvement, and responsibility, determines the successful implementation of shared governance on some units compared to other units (Carroll & Arneson, 2003; Hess, 1998).

Conflicted results (Anthony, 2004; Bartunek et al., 2006; Hall, 2007; Hess, 1998) since the inception of shared governance frameworks induced researchers to pursue further evaluations. Williamson (2005) found that barriers to shared governance implementation included lack of systematic processes for project generation, lack of consistent feedback for project progress, lack of standardized educational training, and lack of effective leadership coaching and mentoring. The collaborative processes of a shared governance model support the development of leadership, professional practice based on evidence, cohesive organizational cultures, and quality service provision (Hilburn et al., 2006; Schryer, 2004). Keys to successful shared governance include empowerment (Attree, 2005; Edmonstone, 2000), leadership (Carroll & Arneson, 2003; McGoldrick et al., 2001; Porter-O'Grady, 1994), and participation (Bartunek et al., 2006; Kennerly, 1996) to develop professional practice (Hess, 2004; Moore & Hutchison, 2007; Porter-O'Grady & Finnigan, 1984).

Conclusion

The conceptual framework of the current research study included Wenger's community-of-practice perspective, Porter-O'Grady and Finnigan's shared governance perspective, and Habermas' theory of communicative action as a means to represent the individual, the organization, and society. The topic of the research study was leadership

development during change as reflected in the present healthcare environment. A redesign of healthcare practices and processes to meet quality service delivery requirements challenges healthcare organizations to seek new solutions through research (Horton et al., 2007; Prybil, 2003; Rundall et al., 2007). The literature review included elements of the conceptual framework that have significance for healthcare organizations and leadership.

Social cognitive theory (Wood & Bandura, 1989) pertains to the connection of performance, personal goals, self-efficacy, and analytic strategies to the workplace. Identity theory (Nario-Redmond et al., 2004; Sluss & Ashforth, 2007; Stewart et al., 2004; Stryker & Burke, 2000) concerns the role of individuals from a personal, societal, and workplace perspective. Habermas (1981/1984, 1981/1987) examined the structure of society by showing the limitations of bureaucracy (Parkin, 1996) and the ability of individuals to expand through linguistic communication toward full involvement in society (Habermas, 1981/1984, 1981/1987). Individuals' autonomy through communicative action demonstrates a way to integrate change into the normative, objective, and subjective worlds (Chriss, 1995; Foster & Jonker, 2005; Habermas, 1981/1984, 1981/1987).

A focus on changing the practice environment (Hoffman et al., 2005; Morgan & Ogbonna, 2008; Smollan, 2006; Williams, 2006) targets the culture of the organization (Buchanan, 2003; McKenna, 1992; Natarajan, 2006; Yemm, 2007). Organizational culture (Pillay et al., 2003; Savolainen, 2000) supplies the ingredients in the organization that need melding, altering, and aligning. Organization and groups detail the strategic benefit of group formation and collaboration (Carney, 2004a, 2004b; Martin et al., 2005;

Slater, 2006). A community-of-practice approach to organizations (Wenger, 1998) generates a sense of belongingness as the central ingredient in the development of environments of care, connecting professional practice to the workplace.

Changing healthcare environments prompted the need for participative communities-of-practice (Tilley, 1999; Whitehead, 2006). Earlier leadership development efforts aligned the type of leader with specific leadership traits and qualities (Barbuto, 2005; Felfe & Schyns, 2004). Researchers (Cain, 2005; Higgs & Rowland, 2005; Leslie et al., 2006; Österberg, 2004; Rafferty & Griffin, 2006; Spinks & Wells, 1995; Stewart & Kringas, 2003) believed leadership style influenced the culture of the organization and the development of new leaders. An exploration of leadership models provided a framework for leadership development.

Effective nurse managers require ongoing leadership development to manage the evolving requirements for excellence in service provision (Bowles & Bowles, 2000; Duffield, 2005; Scoble & Russell, 2003; Sullivan et al., 2003). Researchers (Lin et al., 2007; Mathena, 2002; Sanders et al., 1996; Shivers-Blackwell, 2004; Wicks & St. Clair, 2007) determined that nurse manager skills and competencies varied because of lack of standardized practice frameworks and standards. Shared governance provides a means for reworking the practice environment (Hess, 2004; Parsons, 2004; Porter-O'Grady, 1994; Porter-O'Grady & Finnigan, 1984). The purpose of the review of literature was to present theoretical foundations, organizational foundations, and leadership foundations as a bridge to developing a wider picture of the healthcare organization and change.

Summary

Reviews (IOM, 2000, 2001, 2004) of healthcare in America targeted a need for system change (Waldman et al., 2003). Effective change efforts in healthcare are based on an analysis of present organizational cultures and environments (Higgs & Rowland, 2005; Meynell, 2005; Morgan & Ogbonna, 2008), the development of processes to communicate change efforts (Carney, 2004b; Smith, 2003), and a transformation of the environment of care to reflect the needs of organizations and the global healthcare context (Anderson et al., 2007; Porter & Parker, 1992; Prybil, 2003). Leadership, organizational culture, and service environments align to provide a comprehensive approach to healthcare delivery (Kammerlind et al., 2004; Naude & McCabe, 2005). A lack of focused leadership development at the practice level challenges the sustainability of change efforts in healthcare (Block & Manning, 2007; Edmonstone & Western, 2002; Prybil, 2003; Ulrich et al., 2005).

The purpose of the review of literature was to show the complexity of the organizational environment. Theoretical perspectives align the cognition of the individual with environment, culture, and society. Organizational perspectives in the review included characteristics of change, groups, culture, and environment. Leadership perspectives pertained to leadership models, the role of the nurse manager, and shared governance.

The purpose of the research study was to explore the leadership development of nurse managers in a changing organization. The primary research question asked, How does leadership develop in a changing organization? Secondary research questions included the following:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

Chapter 2 provided connections between previous research in the literature and the conceptual framework and research questions of the study. Chapter 3 includes the research methodology with an inclusive description of the qualitative case study approach as it relates to the research questions.

CHAPTER 3: METHOD

The literature review presented in chapter 2 consisted of peer-reviewed research detailing aspects of identity, culture, environment, organizations, and roles for the purpose of the current study. The purpose of the qualitative case study was to determine how leadership developed in a changing healthcare environment. Leadership in healthcare evolved from various perspectives, orientations, and paradigms relevant to the educational, societal, and professional background of individuals (Alarcon et al., 2002; Block & Manning, 2007; McAlearney, 2006). Healthcare organizations have started to shift from a hierarchical to patient-focused service delivery. The shift created a need to change leadership approaches (Länsisalmi et al., 2006).

Fragmentation of leadership development approaches in nursing highlights the need to develop specific models incorporating the unique qualities of nursing leadership (Block & Manning, 2007; Millward & Bryan, 2005; Wiggins, 2006). Guiding the research study was the following question: How does leadership develop in a changing organization? Subquestions targeting the leadership development of nurse managers were as follows:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

The research questions addressed the development of leadership in a changing healthcare environment in which healthcare leaders experience complex challenges.

The qualitative case study approach provided an opportunity for first-tier leaders to express their perspectives as they experienced the changing healthcare environment.

Chapter 3 begins with a detailed description of the qualitative case study process followed by the rationale for the design selection and its appropriateness to fulfill the goals of the research. The chapter includes details of the sampling procedure, consent and confidentiality issues, the study location, and the data collection and analysis processes. The chapter concludes with a discussion of issues of validity and reliability in qualitative research, followed by an overview of significant key points.

Research Design and Design Appropriateness

Research Design

Baldwin (2008) stated, "The foundation of any research is its design" (¶ 1). The creation of new knowledge necessitates a choice of research design and the specific research methods characterizing the selected design (Neuman, 2003; Pelit & Huault, 2008; Woodside & Wilson, 2003). Researchers differentiate between types of inquiry, the degree of control over variables and processes, and the contemporary as opposed to historical perspective (Yin, 2003). Rowley (2004) maintained good research added to existing knowledge, demonstrated clarity of purpose, showed objectivity and reliability, and revealed ethical, political, and access-related considerations and affiliations.

Singleton et al. (1993) defined science as knowledge developed through research. Active involvement of investigators in their field of interest generates data reflecting knowledge-gained experience in the context of the chosen research method (Patton, 2002; Pelit & Huault, 2008). A connection with the reader through a research design encourages knowledge generation (Hesse-Biber & Leavy, 2004; Pelit & Huault, 2008). According to Creswell (2005), the development of knowledge improves the practice of the professional.

Design Appropriateness

The selection process between quantitative and qualitative approaches starts with the identification of a specific topic narrowed to a manageable perspective (Hesse-Biber & Leavy, 2004; Singleton et al., 1993). Quantitative researchers focus on the identification of relationships among variables. The focus of quantitative study designs is control of variables, a reliance on statistical grounding, and the connection of data to logical reasoning with the use of quantification (Singleton et al., 1993). Cooper and Schindler (2003) associated quantitative inquiry with a problem-based scientific method supporting a decision-based approach to data collection, analysis, and display.

Grbich (2007) proposed the study of biopsychosocial models of nursing practice called for realism (i.e., positivism). Rubin and Rubin (2005) believed the positivist approach was restricted to the investigator's worldview. Flesher (1997) argued that research collaboration with the field professional enhanced the capacity of academics to educate future professional leaders. The complexity of organizational studies limits the ability to determine specific variables and to manipulate individual elements of the environment (Jean Lee, 1992; Pelit & Huault, 2008). A quantitative research design would not have been appropriate for the current research study because of lack of previous knowledge of the specific variables related to how first-tier leaders develop in a changing healthcare environment.

Qualitative inquiry was appropriate to guide the current research study and discover how leadership developed in a changing organization. Creswell (2005) defined qualitative research as exploratory and creating understandings. Qualitative inquiry supports building upon past research to increasing knowledge (Guba & Lincoln, 2004;

Pelit & Huault, 2008; Woodside & Wilson, 2003). Patton (2002) described qualitative inquiry as an evolving process that supports the interaction of researchers with the collection of data from interviews, observations, and documents.

The development of a new leadership role in one organization is an opportunity for knowledge generation through qualitative inquiry (Pelit & Huault, 2008). Arminio and Hultgren (2002) offered qualitative research criteria included connecting methodology with the "representation of voice (researcher and participant) . . . the art of meaning making (interpretation and presentation) . . . and the "implication for professional practice (recommendations)" (¶ 18-24). Patton (2002) stated qualitative research must include "rigorous methods", "credibility of the researcher", and "philosophical belief in the value of qualitative inquiry" (pp. 552-553). An important element of qualitative inquiry is the interaction of researchers with research participants.

Greenwood and Lowenthal (2005) and Pelit and Huault (2008) encouraged immersion into the textual language of the participants to create understandings and meanings. Sailor and Paul (2004) recommended focusing on understanding the deep textures discernible in the voices of participants. A focus on cultural dimensions (Hooks, 2004) strengthens diversity in research. Qualitative inquiry includes narrative, ethnography, and case study research to demonstrate voice (Rubin & Rubin, 2005).

Narratives and ethnographies provide only the perspective of the participants, limiting application to organization studies (Patton, 2002). Cooper and Schindler (2003) stated, "Case studies place more emphasis on a full contextual analysis of fewer events or conditions and their interactions" (p. 150). The case study design supported the in-depth inquiry into the leadership development of nurse managers in a changing organization.

The study was conducted to understand the perspectives of multiple participants, using the case study design.

Case Study Method

A case study approach targets people and critical incidents or events as research focus (Patton, 2002). Singleton et al. (1993) defined case study research as the study of "a single social phenomenon or unit of analysis" (p. 317). Creswell (2005) stated case study research was intrinsic (i.e., unusual) or instrumental (i.e., insightful). Case studies (Morra & Friedlander, n.d.; Riege, 2003) require depth of research-based inquiry to justify single populations or sites.

Cooper and Schindler (2003) identified case study research as "reporting, descriptive, explanatory, or predictive" (p. 10). Yin (2003) maintained case study research was "inclusive and pluralistic," (p. 3) allowing the use of exploratory, descriptive, and explanatory strategies in the same study (Anderson et al., 2005; Yin, 2003). Case study research includes explanatory, descriptive, or cumulative formats combining descriptive, normative, and causal methods of inquiry (Morra & Friedlander, n.d.). The case study approach includes description, understanding, prediction, or control to elicit knowledge from the participants and researchers through sense making (Woodside & Wilson, 2003).

Exemplary case studies (Yin, 2003) contain elements of significant interest or importance such as clearly defined case and research boundaries, discussion of alternative perspectives and paradigms, sufficient, critical, contradictory, and conclusive display of evidence, and a clear, confident, and engaging writing style. Singleton et al. (1993) stressed the importance of designing the case study to collect data specific to the unit of

analysis. Identification of the unit of analysis results from defining and narrowing the research topic and questions, reviewing previous research and literature, visualizing limitations connected with the research study, and confirming research direction during data collection (Yin, 2003). The unit of analysis for the current study was the individual nurse manager.

Yin (2003) designated the case study as appropriate for *how* questions. The question, How does leadership develop in a changing organization, determined the research design in the current study. Providing a richness of descriptive data (Creswell, 2005; Hesse-Biber & Leavy, 2004; Woodside & Wilson, 2003; Yin, 2003), the qualitative case study process helped answer the *how*, *why*, *who*, and *what* questions of leadership development during change in a healthcare organization. The backgrounds, perceptions, and experiences of each nurse manager provided a basis for comparison with qualitative research techniques to supply the perspectives of professionals (Meadows, 2003).

The goals for the research study included exploring the change process as it relates to leadership development, show the relationship between leadership development processes and perceived growth as leaders, and determine the role of leadership in developing environments of care that supported excellence in service provision. Leadership development processes emerge from healthcare research (IOM, 2001). The current research study contributed to the knowledge base on healthcare leadership development. The choice of a qualitative case study format was appropriate for the research purposes of the study.

Feasibility of Design

A qualitative case study design requires adequate planning to enhance the reliability of the study (Creswell, 2005; Riege, 2003; Yin, 2003). Planning includes development of a case study protocol and an interview guide (Rubin & Rubin, 2005; Yin, 2003). Qualitative methods of interviewing and analysis allow for the retrieval of information from many perspectives with learning and knowledge enhanced by the repeated review of data (Pelit & Huault, 2008; Rubin & Rubin, 2005; Seidman, 2006; Yin, 2003). In the current study, the use of two in-depth interviews for each study participant enabled the adjustment of study questions and interviewing techniques for a comprehensive data collection process.

Sampling Frame

The purpose of the case study was to discover how leaders develop in a changing healthcare organization. The case study approach to qualitative research facilitates the exploration of the experiences of a particular group of individuals (Patton, 2002). The qualitative approach embodies a holistic perspective encompassing each individual as part of a specific group as well as separate units of analysis (Hesse-Biber & Leavy, 2004; Singleton et al., 1993; Yin, 2003). Criteria for purposeful sampling include the uniqueness of a case, a need for specific information, and a need for a specific population (Creswell, 2005; Neuman, 2003).

Effective leadership at the practice level is necessary to the development of environments of quality (IOM, 2001). Purposeful sampling guided the selection of nurse managers at one mid-size community hospital in suburban New York State as the target population. The role change from staff nurse to nurse manager created a group of

individuals specific to one organization. The importance of the research topic consisted of the collective value (Gould et al., 2001; Mathena, 2002; Wong, 1998) of the group of individuals essential to the smooth functioning of the healthcare organization.

Purposeful sampling in qualitative research supports comprehensive data collection to obtain depth in information (Creswell, 2005; Patton, 2002). The case study approach to research was appropriate when using one organization for the setting of the study. Inclusion criteria were at least 1 year tenure in the nurse manager position and no previous experience in the nurse manager role. Access approval by the associate executive director of nursing services was obtained in 2007 (see Appendix D). The research approval process included the following steps: (a) chairperson and committee acceptance, (b) academic research board acceptance, (c) institutional research review board acceptance (see Appendix I), and (d) academic dean acceptance.

Informed Consent

Informed consent was a two-step process that included providing information about the study and detailing the possible risks of the study to the participants. The goals for the research included exploring the change process pertaining to leadership development, showing the relationship between leadership development processes and perceived growth as leaders, and determining the role of leadership in developing environments of care that support excellence in service provision. The use of a purposeful sampling strategy generated four nurse managers in one mid-sized community hospital.

A comprehensive statement of research intent created a clear description of the research study for each participant (Seidman, 2006). The informed consent form (see Appendix D) included several informative statements for the participants. The topics

included (a) the research goals, (b) the purpose of the specific investigation, (c) the anticipated duration of interviews, (d) full disclosure of risks and benefits of the research study, (e) the level of confidentiality, (f) contact information, and (g) explanation of voluntary participation (United States Department of Health & Human Services [USDHHS], 2005).

The awareness that voluntary consent was a primary concern in the research process guided the relationship between participant and investigator (Rubin & Rubin, 2005). Solicitation for the research study by e-mail consisted of a letter of request for participation (see Appendix H). Participant acceptance occurred with the return of an e-mail reply to the solicitation letter. The e-mail communication included the scheduling of interviews with each accepting nurse manager.

Confidentiality

Confidentiality in qualitative research pertains to the dialog between participant and researcher concerning the degree of anonymity in the research study (Rubin & Rubin, 2005; Seidman, 2006). Each interview session began with a review of confidentiality, anonymity, and voluntary participation. Each participant in the interviews received an identifier from 1a to 4b. Pseudonyms replaced identifiable names, organizations, and settings, preserving dialogic flow during the in-depth interviews (Rubin & Rubin, 2005).

The signed consent form included an acknowledgment that participants agreed to the audio recording of each interview. The research participants scheduled each interview at their convenience by e-mail. E-mail communication through the password-protected computer assured the confidentiality of the transcribed audio-recorded interviews. A

contract with a transcription company (see Appendix F) assured the confidentiality of the research data and anonymity of the research participants.

Auto-recordings, paper copies of transcripts, and consents were stored in a locked storage box in the investigator's home office. All audio-recorded data, research notes, and transcripts were stored in a password-protected computer, separated from identifiers. Access to the research data and files in the password-protected computer and the locked storage box was strictly limited. The study results are presented in chapters 4 and 5 without identifiers.

Geographic Location

The healthcare organization under study was a mid-sized community hospital in suburban New York State, in the United States of America. One assumption of the research study was that the community hospital was representative of other suburban mid-sized community hospitals in the United States.

Instrumentation

In qualitative inquiry, investigators are the instrument essential to the collection and analysis of research data (Patton, 2002; Pelit & Huault, 2008). In the current study, qualitative inquiry expanded the scope of the research design to incorporate perspectives emerging from the relationship of investigator and participant (Grbich, 2007; Miller & Crabtree, 2004; Patton, 2002; Pelit & Huault, 2008; Rubin & Rubin, 2005). Two in-depth audio-recorded interviews carried out with responsive interview techniques elicited the perspectives of the participants (Miller & Crabtree, 2004; Rubin & Rubin, 2005). Reflective and descriptive research notes provided the investigator's perspectives

(Creswell, 2005; Hand, 2003; Patton, 2002). Document review of director/nurse manager meeting minutes provided organizational data.

Data Collection

"The research process begins with conscious and unconscious questions and assumptions that serve as the foundation for an epistemological position" (Rubin & Rubin, 2005, p. 2). The central research question asked, How does leadership develop in a changing organization? The following two sub questions guided the research and supported the use of qualitative inquiry:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

Purposeful sampling generated a population of nurse managers in one organization for a case study research design. The concept of each individual nurse manager as a unit of analysis corresponded with the single case study approach (Yin, 2003).

Patton (2002) stated, "Well constructed case studies are *holistic* and *context sensitive*" (p. 447). According to Barbour and Barbour (2003), "As the focus of most qualitative research is on issues that are salient for respondents, it is impossible, at the outset, for the researcher to determine the precise content and scope of the data to be generated" (¶ 5). Yin (2003) recommended that a case study protocol (see Appendix C) guide the inquiry with the discovery of corroborative evidence significant to the research process. The case study protocol in the current research included project overview, field procedures, case study questions, and a guide for the case study report.

The purpose of the qualitative case study was to determine how leaders develop in a changing healthcare environment. The data collection strategy consisted of conducting two audio-recorded in-depth interviews. An interview guide (see Appendix G) supplied a framework to explore the experiences of the nurse managers. Descriptive and reflective research notes provided data from the investigator's perspective (Creswell, 2005; Hand, 2003; Pelit & Huault, 2008; Schutz, 1994). Document review of director/nurse manager meeting minutes included organizational data.

Data Collection Tools

Qualitative interview. "The interview gives individuals appropriate outlets through which their experiences and thoughts can be shared with others in meaningful interactions" (Cisneros-Puebla, Faux, & Mey, 2004, ¶ 5). Interviews conducted in the environment of the participant present unique opportunities and obstacles specific to each participant (Singleton et al., 1993). Meadows (2003) described, "Structured, semi-structured, and in-depth" (¶ 11) interviews as the three major types of qualitative research instruments. Cooper and Schindler (2003) proposed the types of question structured the interview process.

Case study research requires "flexibility" and "adaptability" (Yin, 2003, p. 60). Rubin and Rubin (2005) encouraged the qualitative interview to contain "depth and detail," "vividness," "nuance," and "richness" (pp. 129-134) with the use of an interview guide. Responses to open-ended questions encourage the generation of conversation between researchers and participants (Creswell, 2005). W. L. Miller and Crabtree (2004) stated that in-depth interviewing consisted of open-ended questions.

The qualitative case study design required an in-depth interview method. The interviews in the current study (Guba & Lincoln, 2004) provided a time-limited approach to exploring the leadership development of the nurse managers as the topic of interest. Looking for the meanings behind the *how*, *what*, *when*, and *why* questions, the use of in-depth interview techniques provided both concrete and abstract understandings of the layered interactions in organizational environments (Pelit & Huault, 2008; Rubin & Rubin, 2005; Singleton et al., 1993; Yin, 2003). The approach facilitated the emergence of connections, perceptions, impressions, and understandings through the interview process, providing rich, thorough, and credible descriptive data (DiCicco-Bloom & Crabtree, 2006; Patton, 2002; Yin, 2003) on the leadership development of nurse managers in a healthcare organization during change.

The choice of two in-depth interviews with each participant created a discursive component that bridged the gap between conversation and formal interview. A two-interview approach provided a complete coverage of the research goals without overwhelming the participants with an extended interview process (Hesse-Biber & Leavy, 2004; Rubin & Rubin, 2005). A three-interview approach as recommended by Seidman (2006) would have increased the complexity of the research study and limited the number of participants because of time restrictions in the workplace. The two-interview design of the current research study helped alleviate discomfort and achieve concordance.

Interview guide. An investigator-prepared interview guide (see Appendix G) combined initial demographic and topic questions, open-ended questions, semi-structured questions, follow-up questions, and prompts (Miller & Crabtree, 2004; Rubin & Rubin,

2005). The background questions were used at the beginning of the interview. The main questions generated descriptive data and gave direction to the interview toward “details, depth, vividness, and nuances” (Miller & Crabtree, 2004, p. 193) with follow-up questions and prompts. General topics for questions incorporated key findings, themes, and concepts from the literature review, the conceptual framework, and the study goals (Miller & Crabtree, 2004; Patton, 2002; Rubin & Rubin, 2005).

The participants' responses to topic questions supported use of interview techniques to promote the free flow of conversation. Semi-structured interview questions within the context of an interview guide created dialog, generated discourse, and allowed versatility of response in the qualitative study (Hesse-Biber & Leavy, 2004; Singleton et al., 1993; Yin, 2003). The perception of “guided conversations” (Yin, 2003, p. 89) instead of formalized interviews emphasizes the need for researcher flexibility. W. L. Miller and Crabtree (2004) maintained that multiple roles inherent in the structures of society influence individuals' perspectives and contribute to the complexity of the interview process.

Rubin and Rubin (2005) defined the interview guide as a conversational construct. As an outline (see Appendix G) detailing suggested topics, questions, prompts, and probes into areas of concentration, the interview guide in the current study helped keep the interview focused on the research goals. Qualitative inquiry methods support the expansion of the interview guide (DiCicco-Bloom & Crabtree, 2006). The use of two in-depth interviews for each participating nurse manager supported a systemic data collection process through the framework of the interview guide.

Investigator notes. Yin (2003) depicted investigator notes as peripheral to data analysis and stated, "[Notes must] be organized, categorized, complete, and available for later access" (p. 103). Notes include detailed field observations (Grbich, 2007). Koch and Harrington (1998), using critical feminist theory, "contend[ed] that researchers bring to the research project the following: a range of literature; a positioning of this literature; a positioning of oneself; and moral socio-political contexts" (¶ 38). Qualitative inquiry supports the use of conversational, observational, and reflective notes to document the perspective of the investigator (Creswell, 2005; Grbich, 2007; Neuman, 2003; Patton, 2002; Pelit & Huault, 2008; Yin, 2003).

Descriptive and reflective notes combined research observations and personal perceptions expand the research interview beyond textual conversations (Chiu, 2006; Creswell, 2005; Hand, 2003; Pelit & Huault, 2008; Schutz, 1994). Phenomenological note taking consists of journaling to include the investigator in the research study (Sjöström & Dahlgren, 2002). Note taking in the case study (Rubin & Rubin, 2005; Yin, 2003) provides a venue for observations and reflection. The current case study included descriptive and reflective research notes.

Descriptive research notes (Creswell, 2005) documented facial expressions, movements, and gestures of participants. The audio recording of the in-depth interviews provided information such as interview interruptions, technical difficulties, communicative patterns, and distractions (Denzin, 2004; Miller & Crabtree, 2004). Reflective notes contained comments on the content of the interview, questions for data collection and analysis, and personal thoughts (Chiu, 2006; Creswell, 2005; Hand, 2003;

Schutz, 1994). Brannick and Coghlan (2006) described the use of reflexivity in research notes as a means of connecting to the research study, confirming reliability and validity.

Cooper and Schindler (2003) stated, "An emphasis on detail provides valuable insight for problem solving, evaluation, and strategy" (p. 150). The current research included note taking (Rubin & Rubin, 2005; Yin, 2003) as a tool to avoid interrupting the participants and as a valued adjunct to the research process. The audio recording of interviews allowed review of the data after the interviews were completed. A two-step interview process allowed note taking to contribute to the planning process as well as provide depth to the spoken word.

Document review. Archival documents provide data and information pertinent to the topic of a study (Creswell, 2005). White and Marsh (2006) discussed the need for data to align with the research questions. Yin (2003) warned, "Every document was written for a specific purpose and some specific audience *other than* those of the case study being done" (p. 87). Patton (2002) discovered that valuable insights emerged from the comparison of organizational records and the recollections of organizational members concerning actual meetings.

The current study included director/nurse manager meeting minutes from the target organization from January 2005 to January 2009. Archival documents provided information to complement the interview data (Singleton et al., 1993). The inclusion of documents supports the validity of the research study (Patton, 2002). Multiple sources of data demonstrate construct validity (Yin, 2003).

Minutes from the director/nurse manager meetings connected internal processes of the organization to the interview data. Document review of the minutes occurred after

the completion of the interviews. An awareness of the limitations of available data guided the use of the archival material. A critical review of the minutes facilitated evaluating the connection of the data to the in-depth interview data, the case study protocol, and the goals of the research study.

Data Collection Process

Each interview session began with a discussion on confidentiality, anonymity, and voluntary participation and a review of informed consent. The purpose of the study was explained to each participant who had an opportunity to ask questions or decline to participate. Each participant interview was assigned a coded identifier from 1a to 4b.

In an e-mail communication, the participants determined the setting, time, and date of each interview. Each in-depth interview was audio-recorded as stipulated in the informed consent. The participants had the opportunity to review and adjust their individual transcripts for accuracy after each interview (Holloway & Fulbrook, 2001; Rubin & Rubin, 2005; Seidman, 2006; Yin, 2003). Secondary techniques included descriptive and reflective research notes and document review of director/nurse manager meeting minutes.

In-depth interviewing captured the experiences of the individuals through the lens of the self instead of the investigator's understandings. Listening and interviewing skills are conducive to creating a dialog from the emerging content of the interview (Miller & Crabtree, 2004; Rubin & Rubin, 2005; Seidman, 2006; Singleton et al., 1993). Successful in-depth interviewing necessitates specific skills and a protocol developed to guide the research study (Rubin & Rubin, 2005; Yin, 2003). In the current study, a case study

protocol (see Appendix C) and an interview guide (see Appendix G) supported the data collection process.

First interview. To obtain candor responses, all parties must be comfortable with the interview process. The following demographic questions provided an opportunity for the development of rapport (Miller & Crabtree, 2004; Patton, 2002; Rubin & Rubin, 2005; Seidman, 2006):

1. How long have you been a nurse manager?
2. What has been your educational background?
3. How long have you been in nursing?
4. Why did you decide to become a nurse?
5. What type of nursing have you practiced?

The demographic portion of the interview was limited to 15 minutes.

The next section of the interviews was based on the interview guide as a resource to begin each conversation segment. To generate dialog, the first topic open-ended question asked, Please describe what it means to be a nurse (Patton, 2002; Rubin & Rubin, 2005). The topic questions (see Appendix F) were the same for each participant. The emerging interview content questions demonstrated flexibility in eliciting varied perceptions, experiences, and perspectives from each nurse manager (Patton, 2002; Rubin & Rubin, 2005; Seidman, 2006; Yin, 2003).

The audio-recorded participant interviews lasted no more than 60 minutes. The first stage of the interview process took place over a 2-week period. Descriptive and reflective notes were written during each interview session. A notebook was used for recording descriptive and reflective notes.

Opposing pages in the notebook were labeled descriptive notes and reflective notes. Each page was labeled with the interview identifier for each participant. The descriptive and reflective research notes were transcribed from the notebook to a document in the password-protected computer within 48 hours of each interview.

Interview interval. Patton (2002), Rubin and Rubin (2005), and Seidman (2006) recommended the interval between interviews be used to organize collected data, type research notes, formulate follow-up questions, and review for missing data. The audio recording was sent electronically to the contracted transcription service after initial review. Each transcribed interview session was authenticated by listening to the audio recording with corrections inserted while verifying accuracy.

A review of the first interview supplied areas needing further clarification related to gaps in data, undefined words and phrases, alternate explanations, implied concepts, and partial or missing answers to questions (Rubin & Rubin, 2005). Descriptive and reflective research notes added insight, knowledge, perception, and perspective (Creswell, 2005; Hand, 2003; Miller & Crabtree, 2004; Patton, 2002). A table was created using concepts and categories from the conceptual framework, questions, and topics. The interview guide was revised based on this preliminary analysis of the first interview transcripts.

Second interview. Second interviews in qualitative inquiry provide the opportunity to follow-up on significant and divergent concepts, topics, themes, meanings, and statements (Patton, 2002; Rubin & Rubin, 2005; Seidman, 2006). The second stage of the interview process occurred over another 2-week period. Each participant's second interview began with a review of the research purpose, confidentiality process, and last

interview endpoints. The use of the revised interview guide provided a framework for the completion of the interview process.

At the end of the second interview, the participants received a copy of the transcript for the first interview with thanks for contributing to the research endeavor. The question, Is there anything else that you wish to share with me, closed the interview. A review of pertinent points for each participant included providing an estimated time of study completion, confirming that a copy of the second interview transcript was sent electronically before to final data analysis, emphasizing removal of identifiers during data analysis, and offering a copy of the completed dissertation.

The two-step interview process generated large amounts of rich data with the comprehensiveness needed for a thorough qualitative analysis (Hesse-Biber & Leavy, 2004). Descriptive and reflective research notes were transcribed from the notebook to a document in the password-protected computer within 48 hours of each interview. Additional reflective research notes were written and transcribed during each phase of the research process. The additional reflective research notes were categorized by date and task and were kept separate from participant interview notes.

Document review. The director/nurse manager meeting minutes provided data concerning the healthcare organization. Copies of the meeting minutes were saved into the password-protected computer, and data analysis of organizational documents occurred after the analysis of the interview data. A review of each document added confirmatory information concerning the perspectives of the participants. Integrating qualitative inquiry with observation, analysis, and reflection, in-depth interviewing combined the spoken word with researcher notes and document review for a

comprehensive approach to data collection (Creswell, 2005; Miller & Crabtree, 2004; Yin, 2003).

Data Analysis

Qualitative data analysis involves "reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and constructing a framework for communicating the essence of what the data reveal" (Patton, 2002, p. 432). Pelit and Huault (2008) and Yin (2003) recommended the use of strategies for in-depth data analysis. The strategies for the current case study included "relying on theoretical propositions" (Yin, 2003, p. 111) and "thinking about rival explanations" (p. 112). Priest et al. (2002) and Patton highlighted the use of the interview guide in data analysis and pattern construction. The study included cross-case analysis (Riege, 2003; Yin, 2003) with the interview guide and the conceptual framework (Smyth, 2004), providing structure for data analysis.

Rubin and Rubin (2005) recommended conducting data analysis in phases consisting of recognizing importance, defining concepts, explaining themes, targeting events, and marking data connections. A starting point for qualitative data analysis consists of identifying concepts and categories from the interview guide (Patton, 2002; Woods, Priest, & Roberts, 2002) and conceptual framework (Smyth, 2004) to develop connections to the data (Riege, 2003). A table created during preliminary analysis provides support for data input during the initial phase of data analysis. In the current study, in-depth data analysis occurred after participant verification of interview transcripts.

Stage 1

Qualitative data analysis involves "reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and constructing a framework for communicating the essence of what the data reveal" (Patton, 2002, p. 432). The present research study involved connecting the conceptual and theoretical foundations of shared governance, community-of-practice, and the theory of communicative action to the collected data. Pattern matching consists of sorting the interview data by question, topic, concept, and category, using manual and computer-assisted collating (Rubin & Rubin, 2005; Yin, 2003). Reflective research notes provide the perspective of the investigator.

Stage 2

Pattern matching and theme development provides a connection to the concepts and theories in the conceptual framework and the literature reviewed (Patton, 2002; Riege, 2003; Smyth, 2004; Woods et al., 2002; Yin, 2003). The development of rival explanations consists of using the same connections to support divergent data results (Patton, 2002; Yin, 2003). The Qualrus computer software was used in the second and third phases of the research analysis process. The qualitative data analysis tool speeded the research analysis process without introducing extraneous data and information by organizing patterns with word processing techniques (Hesse-Biber, 2004; Rubin & Rubin, 2005; Yin, 2003).

Once the data were organized, theoretical and conceptual connections occurred. The identification of patterns generated a structure for the development of themes integrating previous theory, knowledge, literature, and insights from the literature review

and the conceptual framework (Seidman, 2006). The retrospective approach to the case study allowed a chronological comparison (Yin, 2003) of each nurse manager's recollection of common events, creating an opportunity to display similar and divergent perceptions. The director/nurse manager meeting minutes aided in connecting the interview data to the nurses' recollections.

Stage 3

The building of the qualitative data set consisted of a process of simultaneous data collection and analysis (Creswell, 2005). Interpretation was based on theory and reflexivity to support the development of perspective (Creswell, 2005; Johnson, 1997; Patton, 2002; Savin-Baden, 2004). Pelit and Huault (2008) and Neuman (2003) described the data interpretive process as developing meaning from the perspective of the participants, reconstructing meaning from the perspective of the investigator, and assigning theoretical meaning to provide significance. Reflective research notes aided with the interpretation of such relationship (Denzin, 2004; Hesse-Biber & Leavy, 2004; Schutz, 1994).

R. Johnson and Waterfield (2004) submitted the qualitative research process resonated with a transparency created by incorporating data collection, analysis, and interpretation with descriptive reflexivity. Pelit and Huault (2008), Patton (2002), and Hesse-Biber and Leavy (2004) recommended that qualitative inquiry go beyond analysis, interpretation, and reporting of findings. Voice, reflectivity, and questioning build on contexts, understandings, and meanings (Grbich, 2007; Savin-Baden, 2004; Schutz, 1994). The third stage of research analysis was based on questions to expand data analysis. The questions included the following:

1. What is the meaning of the study data?
2. In what way do the data connect to the participants?
3. In what way do the data connect to the investigator?
4. In what way do the data connect to the study audience?
5. In what way do the data connect to the practice environment?
6. In what way do the data connect to leadership?

Interpretive analysis brought the perspective of the study audience into the research data set (Patton, 2002; Savin-Baden, 2004). The addition of descriptive and reflective research notes to the last phase of data analysis provided the perspective of the investigator. Interview data contained the perspective of the participants. The review of nurse manager/director meeting minutes connected organizational data to the participants. The research study on leadership development of nurse managers in a changing organization generated the perspectives of the nurse manager, the investigator, and the study audience into a comprehensive approach to data analysis and interpretation.

Validity

Qualitative research studies belong to the conceptual, methodological, and substantive domains (Brinberg, 1982; Pelit & Huault, 2008). R. B. Johnson (1997) focused on descriptive validity, interpretive validity, and theoretical validity as means to strengthen qualitative research studies. Maxwell (1992) submitted that descriptive validity, interpretive validity, theoretical validity, generalizability, and evaluative validity provided a construct that suited qualitative inquiry. “Validity is part of a dynamic process that grows by accumulating evidence over time” (Neuman, 2003, p. 182).

Research studies progress from idea generation to result presentation, showing stability and quality with construct, internal, and external validity (Riege, 2003). Whittemore et al. (2001) stated, "Assuring validity becomes the process whereby ideals are sought through attention to specified criteria, claims to knowledge are made explicit, and techniques are employed to address the most pressing threats to validity for each type of inquiry" (¶ 23). Patton (2002) put forth that case study research with in-depth interviewing provided a venue "to achieve empathy and give the researcher an empirical basis for describing the perspectives of others," (p. 53) increasing relevance and validity. Yin (2003) stated construct validly, internal validity, external validity, and reliability applied to case study research.

Construct Validity

"Construct validity is based upon an accumulation of research evidence and not on mere appearances" (Singleton et al., 1993, p. 125). Yin (2003) proposed that the "use of multiple sources of evidence" (p. 34) during data collection enhanced construct validity. In-depth interviews, reflective and descriptive research notes, and document review supplied multiple sources of evidence for the present case study. A reliance on accuracy, detail, and rich description (Creswell & Miller, 2000; Maxwell, 1992; Patton, 2002; Rubin & Rubin, 2005; Yin, 2003) show the benefit of using case study methods to discover how leadership develops in an organization undergoing change.

Internal Validity

In case study research, the visualization of causal relationships is verification of internal validity (Rowley, 2002). Cross-case analysis using pattern matching, theme development, and the connection of data results to the conceptual framework demonstrate

causal relationships signifying internal validity (Yin, 2003). Pattern matching during data analysis determines the degree of equivalence in the research data, increasing internal validity. A discussion of rival explanations for data results increases internal validity (Johnson, 1997).

Tobin and Begley (2004) offered completeness as a means of determining whether a research study meets criteria for internal validity. The two-interview method in the current research study demonstrated completeness by closing the data gaps in the second interview. Reflexivity (Johnson, 1997; Roberts, Priest, & Traynor, 2006; Savin-Baden, 2004; Schutz, 1994; Whittemore et al., 2001) generated the perspectives of the participants, the investigator, and the study audience. Case study research provides a means to achieve data completeness and credibility, signifying internal validity.

External Validity

External validity pertains to connecting research methods, data, theory, concepts, and results to other research studies (Johnson, 1997). Robustness and generalizability are terms used to describe external validity (Brinberg, 1982). Ferguson (2004) approached external validity and generalizability as a function of the investigator, the participant, and the study audience in knowledge generation and utilization. Qualitative research (Brinberg, 1982; Holloway & Fulbrook, 2001; Yin, 2003) produces findings that reflect the situated perspectives of the population.

Analytic techniques pertinent to the current study included using the "articulation of data analysis decisions," "using computer programs," "exploring rival explanations," "performing a literature review," and using "reflective journaling" (Whittemore et al., 2001, Table 2). Analytic generation uses existing theory as a means to connect case study

findings to other research studies (Yin, 2003). Brinberg (1982) defined robustness as the ability of the conceptual framework to connect concepts to data results. Analytic techniques connected the current research study to other research studies.

The literature review and conceptual framework provided theories and concepts allowing connections between the findings and other research studies, confirming external validity. The role of nurse manager, as an example of first-tier leadership, offers a leadership component permitting generalization of the current research findings to other similar research studies on first-tier leadership. The topic of leadership development during organizational change supports the generalization of the current study findings to other industries and organizations.

Reliability

Cooper and Schindler (2003) explained, "Reliability has to do with the accuracy and precision of a measurement procedure" (p. 231). Neuman (2003) described reliability as coming from the ability of researchers to reproduce or replicate "the method of conducting a study or the results" (p. 187). Yin (2003) stated, "A good guideline for doing case studies is therefore to conduct the research so that an auditor could repeat the procedures and arrive at the same results" (p. 39). The use of a case study protocol (Yin, 2003), an interview guide (Miller & Crabtree, 2004; Patton, 2002; Rubin & Rubin, 2005), and a conceptual framework (Smyth, 2004) support replication and provide rigor and transparency (Meyrick, 2006).

Summary

The purpose of chapter 3 was to provide details about the structure of the current case study. Cooper and Schindler (2003) listed eight significant characteristics of a

research study. The characteristics include “purpose clearly defined,” “research process detailed,” “research design thoroughly planned,” “high ethical standards applied,” “limitations frankly revealed,” “adequate analysis for decision maker’s needs,” “findings presented unambiguously,” ” conclusions justified,” and “researcher’s experience reflected” (p. 15). The purpose of the present qualitative case study was to study leadership development of nurse managers in a changing organization. When change reaches a particular point, the growth of the individual can be influenced (Senge, 1990/1994).

A qualitative inquiry approach was appropriate to explore the topic of interest behind standardized variables (Pelit & Huault, 2008; Yin, 2003). Validity and reliability in research are demonstrated by “developing a self-conscious research design,” showing “sampling decisions,” “giving voice,” “articulating data collection decisions,” “providing evidence that support interpretations,” and “ acknowledging the researcher perspective” (Whittemore et al., 2001, Table 2). Purposeful sampling, in-depth interviewing, descriptive and reflective research notes, and document review confirmed the suitability of qualitative inquiry as the vehicle for the research study. The literature review and the conceptual framework provided theoretical connections to data through pattern matching and theme conception (Rubin & Rubin, 2005; Yin, 2003). Chapter 4 includes details of data collection and analysis and displays of the results.

CHAPTER 4: ANALYSIS

Chapter 3 included the rationale and description of the qualitative case study. The purpose of the study was to determine how healthcare leadership developed in a changing organization with a focus on the role change to nurse manager at the practice level in one organization. Chapter 4 includes the description of the research design and the presentation of the study results.

Research Questions

Qualitative questions widen the scope of research and contribute to the understanding of complex interactions and situations (Patton, 2002; Pelit & Huault, 2008; Rubin & Rubin, 2005; Yin, 2003). The following central question guided the study: How does leadership develop in a changing organization? Subquestions targeting the leadership development of the nurse manager included the following:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

Research Processes

Qualitative inquiry guided the research study in the discovery of leaders' development in a changing organization. Creswell (2005) stated qualitative research was exploratory. Patton (2002) defined qualitative inquiry as an evolving process supporting the interaction of the investigator with the collection of data from interviews, observations, and documents. The current research study included two audio-recorded in-depth interviews, researcher notes subsequently referred to as RN, and director/nurse manager meeting minutes, subsequently referred to MM, as data sources. To protect the

anonymity of the nurse managers in data reporting, participant responses were combined. Figure 1 illustrates the research process timeline.

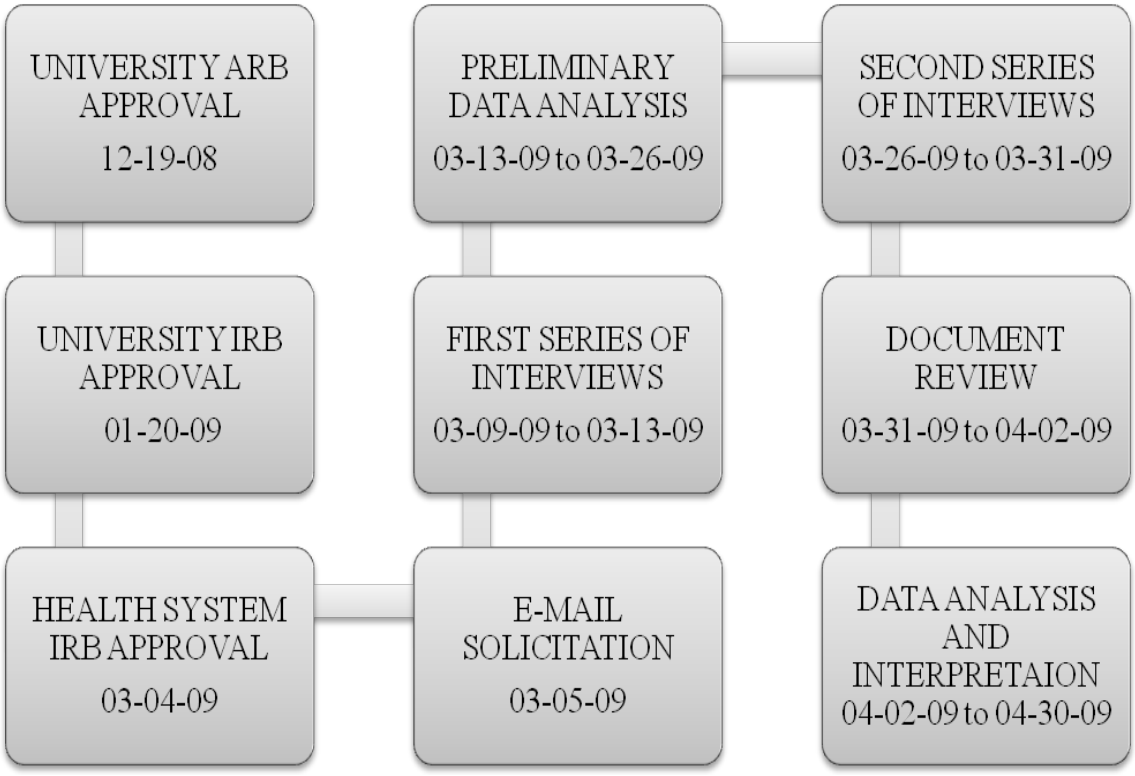


Figure 1. Research process timeline.

Participant Sample

Purposeful sampling generated a population of nurse managers at one mid-size community hospital in suburban New York State. The criteria for purposeful sampling included the uniqueness of the case, a need for specific information, and a need for a specific population (Creswell, 2005; Neuman, 2003). The study sample met the criteria. The role of nurses was changed to nurse manager in the participating organization. The

individuals had no previous experience in the management role, creating a unique population.

A single e-mail solicitation in the form of a standardized letter (see Appendix H) was an invitation to 10 nurse managers to participate in the case study. The use of a single e-mail without reminder e-mails eliminated a concern of the IRB members that the organizational relationship of the investigator might influence consent to participate. Four out of 10 nurse managers responded to the single e-mail solicitation. All four nurse managers completed the two in-depth audio-recorded interviews, reviewed both interview transcripts, and requested a copy of the completed dissertation.

Data Collection and Analysis

The data collection methods consisted of two in-depth audio-recorded interviews, notes, and document review of director/nurse manager meeting minutes. Tools for data collection and analysis included the conceptual framework (see Appendix A), the case study protocol (see Appendix C), the interview guide (see Appendix G), a digital audio recorder, a marble notebook, and Qualrus computer software program. A contracted transcription company (see Appendix F) received the audio recordings and returned the completed transcripts by e-mail. The password-protected computer contained all research data and audio files.

Each nurse manager responded by e-mail and selected a private place in the organization for each interview. An informed consent was obtained from each nurse manager before the first series of interviews. Each interview session started with a scripted conversation (see Appendix G) describing the confidentiality process. The nurses' facial features relaxed and audible expressions of relief occurred when it was

explained that research data would be aggregated to decrease recognition and ensure anonymity.

In-depth interviews. The first series of interviews (see Figure 1) ranged in length from 35 to 40 minutes. Each nurse manager answered each question completely with pauses and expressions reflective of deep thought (RN). Body language, laughter, and hand motions showed relaxation and engagement (RN). Each interview session ended with the question, Is there anything else that you wish to share? Each participant was thanked, informed the transcript of the first interview would be sent by e-mail, and reminded that a second interview would be scheduled after the review of the first transcript.

Manual coding of the first series of interview transcripts referenced the conceptual framework (see Appendix A), the literature review, the research study goals, the case study protocol (see Appendix C), and the interview guide (see Appendix G) as a framework for preliminary data analysis. The manual coding process extracted data from each interview transcript through questions, topics, and concepts of identity, culture, and organization to separate the data (see Table 1). The process added 54 questions to the interview guide (see Appendix G).

The second series of interviews (see Figure 1) ranged in length from 40 to 60 minutes and included the 54 additional questions for each participant. In-depth interviewing techniques expanded the questions, eliciting a complete recollection of the leadership experiences for each participant. Frequent bursts of laughter interspersed interviews with some of the participants (RN). Each interview session ended with the

question, Is there anything else that you wish to share? Each participant was thanked and informed the transcript of the second interview would be sent by e-mail.

Document review. The organizational education secretary sent the director/nurse manager meeting minutes covering January 2005 to January 2009 by e-mail to the investigator. The documents were categorized in a table by date and change. The meeting minutes prior to January 2006 were labeled Director/Head Nurse meeting minutes. The director/head nurse meeting minutes were used to determine the start of organizational change. The start of the nurse manager role (MM) began in January 2006.

Computer-assisted coding. The participant responses were combined by interview into two text documents and loaded into the Qualrus software program. Using concepts from the preliminary data analysis stage (see Table 1), the development of patterns occurred with the review of data during the coding process. Six themes and 22 key words reflecting the perspectives of the participants were developed (see Appendix J). A discussion of the themes and key words will be presented in the results section.

Table 1

Preliminary Data Analysis Concepts

Conceptual Framework	Literature Review	Interview Guide	Case Study Protocol	Research Study Goals
Culture	Leadership style	Leadership description	Nurse manager role	Leadership development
Identity	Shared governance	Professional knowledge	Pre-existing culture	Workplace environment

Table 1 (*continued*)

Organization	Model of leadership	Role of teams	Leadership path and background	Organizational experiences
	Optimal workplace	Leadership practice	Relationships and interactions	

Research Results

Qualitative inquiry methods generated copious amounts of data (Patton, 2002; Yin, 2003) relevant to the experiences of nurse managers in a changing organization. A two-interview process generated rich data. Manual and computer-assisted coding of the data revealed patterns resulting in 6 themes and 22 key words (see Appendix J).

The director/nurse manager meeting minutes included detailed organizational data, confirming validity. Investigator notes added reflection and observation. The results section includes situation assessment, key factors, findings, comparisons, and interpretation of findings.

Situation Assessment

The Participants

Each participant entered the position of nurse manager with over 10 years of experience as a staff nurse (see Figure 2). All participants had a medical-surgical hospital background and had progressed to a specialty practice area. The educational background of the participants ranged from associate degree in nursing to master's in nursing degree

and family nurse practitioner certification. Each participant responded *no* to the question concerning whether their educational experiences prepared them for the nurse manager role.

Each participant placed emphasis on life experiences as preparation for the nurse manager role. Participants shared rationales for becoming a nurse that alternated between always wanting to be a nurse and families encouraging the profession. I always wanted to be a nurse. According to some nurse managers, relationships with family members and as a social leader provided the skills for leadership. The reasons for accepting the nurse manager role included good opportunity, persuaded by director, believed to be suitable, best person for job, wanted to make a difference, and believed in the ability to affect change.

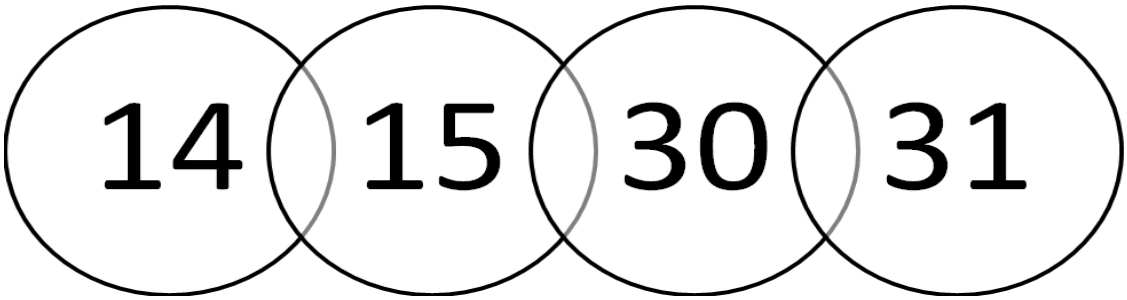


Figure 2. Nursing experience.

The Organization

A community hospital in Long Island, New York, provides an eclectic mix of services and population. Fiscal concerns over the mix of paying and non-paying customers challenged the organization to develop services to increase profitability (MM). A change from a stand-alone community hospital to a member of a large health system in 2005 was the impetus for the development of the nurse manager role. Figure 3 illustrates the changing dynamics of the organization.

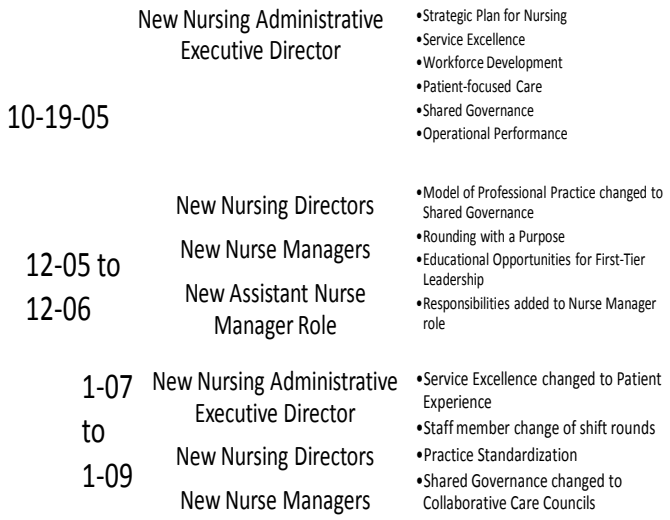


Figure 3. Organizational change timeline.

Key Factors

The participants' understanding of the research study process was limited. Only one participant had any knowledge of a research study due to completion of a master's degree program requiring a thesis. The other participants required explanation of the research study process. The scripted conversation (see Appendix G) was helpful in explaining the research process (RN). Before the start of each interview, a reiteration of the scripted conversation refreshed the participants' understanding of the research process.

The focus of the research questions was the leadership development of nurse managers during change. The interview questions helped explore the role and experiences of the nurse managers. The approach allowed the participants to become comfortable with the research process without focusing on the persons.

Many instances of laughter, nodding, and smiling peppered the interviews (RN). A key aspect of participant consent was the assurance that the data findings would be aggregated to ensure anonymity. The next sections include the combined data findings.

Findings

The central research question was, How does leadership develop in a changing organization? Two subquestions narrowed the central research question to the specific organization and participant as follows:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

By the completion of the second series of in-depth interviews, the interview guide contained 86 questions. Computer-assisted coding elicited 6 themes and 22 key words (see Appendix J). The following themes were used to organize the data findings sections: (a) defining a leader, (b) to become a leader, (c) searching for balance, (d) the influence of others, (e) make a difference, and (f) building the practice environment.

Theme: Defining a Leader

Topic Question 6 in the interview guide (i.e., Please describe what it means to be a nurse manager) challenged the participants to define their work identity. One participant needed to think further and answered Question 6 later as part of another question. Two participants focused on task-related skills. One participant discussed feelings associated with the role. Table 2 illustrates the responses in categories of identity, culture, and organization.

Table 2

Nurse Manager and Meaning

Identity	Culture	Organization
Leader	Professional	Provides safe care for the patient
Facilitator	Two-dimensional	Provides safe care for the community
Professional	Accountable	Organizational representative
Problem solver	Open	Negotiator between administration and staff
Mentor	Accessible	Provides a model of leadership that is visible, open, and accessible
Role model		
Accountable		
Conflicted		
Participant		

Topic Question 7 (i.e., Please describe what leadership means to you) was an opportunity of the nurses to delved further into their identity. Two participants related leadership to excellence in job performance and setting an example. One participant defined setting an example as working alongside the staff members and not setting performance tasks that the participant would not perform. One participant noted that leadership provides the support, resources, and direction for the growth of nurses as coworkers and professionals. Table 3 illustrates the responses organized by identity, culture, and organization.

Table 3

Meaning of Leadership

Identity	Culture	Organization
Setting an example	Working along with the	Provide a way for the nurse to be
Communicator	nurses	successful
Accessible	Showing the way to success	Support the mission of the
Listener	Pitching in during a crisis	organization
Resource person	Accountable	
Role Model		
Problem solver		

Key words associated with defining a leader included supportive, participation, knowledge development, and stakeholder engagement (see Figure 4). All the participants answered *yes* when asked if they identified with being a leader. The reasons for the identification paralleled setting an example. Communication, development, and growth linked interaction with staff members to perceptions of leadership. The participants

mentioned organized, non-confrontational, fair, encouraging, effective, helping, delegating, and strict as personality traits associated with leading.

Some participants stated,

> Many of my supervisors prior to this, I didn't believe were as, and I hate to say this, smart as me. I think the issue is more that I was making an opinion on my educated guess and they were allowing it to happen because they didn't have any education to back it up so now when I make decisions and thoughts I have a backup that I am right and making the right decision, or not making the right decision because it does happen. I think that you have to be able to listen, and I think you have to be able to speak intelligently.

Other participants stated,

> Not that I have old ideas but the attitude towards me is different. I'm not their co-worker anymore, I'm their superior. They'll tell me that all the time, you're my boss. I know that one but I don't like the word boss. My gut feeling with leadership in nursing is that unfortunately it's . . . and not predominately, there are many nurses who go into management because it looks like somebody who doesn't function well at the bedside so they are trying something new. The problem that I see with that is that it's . . . when nurses look to each other for leadership; the thing that they respect most is experience.

Other comments were,

> Again, I feel that if you are in your office you are not going to be able to lead. So I think the issue is more that the type of leader I am; I'm visible, I'm there while others are not. If you're not there you can't help. They should be kind,

> straightforward, and honest. I think you have to know your own strengths and weaknesses and not be afraid to look outside for help. You can't pretend to know everything, and you have to be not afraid to go to the right resources to find the people that do have the answers.

The purpose of Question 75 (i.e., Do you think that there should be a specific model for leadership in nursing) was to look at standardization in nursing practice (RN). Florence Nightingale has been the model for leadership in the health system (MM). Two participants answered *yes* to Question 75. One participant believed that individualization triumphed over standardization and that leadership classes and mentoring accomplished more than models by furthering professional knowledge. The other participant had concerns over continued practices of fear-driven leadership limiting professional growth.

The purpose of Questions 15 (i.e., Is the role of the nurse manager defined by the organization) and 16 (i.e., What do you see as the role of the nurse manager) was to examine the nurses' managerial role individually and globally. An organizational job description was the first response by two participants, but the nurses were unsure of the specific description. The other two participants described the role as a series of expectations expanded by leadership classes, conferences, and opportunities for discussions with supportive second-tier leadership.

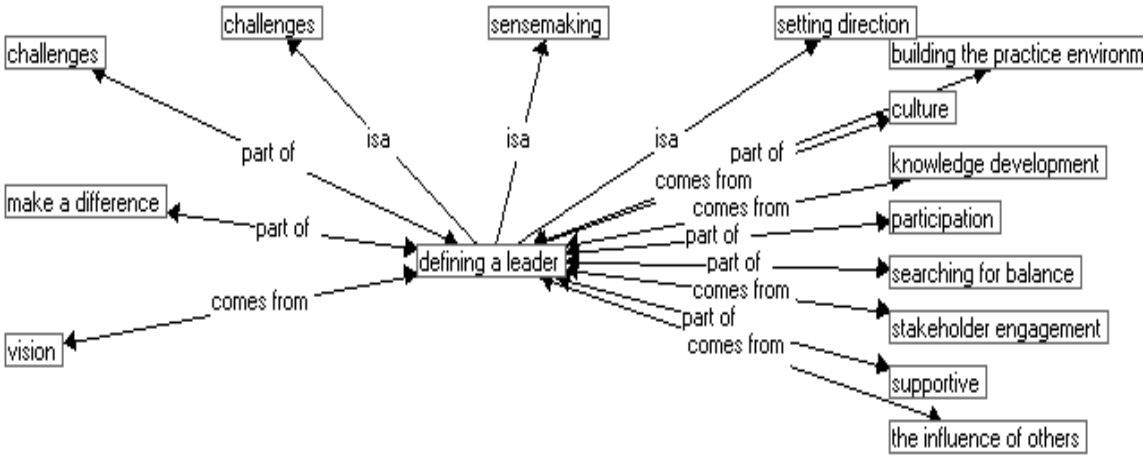


Figure 4. Linkage for the theme: Defining a Leader.

Theme: To Become a Leader

Question 12 (i.e., Is there anything in your background that you feel prepared you for this role) elicited the word *no* from all participants. The participants responded immediately with a clear, resounding, and firm voice (RN). One participant was actively pursuing a bachelor's degree in nursing at the time of the interviews.

A second participant had completed a bachelor's degree in nursing over 30 years ago. Another had completed a master's of science degree with nurse practitioner certification within the last 30 years. The fourth participant had degrees in another field, a nursing degree, and a nurse practitioner certification from over 15 years ago.

Some participants stated,

> The staff nurse role was too isolating as preparation for leadership due to the focus on the needs of the patient instead of the organization. Anticipating the needs of the staff nurse was easy. The hard part was determining the needs of the secretaries, the aides, and other non-nurses.

Tenure in the organization and knowledge of organizational history supplied a support system enabling the recognition of the effectiveness and the importance of specific initiatives and practices (RN).

The focus of Question 74 (i.e., Is there a specific model of leadership for the organization) was specifically on the organization. One participant acknowledged there was a mixture of different styles but was concerned with an overabundance of tyrannical (i.e., yelling) hierarchical leadership. Another participant answered *yes*, but described the hierarchical chain of command in the organization when asked for a description. Two participants answered *no*.

The role change spurred administrators of the health system to design leadership programs specifically for the development of nurse managers. Flexible work hours allowed attendance at classes. Second-tier leadership elicited feedback concerning the needs of nurse managers (MM). A question that occurred during the data review was whether the nurse managers had benefitted from the classes run by the health system (RN).

According to some participants,

> For the most part, the tools were helpful. The nurse executives were quick to send us to classes. Encouragement was a major factor in developing the ability to decide what information would work for the individual person. It was more than just handing us the information and telling us to learn how to be a leader. I guess a person that reflects back on whoever they encounter and, personally, I try to take what is good from what I perceive to be good qualities in a leader, and try to blend that into the way that I lead.

The same participants further stated,

> I have never seen so much education in my life available. At the beginning, I took every class and went to every meeting. Many of the classes that I was sent to in the beginning occurred too soon for me to absorb and utilize the knowledge and information. Once I had a basis for understanding the role and the expectations, I was able to choose what benefited me the most. The Spanish and computer classes are useful and helpful.

Some nurse managers explained,

> A major portion of the job is problem solving. I was encouraged to work out solutions using the information, resources, and tools provided in the leadership classes and the organization. The change from a punitive culture enabled confidence to develop. You can bounce ideas off of each other, if it works for me it's fine, and if it doesn't it's not a problem.

According to some participants, "The new administrative leadership supported communication and learning by looking at your strengths and weaknesses. Although fear of punitive blaming still exists, the tools are reinforced as necessary to develop us into strong leaders." The question about what happens to the new nurse manager during change triggered a more reflective examination of the data (RN).

Nurse managers stated,

> A nurse manager is sandwiched between two different levels of the organization. I did not think that I could fulfill the expectations of the administrative leaders, the staff members, and the patient. I was overwhelmed and considering leaving the position.

Other nurse managers stated, “Without the support of my director, other organizational leaders (mentors), and staff members, I would not have been successful with this difficult transition into a leadership position.”

According to some nurse managers,

> As a nurse manager, you’re working 24 hours a day. I did not have the confidence to just say no. I think that I needed to be more assertive. I was working 16 hours to try to make it better for the nurses. I couldn’t say that I was really a leader. I was doing the nurses’ jobs for them instead of helping them to do their jobs better.

Other nurse managers said,

> My original director left and the new director did not have the insight and knowledge that I needed to learn this role. My director changed, but I was lucky that the old and new director listened and built up my confidence. A mentor helped me to break down the challenges in the role into tiny steps. My director included me in strategizing for the service line and increased my understanding of the workings of the organization.

Figure 3 illustrates the frequency of second-tier leadership change in the organization. Six directors left the organization during the study period. New directors were hired and other directors shifted positions and units as part of the changing organizational structure. Nursing work hours changed from 8-hour shifts to 12-hour shifts. The role of the licensed professional nurse changed to an assistive role (MM).

The purpose of Question 67 (i.e., How do you think leadership develops in a person) and Question 68 (i.e., How do you build professional knowledge) was to examine the resources available for leadership development. All four participants emphasized that

leadership was an inherent part of personality. Participants believed leadership expanded and developed with the support of individuals in the workplace. The extent of effective leadership development depended on how each individual used the available resources, professionally, personally, and educationally.

According to some nurse managers,

> The new managers that have come to Southside in the last year; they have different ideas. I believe that we build professional knowledge on a daily basis. I believe that comes from your own drive to be the best at what you do. There is a fine line between do you tell people that you don't know what you're doing and ask or just stumble along. You have to be a very active listener. You have to be in control at all times. You have to be professional, very professional. Sometimes, you have to learn to walk away and come back to this thing that is not right and then it straightens out.

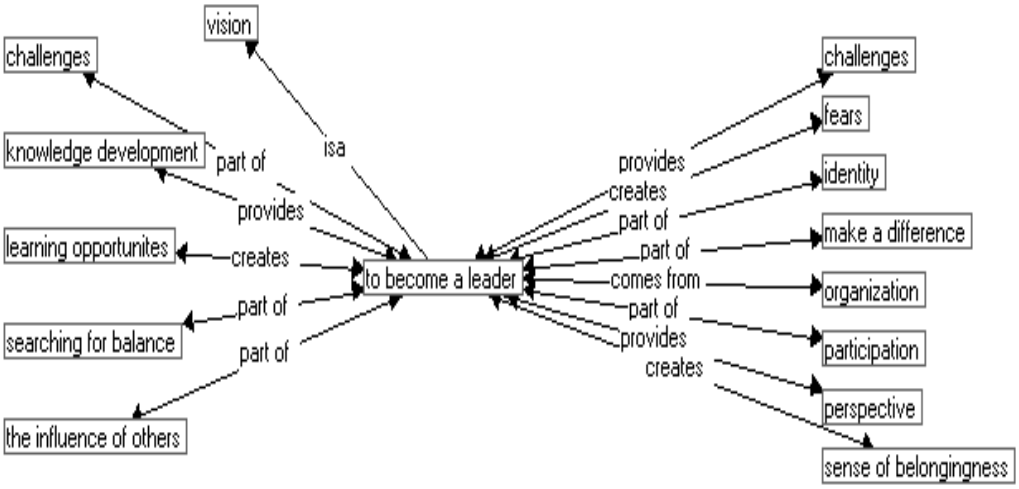


Figure 5. Linkage for the theme: To Become a Leader.

Theme: Searching for Balance

Table 4

Components for an Optimal Workplace

Identity	Culture	Organization
Willingness to grow	Agree to disagree	Support from every avenue
Willingness to look forward as a nurse	Put the patient first	
Willingness to compromise in problem solving	No sick calls when unit is full	Open communication
Accessibility	Patient-centered	Open floor plan
Lack of aloneness	Accountable for behavior	Warm and welcoming
	Service-oriented	Access to resources
	Team-oriented	Shared expectations and accountability
	Supportive environment	Optimal staffing
	Collaborative environment	Nurse manager at the center
	Non-isolating	Nurse manager role as a shared position

The Topic Question 8 (i.e., Please describe what you consider an optimal workplace environment) tied identity, culture, and organization to the perceptions of the nurse managers (see Table 4). One participant equated an optimal workplace with a full staffing component on the unit. Two participants talked about changes in the nurse

manager role that targeted sharing responsibilities and increased support. A fourth participant advocated standardizing the nurse manager role and emphasized visibility on the unit as a trait that would improve patient care delivery.

Key word: Culture. The purpose of Questions 34 (i.e., Does the organization have a specific culture), 35 (i.e., How would you describe the culture of your unit), and 36 (i.e., How would you describe the culture of other units in the organization) was to compare the cultural mix of the organization. Two participants detailed a progressive, caring, and innovative environment with a focus on a team approach to service delivery. One participant was only aware of her own culture described as difficult and tough. Another participant described a culture challenged by an inability to mentor staff members toward excellence despite levels of experience from novice to expert in the workplace.

Three participants mentioned the union in describing the organizational culture but only one defined the union as a predominantly a negative characteristic of the organization. The union culture in the organization created adversarial relationships in the workplace, requiring intensive interaction with the human resources department (RN). A new union contract prompted special meetings with leadership (MM).

Some nurse managers stated,

> Before you say anything in this environment, sometimes it's best to consult an expert before you approach certain subjects or certain personnel. Integrating the most compatible person into the unit was complicated by needing to hire the most senior person that applied for the position. Adding layer upon layer of

bureaucracy; the union environment limited effective decision making and teambuilding.

Others said,

> We have 30-year nurses and 6-month nurses working side by side. Everybody is running around doing their own thing and staying in their own little shelter. The novice nurses are eager to learn while the experienced nurses are hiding their heads in the sand.

According to some, "I think that we have an upbeat, happy staff that has good working relationships with each other, the physicians, and the rest of the hospital." And others stated, "I believe that nurses are put in a position where they are always the fault person regardless. You have to know your own strengths and weaknesses and not be afraid to look outside for help."

Key word: Challenges. Some nurse managers commented, "I think that each person brings to the unit a different component and style. They mesh with each other. They interact as friends."

Others explained,

> Hope . . . when you're the nurse manager, only because we have unions, it's a matter of you get what you get because of the union. I have some people who do the right thing for the right reasons. They believe that they provide excellent care due to high standards. I have some people who feel that they go above and beyond but when I give them my perception on how they can improve their practice, they give me excuses.

According to some nurse managers,

We need to be able to disagree and agree to disagree and move on to what's right. Our major concern is the patients but other departments sometimes miss that fact. Sometimes that cooperation that you need to get is just not there. It is always the nurse who needs to prod the other departments to function at a better level. Sometimes it seems like there are things that might resolve on their own if give time. People just need to verbalize that there is a problem. It's one thing to solve problems and feel good about it. It's another thing to feel like the problems never end.

Other repsonses were,

It can be difficult answering to almost two different sets of people with two different needs, a need to be cost-effective and efficient and a need to satisfy the problem-solving issue of staff. There is obviously, as you get into management, there is more to this business than just, unfortunately it's not just the patient, it's also the bottom line, sometimes, which we have to look at. I think that we are just evolving in a better unit on how to treat the patients better. Differently, to look at patients as you would look at yourself. Treat them like you would want to be treated.

Some nurse managers commented,

Sometimes it is hard for the novice nurses to accept that what they're learning in nursing school isn't the same as what they're seeing in the unit. We could say yeah, that's just what nurses do but it is not clearly defined in the sense that there are things on the peripheral of nursing that aren't taught to you in nursing school.

> My staff members can be a little antagonistic towards one another. I don't think that's unique to my particular environment. I think things are magnified when you're in a small environment. By leading them instead of pushing them, you are helping them grow in their roles as nurses or even friends.

All the participants echoed the same expectations of excellence in service delivery. Teamwork, as a component of the environment, existed in all the participants' perceptions of service delivery in the organization. Teamwork was a major factor in the uniqueness of nursing practice and encouraged a sense of camaraderie and friendship with the ability to ask any question without hesitation. Teamwork existed despite the influence of many different and opposing personalities (RN).

Theme: The Influence of Others

Answers to Question 13 (i.e. What has been your perception of support for you in this role) and Question 14 *(*i.e., Has anyone been of influence to you in this role) revealed the importance of the directors in the organization for all participants. Three of the participants had more than one director during the study period. Only one participant reported having positive experiences with each director change. One participant had experience with only one director in the nurse manager role but was influenced by many individuals throughout a nursing career of positive and negative experiences. A review of the data established a need to explore the relationships of the nurse managers with others in the organization (RN).

Key word: Culture. Some nurse managers stated,

> Sometimes they have their little spats, but nine out of ten cases, they interact very well together. I think everyone has somebody that they enjoy working with.

Camaraderie, friendship helps, hospital friendships . . . Exactly, I share with the staff, the staff shares with me and I share with my director who again has been very supportive in sharing with me in ways to grow beyond just the nursing aspect. She allows us to be ourselves, to run the unit the way we see fit, because everyone is different, but she also will tell us when she feels something could be done better and gives us clues so she's very helpful.

Table 5

Staff Member Relationships

Behavior	Reason	Solution	Conflict Resolution
Antagonistic Animosity spread by one individual Disconnect between new and longstanding members in the unit Uncooperative with existing team Frustrated with other team members behavior Individual infighting but ability to work together during crisis situations	Small environment Strong personalities Rigidness of longstanding members Unable to accept constructive criticism Not accountable Sense of family Professionalism	Team building initiatives Team building initiatives Personalization Mentoring Ask individual to consider leaving Compromising Team building initiatives	Listening and compromising Staff meeting Listening and supportive strategies Frequent group discussions Let them work it out Provide tools such as employee assistance

Each participant described the challenges of managing individuals in a unit environment. Two participants remarked that a team with limited turnover can deteriorate into bickering and infighting because team members know each other too well. Another participant described a team that functioned autonomously without a need for any guidance from the nurse manager. The other two participants focused on existing problems with their teams consisting of non-functioning individuals who damage cohesion (see Table 5).

Question 24 (i.e., What type of relationships do you have in the workplace) and Question 26 (i.e., What do these relationships mean to you) triggered positive feedback from the participants (RN).

Some nurse managers stated,

> I have relationships with physicians, which I see on a daily basis, strong relationships with physicians. I think I have a very open relationship with the staff . . . Those relationships are probably just as important, if not more important, than any relationships I have in my family. I feel that I have very good relationships in the workplace. I feel that I have been appreciated in the role. They mean a lot because these people are more my family than my friends. We look out for each other.

Key word: Supportive. The purpose of Question 58 (i.e., How do you interact with the other nurse managers in the organization) and Question 79 (i.e., What influence do the other nurse managers have on your nursing practice as a leader) was to examine the relationship of the nurse managers in the workplace. The participants spoke of qualities, advice, concepts, and workplace initiatives as influential in improving nursing leadership

practice. Interaction with the other nurse managers was in the form of meetings, classes, projects, development initiatives, and patient flow interactions. Only one participant described teamwork as influential because of participation in a specific critical care team.

Some nurse managers explained,

> I feel very good that my director, who is the person I answer to immediately, chain-of-command-wise, is extremely supportive, so in regards to that, that's outstanding. My director is extremely supportive; she is a very educated woman and is an excellent resource person. The nursing supervisors and the DON's have been very helpful. The other staff members around in the hospital are very helpful to me.

According to others,

> If there is someone who is not doing so well, I feel like they are willing to come to me for my strengths, and we just play off of each other. You have to have all the tools, I really think, because you have all this information and questions and great ideas. If they don't give you the tools to bring them to fruition, that is where you get overwhelmed and that is when you can get frustrated. I have conversations all day long. I sit in the middle of the nurses' station and we discuss patients. We discuss life. We discuss doctors. We discuss news, you know we're friends at work and we work well together.

The interactions of individuals in the workplace demonstrated the influence of identity, culture, and organization. Relationships in the workplace became significant in the development of leadership for the nurse managers. Reflective questioning elicited

information on the way the development of relationships defined the workplace and influenced the development of leadership (RN).

Key word: Knowledge development. Professional knowledge in the workplace emerges from the interactions of individuals (RN). The participants considered that professional knowledge is acquired daily, comes from a drive to excel, creates an understanding of the job, increases performance, and is based on listening as a significant tool. All participants agreed that knowledge develops from insight, research, information sharing, dialoging with peers and colleagues, interaction with other professionals, and trial and error. One participant relied on sitting in the workstation and observing the interaction of staff members to build professional practice in the workplace.

Some participants stated,

> People have given me a lot of good insight. It was also that recognition that when I did do something right, they were quick to let me know and when I did something wrong, it wasn't punitive and they still supported my decision. They just explained a better way to do it. I don't think that I have all the top expectations; I don't expect them to do any more than I would do as a staff nurse. I know that they are not people who can work to my caliber, I get that but that doesn't mean they shouldn't strive for it.

Others commented,

> I think that I have a good relationship in the work place. My peers and I sometimes are like daggers drawn, but then we stop and think about things, and it works right out. We have a new nurse manager . . . who has worked in the hospital for years, but now this is a new position for her and it's interesting to see

the problems she's having only because she used to work with them and now she's working above them. You rely on your peers and your colleagues to give you insight and it's a bit trial and error.

Theme: Make a Difference

Key words associated with the theme of making a difference included excellence, vision, sense of belongingness, culture, participation, family, and strategies (see Figure 6). The organization recognized individuals who made a difference with a monthly ceremony (MM). Question 48 (i.e., Are there any individuals who particularly stand out) and Question 49 (i.e., How do they influence the functioning of the team) targeted excellence in practice.

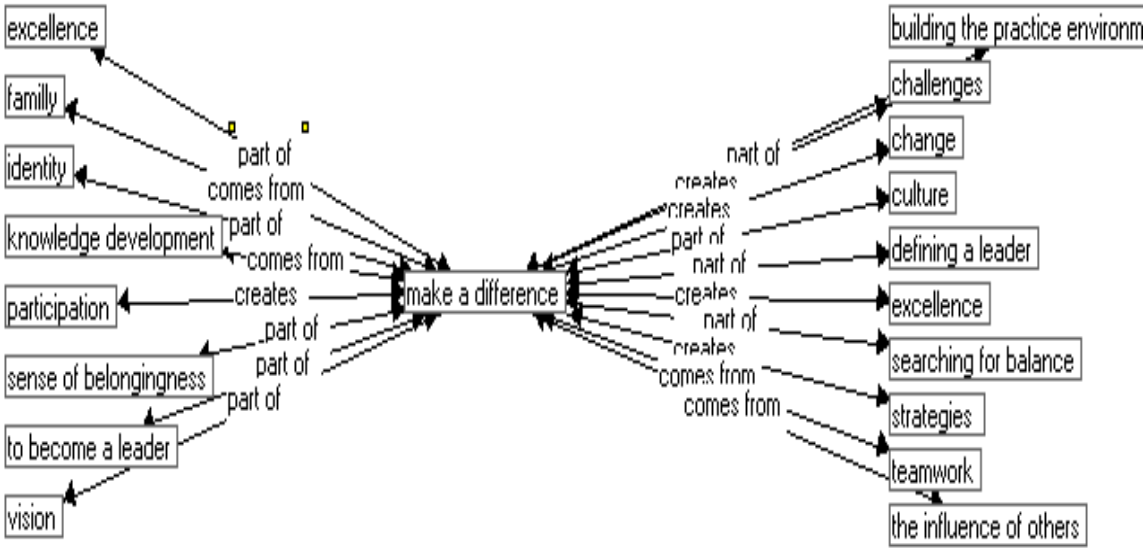


Figure 6. Linkage for the theme: Make a Difference.

One participant described individuals who stand out by their differences in reacting to particular experiences. Another participant emphasized individuals who took

pride in doing a job, expanded knowledge by asking the correct questions, and did the job for the right reasons. The third participant described an outstanding individual as someone who studied overlooked problems. The fourth participant viewed individuals who stood out as strong role models for the weaker functioning team members.

A few participants stated,

> I think that we need to step back and be able to look past all the red tape, rules, and guidelines and remember why we were here in the fist place. Remember that if you put the patient first, the rest of it is bound to follow. I should be a leader and be able to facilitate my staff. I should provide safe care to the patients and make sure the staff acts professional. I should be able to represent the facility that I work at in a positive light, working with administration to provide the best care for the community. Sitting down in a chair talking to a patient makes a difference.

According to others,

> By attending meetings and stuff like that we all grow together and help the hospital to be a better place to come as a patient. We are here for the patient and if you want to do your job to the best of your ability, you need to go in and see the patients. A person who is willing to do as a leader and demonstrates they are willing to do anything that it takes to deliver their best patient care and to do so without traditional regard to their roles. It is the people that see this as a career that are willing to make it work and do the extra things you need to do in order to be successful.

A few participants commented,

> You need to listen . . . Most nurses become nurses because they want to help . . . So when you feel that no matter what you do is not going to help this person, you need to be relieved of that emotional letdown because if you go home and you say you did nothing for that patient, you're not fulfilling your dreams and that's not fair. To keep the team flowing, seamlessly, to help in whatever way I can. In order for me to be effective in my role, I would like the staff members to be able to do their jobs without me telling them every five minutes that this wasn't done and this wasn't done.

Others said,

> My personal and professional vision is exactly the same; that I want to ultimately deliver the best quality care to the patients that we have and also to create an environment that both the workers and the patients feel safe in. I think that the organization's culture is that we are expected to do the right thing for the right reasons for the benefit of the patient. You can't ever lose sight of the fact that this is all about taking care of the patient.

Theme: Building the Practice Environment

Key word: Challenges. Understanding the role of the nurse manager required asking questions that explored how the nurse manager functioned in the organization. Questions 11 (i.e., Please describe any positive and/or negative aspects of this role), 17 (i.e., What qualities are needed by the individual to be effective in this role), and 18 (i.e., What does the nurse manager need from the individuals in their unit to be effective in this role) were asked to explore nurse managers' functioning. Responses indicated positive

aspects of the role revolved around the ability to be a change agent. Autonomy, positive feedback, and staff satisfaction contributed to happiness and identified with functional ability to be a leader. The organizational culture supported second-tier leadership who facilitated the use of leadership tools, provided positive reinforcement, and modeled consistency in direction during change (RN).

Negative aspects centered on perceptions and expectations associated with the role. A feeling of being pulled in many directions described the frustrations of three participants. The tone of the three participants changed from open to closed, and facial expressions showed frowns when discussing negative aspects of the role (RN). The nurses shared they had the most difficulty with directors who were not knowledgeable enough to give clear direction, staff members who asked questions instead of pursuing knowledge, and repetitive tasks.

The participants believed the organization depended on nurse mangers to develop and maintain staff and patient satisfaction. All participants realized the community viewed the nurse managers as representatives of the organization. The participants identified that supportive directors, administrative leadership, and staff members would benefit from the development of practice environments that gave exemplary service delivery. Table 6 is a list of the relationships of the nurse manager delineated by identity, culture, and organization.

Some participants explained,

> The biggest challenge is the blending of the unique personalities, which is like I said; I don't feel it is at all unique to this particular area. I think that everybody is an individual and each person has their own style and will flourish in their own

style. You need to give support. You need to give education. You need to praise. You need to show mistakes and work on progress toward a joint goal. The other Nurse Managers, good or bad, and I can look at what they are doing and how they are doing it. I can benchmark it against myself.

Table 6

Relationships and the Nurse Manager

Identity	Culture	Organization
Fair	Open	Longstanding
Communicator	Sense of equality	Toxic units
Significant	Sense of family	Supportive, knowledgeable, and
Flexible	Togetherness	forward thinking directors
Change agent	Ability to mediate without	Development of independent,
Flexible	damaging relationships	autonomous leadership skills
Peacemaker	Developed from a commonality of	Builds leadership capacity
Mother	experiences during the process of	Positive and negative feedback
Father	nursing growth	Suggestions for problem solving
Collaborator	Sense of appreciation	and improvement
Mentor	Collaborative	Appreciation and support for the
Leader	Autonomous	individual
Compromiser	Supportive	
Sounding board		

Key word: Role expectations. Questions 37 (i.e., How do individuals work together in this organization), 38 (i.e., How do individuals work together in your unit),

and 54 (i.e., How do you introduce new people into your team) associated personal and professional vision and goals to the concept of teamwork. All participants viewed teamwork as essential to developing quality practices in the workplace. Two participants spoke about the financial constraints of the healthcare economy in developing effective strategies for excellence in practice. One participant decried the elimination of the head nurse or charge nurse as detrimental to effective team functioning.

According to some nurse managers,

> I think that no matter what, you always have to have a go-to person and whether you call it the charge person or, you still have to have someone to ground someone. Having strong people on the team makes it easier for the team to flow properly. I think part of it is the ability to anticipate the daily needs of the unit so to see how our days are going to shape up and then to place the right people in the right place. We just couldn't do what we do without good teamwork.

Other nurse managers stated,

> I had a staff meeting yesterday about my week off and what went on when I was gone . . . I said that when your Press Ganey scores are plummeting for no reason at all that is an issue. So this month their Press Ganey scores have gone back up. The unit that doesn't have a strong manager is not working together and you can tell that that's why they're having issues. I really don't know too much about the other cultures in the other units. I think they are running okay.

The organization used Press Ganey scores for a measure of quality and performance (MM).

A few nurse managers expressed,

> I take them first and I kind of give them a very broad, general groundwork of what is on the unit. Again, the communication part of it; you have to talk to me. I encourage people to follow my example when I take them with me; everybody . . . has spent a day with me so they can see exactly what I do all day. I think the Nurse Managers on the different units expect different things from their nurses as far as being able to give those reports and give that information and know their patients. I would like to see my nurses make rounds more often. During a busy day you might not get in to see patients any more than every two hours.

Key word: Perspectives. Questions 18 (i.e., What does the nurse manager need from the individuals in their unit or team to be effective in this role) and 19 (What does the nurse manager need from the organization to be effective in this role) targeted resources and effectiveness. Questions 23 (i.e., Tell me about an average day in your workplace), 29 (i.e., What experiences have been significant for you over the time that you have been a nurse manager), and 30 (i.e., Looking back, are there any experiences that you would change) allowed the nurse managers to describe their role (see Appendix K). The everyday experiences of the nurse managers reflected leadership, leadership growth, and the problem-solving component of the role (RN).

The participants needed support, education, praise, and adequate, timely communication to be effective. Optimal staffing, appropriate resources, equipment, and people contributed to forming team environments. While the union limited the ability to control team membership, learning to listen and speak effectively factored positively into

the development of cohesive teams for two participants. Three participants revealed concerns that financial constraints would limit service quality and continuity of care.

When asked to describe an average day in the workplace, two participants detailed task-related accounts, and their accounts differed in focus. One participant started with getting a report from the staff members and speaking with the night shift personnel. The participant then spent the day interacting with the patients of the unit while going to a minimal number of meetings.

The other participant started the day by getting a report from the staff members, interacting with the night shift personnel, and organizing the work processes of the unit. The participant's work style consisted of rounding with the patients to increase service quality, attending interdisciplinary meetings in the nursing station concerning patient planning, interacting with the staff members by observing and improving practice patterns, and attending meetings that increased professional knowledge.

One participant described the inability to overcome the backload of paperwork, especially when taking a vacation, as a limitation to effectiveness. The participant described effectiveness as the ability to be a leader instead of a manager. Two participants considered the union an obstacle to effective team building. Solutions to the obstacle were based on the development of respect from team members and a need to enjoy the job.

The organization switched to a collaborative practice model instead of shared governance in 2009 (MM). Questions 70, (i.e., Describe the role of shared governance in the organization), and 71 (i.e., How is shared governance working), acquired the perspective of the nurse managers concerning program development and governance. The

participants described shared governance as a theoretical idea, hard to start, and a new concept that created friction between perceived favorites and non-favorites. One participant looked toward the development of the collaborative care councils as the appropriate tool for effectiveness.

The nurse managers believed it was difficult to achieve buy-in for shared governance from staff members on some units. One participant was surprised to get so many volunteers. Another participant believed staff members who wished to be on councils welcomed shared governance. A third participant believed shared governance created increased roles and responsibilities while connecting staff members with governance and decision making.

Some participants stated,

> My years of experience here have taught me that you can't just take a program from one unit to another and have it work. The unique environment of a union hospital, a lot of governance already exists . . . . Sometimes people just need to hear direction and they don't need to share in every decision. A good reason why, that's enough. They like their questions and concerns answered no matter what it is as anybody does. Give me an answer, tell me no, I can't have it because or tell me I can have it . . . If you can give me a reasonable answer nobody is arguing and nobody ever argues.

Key word: Knowledge development. Questions 20 (i.e., What does the nurse manager need from educational opportunities to be effective in this role) and 21 (i.e., What does the nurse manager need from professional organizations to be effective in this role) formed during data review (RN). Unknown aspects of the role were a key factor

when the participants discussed the need for educational opportunities. One participant recommended shadowing an existing nurse manager for a month before accepting the role. Another participant discussed time constraints from work requirements preventing attendance at leadership classes.

Two participants who equated education with growth welcomed available leadership opportunities and classes. The participants believed their growth as leaders required educational and professional programs that expanded knowledge instead of a review of simple leadership and management principles. One participant responded *nothing* when asked about resources professional organizations could supply to increase role effectiveness. Tracking leadership growth requires determining whether the nurse manager looks beyond the organization for the development of leadership skills (RN).

A few respondents stated,

> Too many times you are told exactly what you already know and nobody gives you any good information and then they want to know why nobody implements anything. The opportunity to be able to go to these classes, to be able to leave your job for a day and spend all day at a conference or to be able to bring a staff member with you to a leadership conference so they understand why you are doing something. The professional organizations need to meet the demands created by technology in the workplace.

Key word: Change. Questions 60 (i.e., In what way is this organization changing), 61 (i.e., What do you see as effective or not effective), and 61 (i.e., What would you change or not change in this organization) encouraged the nurse manager to examine the organization. A positive outlook concerning change emerged from three participants. The

expansion of a stand-alone community hospital to a part of a large health system benefited from standardization of processes, increased availability of resources, and diversification of services (MM). One participant connected multiple layers of administration in a big health system to increased bureaucracy.

According to some participants,

> Building the programs, building the customer service line: that is a very big part of it and making people know that you do have a choice and thank you for choosing us, the return customer kind of a deal. I think that when people realize that the most important thing is that, when patients come into a hospital, that they judge a place by its cleanliness, by the way staff members answer call bells and when their tentativeness to their particular needs, to facilitate through their process, then you will need all the criteria that a patient is looking for and determines a hospital to be a good hospital or a bad hospital.
>
> Everyday we have a new procedure, policy . . . We have to roll with the punches and if you can't you become stagnant and things don't change and you're left very disappointed and unfulfilled. I think that jamming things down peoples' throat is unfair. If you want people to change, you need to have them progress on a steady basis, not all over. I think that this organization is changing for the better. Things are more standardized. You can really put your hands on the stuff you want without too much problems.

Key word: Vision. Responses to Questions 80 (i.e., Do you have a personal and professional vision for your unit) and 84 (Do you have personal and professional goals for your unit) showed the connection of leadership principles to the values of the

participants. Two participants targeted professional certification and knowledge expansion through education. Two participants advocated for excellence in service delivery. One participant did not have an answer and needed to think further on personal and professional goals.

A few respondents stated,

> I would like to see my nurses certified, get more degrees in nursing, and take continuing education. Building quality practices . . . it is demonstrated through people pursuing outside educational opportunities and then in turn sharing that information with the people that they work with in order to better the care that they deliver. I'd like my Press Ganey scores to go up only because that is the driving force behind life in the medical field. I believe that those questions are sometimes a little vague. I would like to do more with my staff. I would like to be able to become more involved on a one to one with them.

Question 22 (i.e., What do you see as the role of the nurse manager in the future) completed the research study. Versatility and adaptability based upon the needs of unit was important to two participants. One participant viewed the changing healthcare environment as an opportunity for nurses to become technically proficient. Two participants believed that the role would remain the same.

Some respondents stated,

> Hopefully, she's just not the person in charge at the desk. An educator, a resource person, somebody who's respected. The role of the nurse manager in the future is going to be working side by side with other nurses as a team and mostly to be a facilitator, and let the team roll along. I think that we are air traffic controllers.

> We have to know our units; we have to know our specialties and we have to be able to cut when we have to cut and grow when we have to grow just to be able to function.

According to other nurse managers,

> With the changing times, there are so many things that we didn't learn in school. Thirty years ago was thirty years ago, like it or not, and things have moved right along quickly as we got out of school. Nursing would have to take a different philosophy of . . . and also train nurses differently if they really wanted managers to develop those kinds of skills. They would probably address that somewhere in the educational process as you were going along, not simply saying if you have a bachelor's degree, you will probably have a good chance of being a manager and then not discuss what that does mean. Probably, as a nursing student, you might think that is like a raise or a good thing, but if you ask many nurses who have been offered the opportunities, they will say no, it's not a good thing, it's not a raise and it's not an opportunity, it's something different. I think there is some education required.

Comparisons

All of the participants placed emphasis on the importance of teams and the belief that teams were an essential part of the workplace (see Figure 9). Question 41 (i.e., Who is on the team in your workplace), Question 50 (i.e., How do the individuals on the team interact), and Question 57 (i.e., Do you consider yourself and the other nurse managers as a team) related to teams. Participants differed on the leadership concepts and qualities that were needed for effective practice and team development (see Table 7).

Table 7

Leadership, Qualities, and Effectiveness

Leadership Qualities and Concepts	Nurse Manager Qualities for Effectiveness	Nurse Manager Qualities for Effective Change
Strong person	Problem solver	Openness for the
Primary focus to deliver best patient care	Organized	benefit of change
Role model	Exemplary listener	Open to the
Non-confrontational	Critical thinker	possibility that
Non-traditional	Intuitive decision	change is for the
Flexible	making	better
Lives by rules	Empathy	A positive attitude
Visible	Engagement in a	A good listener
Organized	vision of nursing	Cooperative with
Accessible	Kind	changes that are not
Kind	Strong	well received
Straightforward	Flexible	Innovative
Honest	Knowledgeable	Motivated
	Communicator	Positive outlook
	Intelligent	
	Collaborator	

Some respondents stated,

I believe that teamwork is the way everyone functions. I think the model looks like any regular medical or surgical floor. You have nurses, you have nursing assistants and you have secretaries or unit clerks. In my workplace, I have everybody in my team, my discharge planners, my ward clerk, my monitor tech, housekeeping, physical therapy, and engineering because at any given time you might need somebody to do something for you and the better relationships you have with those departments the faster you're going to get it done for your patients . In my workplace, everyone who works on the unit, the doctors, the aides, the nurse . . . It is interdisciplinary, our team, and it is across the board.

Other respondents explained,

Physician-to-physician communication will be the death of my team because the doctors do not talk to each other, and they expect us to kind of pick it up and it is the; that causes a lot of disgruntled because I have to call a PA who has to call a medical person who has to call a doctor who has to call and I think that kind of slows that up. The administration is very much involved in it and they are starting to be held more accountable for their actions and it is not the nurses' job to be your babysitter. My physicians usually make rounds early in the morning so the physicians are already telling the patients what's in store for them.

Because I am not a part of any team as far as nurse managers are concerned. I know nothing about the other nurse managers. I tend to communicate with them only if there is a problem. Not all of them. From my team, the critical care team, I

do consider us all team members . . . We all run different types of units but its good that we do talk and we do share and I think that we're a better team because of that. Yes, I do consider them part of my team. We have to help each other.

Enlightenment Offered by Key Players

Topic Question 7 (i.e., Please describe what leadership means to you) and Interview Question 72 (i.e., Do you identify with being a leader, why or why not) challenged the participant to describe beliefs and connect to inner identities. Two participants believed in the concept of inherent leadership. The review of the data review helped identify the categories of participation, education, and professionalism (see Table 8). According to some nurse managers, "Working along with the nurses, showing the way to success, supporting the mission of the organization, and setting an example" emphasized the team focus of the participants.

Table 8

Leadership Identity

Participation	Education	Professionalism
Builds experience and relationships	Provides a basis for knowledge and support	Nursing license only the beginning of practice
Equalizes leadership growth	Expands leadership potential	Keeping current with educational, specialty, and organizational advances
Improves service provision	Strong research component	
Provides alternative viewpoints and experiences	Allows individual to use trial and error	Work ethic of responsibility and accountability

Table 8 (*continued*)

Builds leadership practice over time Builds confidence with other perspectives Allows introspection when combined with listening	Helps to anticipate the needs of other disciplines Geared toward role development and strong work ethic Breaks role aspects into manageable sections	Provides uniqueness Leadership specific to nursing Supports a diversified understanding of other professions Expands role beyond nursing Provides supportive direction

Some nurse managers stated,

Leadership is a situation where I am the resource person and I will direct. The leadership role for me as a manager has gone far beyond what I really initially had anticipated. I think it's from experience. I think it's from acknowledgement. By not taking your license for granted. It's not something that you get and then just leave behind. I feel leadership develops when you look at yourself. You see where you're going and the way you speak to people and listen to them.

Other nurse managers explained,

Proper staffing is probably the greatest asset to a good functioning team. That's my biggest problem. How can I get the staff to come to work every day? You can't hold people to a high standard without having a place where they are comfortable to come to work. And you need to enjoy your job. If you don't enjoy your job it doesn't much matter, you could have the greatest team in the world but

> if you don't enjoy your job or you don't enjoy your profession you're in trouble, you shouldn't be here.

According to a few nurse managers,

> Setting an example, above all else. The best way I can put it, is that you cannot ever take nursing as a job. It's not a job; it has to be a career. If it's a job, it's the wrong job for you. The thing that makes nursing unique is that, and this is true everywhere that I have been, is that when you want something done and no one else will do it, it seems that your nurse will get it done. I don't know . . . nurses take a lot of burden because ultimately their vision is for the care of the patients and they are willing to do those things that probably are much more roles that are more clearly defined in other types of organizations.

Summary

The purpose of the qualitative case study was to determine how leadership developed in a changing organization. The following research questions guided the research process:

1. How does leadership develop in a changing organization?

2. What has been the leadership development process for the nurse manager in this organization?

3. How has the change effort influenced the leadership of the nurse manager? A purposeful sampling strategy generated four nurse managers in a unique organizational situation for the case study. The unique situation involved the role change to nurse manager for the first-tier leadership position in the hospital unit. Four participants responded and agreed to be audio recorded during two in-depth interviews.

Chapter 4 was a narrative and display in tables and figures of the perspectives of the four participants. Manual and computer-assisted coding generated 6 themes and 22 key words (see Appendix J). The research findings were reported in the aggregate to ensure anonymity. Researcher notes and data from document review of director/nurse manager meeting minutes added confirmatory data to the perspectives of the participants. Chapter 5 will complete the qualitative inquiry report with the interpretation of the findings, implications, and recommendations for future research.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Chapter 4 included the findings of the qualitative case study carried out to determine how healthcare leadership developed in a changing organization. Chapter 5 includes the perspectives of the participants, the investigator, and study audience in the data findings. Sections include a summary of the research study, findings and interpretations, implications, recommendations for nursing leadership, conclusions, recommendations for future research, and new hypotheses.

The Research Study

The primary research question was how does leadership develop in a changing organization? The following subquestions targeted the leadership development of the nurse manager:

1. What has been the leadership development process for the nurse manager in this organization?

2. How has the change effort influenced the leadership of the nurse manager?

The goals for the research study included exploring the change process as it related to leadership development, showing the relationship between leadership development processes and perceived growth as leaders, and determining the role of leadership in developing environments of care that support excellence in service provision.

The Participants

The purpose of demographic Question 1 (i.e., How long have you been a nurse manager? was to confirm eligibility for inclusion in the study. All participants had been in the nurse manager role for over one year. The focus of Question 2 (i.e., How long have

you been in nursing), Question 4 (i.e., What has been your educational background), and Question 5 (i.e., What type of nursing have you practiced) was the experience of the nurse manager.

All participants started practice in a medical-surgical unit and progressed to a specialty area. The range of years in nursing was from 14 to 31. The purpose of Question 3 (i.e., Why did you decide to become a nurse) was to examine the inner identity of the participants. All participants expressed excitement and enthusiasm based on a connection with an inner identity reflecting always wanting to be a nurse, making their family happy, and enjoying nursing (RN).

Scope

The purpose of the qualitative research study was to explore one organization and its leaders' efforts to develop leadership at the practice level during change. The scope of the study was limited to participants with at least one year of tenure and no previous experience in the nurse manager role. A total of 10 nurse managers met the criteria, and 4 nurses responded to the e-mail solicitation. The four respondents participated in two in-depth interviews, acknowledged receipt of the interview transcripts, and asked for a copy of the completed dissertation.

Limitations

Chapter 1 included a section outlining two limitations of the study. The first limitation concerned the role relationship of the participants and the investigator, possibly hampering a free dialog. A comprehensive consent process detailing the confidentiality and anonymity processes at the start of each interview alleviated the participants' concerns regarding the research process. The interview guide helped create a responsive

environment. Many instances of laughter and shared dialog during the data collection process were noted (RN).

A second limitation concerned the choice of one organization and the topic of leadership development during change. In order to ensure obtaining rich and valid data for analysis (Hesse-Biber & Leavy, 2004; Yin, 2003), the development of the interview questions was based on the conceptual framework selected for the study (see Appendix A and Table 1). The strategy produced an interview guide (see Appendix G) that facilitated transferability.

Validity and Reliability

The small sample size of four participants challenged the validity and reliability of the study data. Strategies to increase validity included using multiple sources of data collection, visualization of causal relationships, analytic techniques, and replication processes. The case study design incorporated in-depth interviews, researcher notes, and document review for construct validity (Yin, 2003). Completeness of the qualitative inquiry corresponded to internal validity (Tobin & Begley, 2004).

The research processes facilitated the expansion of the interview guide from 32 to 86 questions, the elimination of gaps in the data, and the identification of answers to the research questions. Analytic generation, computer-assisted coding, and reflective analysis ensured external validity by displaying the situated perspectives of the participants. The use of a conceptual framework (see Appendix A), a case study protocol (see Appendix C), and an interview guide (see Appendix G) supported replication, confirming reliability.

Findings and Interpretations

Pelit and Huault (2008) and Neuman (2003) described the data interpretive process as developing meaning from the perspective of the participant, reconstructing meaning from the perspective of the investigator, and assigning theoretical meaning to provide significance. Interpretation in qualitative inquiry consists of perceiving meaning in the participants' responses. The use of the following questions facilitated the expansion of the data findings:

1. What is the meaning of the study data?
2. In what way do the data connect to the participants?
3. In what way do the data connect to the researcher?
4. In what way do the data connect to the study audience?
5. In what way do the data connect to the practice environment?
6. In what way do the data connect to leadership?

Themes

An interview guide containing 86 questions elicited perspectives from 4 participants during two in-depth interviews. The data analysis process generated 6 themes and 22 key words (see Appendix J). The qualitative inquiry supported the ability of the researcher to build on past research, increasing knowledge generation (Guba & Lincoln, 2004; Pelit & Huault, 2008; Woodside & Wilson, 2003). The next section combines research (i.e., study audience) with data results.

Theme: Defining a Leader

The first interview with each participant started with Question 6 (i.e., Please describe what it means to be a nurse manager). The responses clearly indicated the

participants believed that nurse managers needed to develop themselves and staff members in order to excel. The participants defined the nurse manager in terms of providing safe care for patients, providing safe care for the community, being the primary organizational representative, negotiating between administration and staff, and providing a visible, open, and accessible model of leadership.

Traditional leadership models attributed specific leadership qualities and concepts to leadership styles such as transformational, servant, and charismatic (Elenkov & Manev, 2005; Gullo & Gerstle, 2004; Morrison et al., 1997; Österberg, 2004; Yukl et al., 2002). Question 72 (i.e., Do you identify with being a leader? Why or why not) and Question 73 (i.e., Do you think that you have a particular leadership style) generated information about leadership identity. The participants used the terms directive, non-confrontational, organized, strict, fair, communicator, and laissez-faire to describe their leadership type. The research participants preferred descriptive labels to traditional leadership categories, except for one participant.

Responses to Topic Question 7 (i.e., Please describe what leadership means to you) provided perspectives associated with identity, culture, and organization (see Table 3). Challenges in defining a leader existed due to varied approaches to leadership (Doyle & Turkie, 2006; Johnson, 2005; Popper, 2004; Sarros, Gray et al., 2002). A strict interpretation of leadership based on style failed to account for specific cultural and organizational attributes related to healthcare service provision. The inner identity of the participants as nurses complicated their definition of leadership.

Sarros, Tanewski et al. (2002) and Sumner (2006) considered hierarchy the opposite of caring in nursing. The nurses in the current study frequently expressed their

views about hierarchy and directive behavior. Johns (2003) stated accountability aligned with hierarchical perceptions and limited the development of leadership in nurse managers. A crucial factor in professional practice models in nursing is accountability (Frith & Montgomery, 2006; Ireson & McGillis, 1998; McGoldrick et al., 2001; Meraviglia et al., 2009; Porter-O'Grady, 1994; Porter-O'Grady & Finnigan, 1984; Williamson, 2005).

Bolton (2005) and Johansson et al. (2007) emphasized that the inner identity of the nurse manager reflects the importance for nurses of associating with the nursing role instead of the leadership role. Responses in the current study demonstrated the nurse managers identified with their nursing role. Stewart et al. (2004) determined that hierarchical structuring in organizations limited the leadership of individuals who perceived their inner identity as that of a nurse and modified leadership toward gendered expectations (Beil-Hildebrand, 2002; Godkin & Godkin, 2004; Seago, 2006). Care and Udod (2003) found that new nurse managers connected more with a nursing perspective than a leadership perspective.

Responses to Question 15 (i.e., Is the role of the nurse manager defined by the organization) and Question 16 (i.e., What do you see as the role of the nurse manager) brought forth no specific description of the role except as organizational expectations and job description. Figure 4 illustrates through the linkages to key words and other themes that the participants viewed the role of the nurse manager as complex. Manfredi (1996) categorized such complexities into subsets of leadership activities consisting of "goals, change, influence, power, growth, mentoring, and vision" (¶ 4). Each participant talked about such aspects of leadership as the interviews progressed.

One question pertained to whether nurse managers move beyond the staff nurse perspective in defining the role of the nurse manager. The purpose of the question was to examine growth in leadership. Glimpses of leadership potential emerged from interviews with three participants who developed a platform for education and information exchange and contributed to understanding staff concerns, conflicts, and needs through informal and formal communication strategies. Van Dyne, Kamdar, and Joireman (2008) and Vitala (2004) found that involved supervisors fostered the development of leadership capacity in staff members. Care and Udod (2003) and Hawkins et al. (2009) recommended leadership development and peer mentoring for advancement of leadership capacity.

Culture associated with leadership (see Table 5) included working along with the nurses, showing the way to success, contributing during a crisis, and being accountable. Leadership includes the ability to acknowledge the importance of interacting with staff members (Chen, Wang, Chang, & Hu, 2008; Laschinger et al., 1999; Manfredi, 1996). All participants in the current study believed their strength in leading came from their clinical functional capacity. Kleinman (2003), Loo and Thorpe (2004), and Sundkvist and Zingmark (2003) found that successful leadership in the nurse manager role integrated clinical competency with management skills and competencies.

Two participants thought the role of the nurse manager required an expansion of competencies to include leadership. The other two participants identified the nurse manager role with clinical mastery. Social cognitive learning theorists argued the development of leadership capacity depends on the realization that expansion benefits the individual (Åmo, 2006; Appelbaum et al., 1998; Billett, 2002a; Fagerberg, 2004; Koberg

et al., 1999; McCormick & Martinko, 2004; McNamara et al., 2002; Naude & McCabe, 2005; Stanley, 2006; Wood & Bandura, 1989). Loo and Thorpe (2004) found higher ratings of clinical than leadership competence and recommended further education and support to foster the development of leadership capacity.

Theme: To Become a Leader

Johansson et al. (2007) found the self-identity perception of the manager as a nurse interfered with leadership goal realization. All participants thought their nursing background left them unprepared for a leadership role. Casida and Pinto-Zipp (2008) believed leadership developed with education and training. Education and training in management skills are significant in preparing successful new first-tier leadership (Gould et al., 2001; Loo & Thorpe, 2004; Sullivan et al., 2003).

Hancock et al. (2005) discovered there was a need to expand educational programs beyond knowledge generation by incorporating critical thinking into knowledge creation and capacity development. Duffield (2005) found nurse managers prioritized staff engagement over management development when ranking educational importance. A wide range of leadership classes and resources facilitated knowledge expansion for the participants. The nurses believed they needed to have an understanding of the role and expectations of the role before they could benefit from education and training in management skills and tasks.

Successful leaders experience innovation capacity with engagement at the macro level and indicate effectiveness at the micro level with organizational tenure (McMurray & Williams, 2004). One participant lacked a sense of inclusion and commonality of experiences in her new role as nurse manager. The three other participants demonstrated

varying degrees of connectedness. Relationship development and social interaction are essential to cohesive team formation (Billett et al., 2005; Kang et al., 2007; Mickan & Rodger, 2005; Petraf & Shanley, 1997; Van der Vegt, 2002; Wenger, 1998).

Question 66 (i.e., Please describe your participation in leadership in the organization), Question 67 (i.e., How do you think leadership develops in a person), Question 68 (i.e., How do you build professional knowledge), and Question 69 (i.e., What are the resources available to you in your workplace to build professional knowledge) addressed leadership development. The development of leadership necessitates adaptability (Gill, 2003; Rowe & Hogarth, 2005) to a wide worldview (Billett, 2006; Habermas, 1981/1987; Vitala, 2004; Wenger, 1998). Positive interactions between nurse managers in the workplace support the advancement of leadership capacity (Buchanan, 2003; Petraf & Shanley, 1997). For three participants in the study, meetings and classes provided the venue for communication, knowledge development, and leadership advancement

The inner identity of each participant corresponded to the belief that leadership is inherent. The nurses shared that interpersonal development, cognitive processing, and integration of normative, objective, and subjective worlds (Habermas, 1981/1984; Wood & Bandura, 1989) contributed to their ability to expand a natural ability to lead. Professional practice in nursing requires autonomy, team cohesiveness, trust, respect, and nurse manager support (Anthony et al., 2004; Kramer et al., 2007). Hodson (2005), Mickan and Rodger (2005), and Porter-O'Grady and Finnigan (1984) found that focusing on individuals with inherent characteristics restricted the development of leadership capacity.

The nurse managers in the study identified the culture of their organization had changed from punitive to supportive. Three participants described leadership development strategies that aligned with the meaning of mentoring. The nurses did not recognize the strategies as mentoring; they used the word supportive. The mentoring of new nurse managers toward professional practice goals increases productivity, retention, and staff satisfaction (McAlearney, 2006; Prince, 1997; Schryer, 2004). Mentoring enabled three participants to form professional goals and share a vision of a safety environment dedicated to quality.

The participants discussed a wide range of organizational and personal strategies for leadership development. A strong work ethic helped the participants focus on knowledge acquisition to build environments of quality. Felfe and Schyns (2004) placed value on leadership development strategies to form cohesiveness in organizations (Vitala, 2004). Fulmer and Graham (1993) emphasized the benefit of combining life-long learning opportunities with practical application of learning experiences.

Successful leadership development models connect content-specific courses to applications in the field (Heller et al., 2004). All participants believed professional knowledge came from the application of learning to the practice environment. Learning experiences consisted of standardized classes, internet-based opportunities, health system initiatives, six sigma projects, and quality monitoring and performance improvement projects. Two participants connected leadership development to strategies and knowledge that integrated all professional disciplines in creating environments of excellence and quality.

Theme: Searching for Balance

Topic Question 8 (i.e., Please describe what you consider an optimal workplace environment) prompted the participants to reflect on healthcare environments. The nurses identified connections between identity and willingness, accessibility, and fellowship. Perceptions of powerlessness, meaninglessness, and self-estrangement lead to work alienation and decrease leadership capacity growth in bureaucratic organizations (Meraviglia et al., 2009; Sarros, Tanewski et al., 2002). Effective leadership requires individuals who exhibit evidence of strategic and innovative thinking, communication skills, and excitement in the workplace (Anderson et al., 2007; Collinson, 2006; Vitala, 2004). Figure 7 illustrates the linkages for the theme of searching for balance.

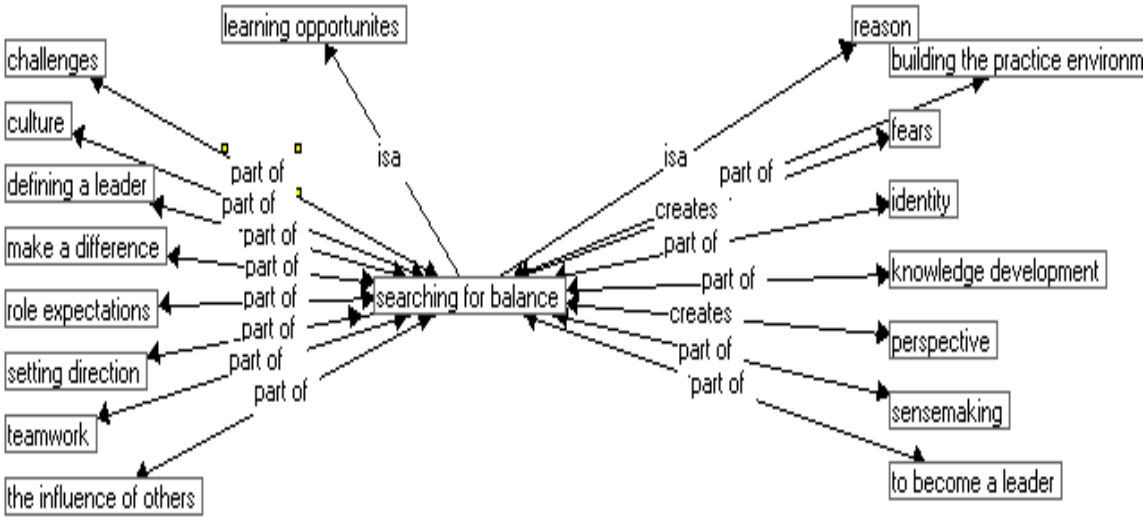


Figure 7. Linkage for the theme: Searching for Balance.

Key word: Role expectations. Job satisfaction, organizational engagement, and role mastery (Rafferty & Griffin, 2006; Rowe & Hogarth, 2005) require leadership development strategies that support autonomy, trust, and professional practice (Garman et

al., 2006; Peltier et al., 2004; Vitala, 2004; Wasonga & Murphy, 2007). Role satisfaction emerges from alignment with the provision of quality care and services (Lageson, 2004). Manfredi (1996) stated nurse managers used goals, influence, and power to fulfill the responsibilities of their role. Expectations for nurse managers include effectively managing staff members by using shared goals, creating shared experiences based on trust and respect, and engaging team members in safety practices (Longo et al., 2007; Naude & McCabe, 2005; Ponte et al., 2007).

The influence of leaders in the creation of a culture of safety includes rational persuasion, inspirational appeals, and an aptitude for consultation (Clarke & Ward, 2006). The concept of the individual as a self-contained arbitrator of practice standards emerged in the nurses' comments pointing to a lack of team approaches in the participating organization. The participants connected accountability and expectations to individual actions and responsibilities instead of an organizational or global perspective. An optimal work environment centers on what the organization could provide instead of how the nurse manager could change the workplace to reflect excellence in practice.

Manfredi (1996) and Vitala (2004) recommended mentoring, modeling, and motivating staff toward growth in leadership. Workplace cultures and environments that support innovation, autonomy, and communication allow nurses to become leaders despite hierarchical structures (Thyer, 2003). Each nurse manager in the current study individualized relationships with staff members and chose strategies to improve staff growth based on individualized goals and expectations. One participant emphasized certification as means to improve leadership capacity. Another participant valued the

concept of patient rounding and effective communication with patients concerning the plan of care as a daily unit practice.

Question 11 (i.e., Please describe any positive and/or negative aspects of this role) elicited information about the challenges of the role of nurse manager. Some positive aspects included support for autonomous practice, the ability to influence change, and a dependence on the nurse managers for patient and staff satisfaction. Some nurse managers separated from clinical practice and focused on management functions to describe role satisfaction (Johns, 2003). Three participants equated leadership with separation from the workplace in order to be free to work in the office. One participant viewed leadership as effective only when actively involved with monitoring unit function instead of staying in the office.

Negative aspects included difficulty in keeping customers happy while keeping within cost effective expectations, no immediate recognition of good work, complicated union environment, continual problem solving, and inability to delegate work responsibilities. Two participants spoke of staffing challenges as detracting from role satisfaction, a comment supporting findings by Sullivan et al. (2003) and Duffin (2009). Meraviglia et al. (2009) stated nurses without a perception of work-life balance and recognition by the organization failed to create quality work environments. The findings in the current study revealed the participating nurses had not achieved a work-life balance because they lacked organizational support systems to would help fulfill work expectations.

Key word: Culture. Question 34 (i.e., Does the organization have a specific culture), Question 35 (i.e., How would you describe the culture of your unit), and

Question 36 (i.e., How would you describe the culture of other units in the organization) revealed the influence of culture on the organization. Strategic success requires the ability of leaders to influence communicative action in the workplace (Habermas, 1981/1984). The rigid union environment challenged the participants. Three participants managed to circumvent such obstacle by applying positive strategies to build trust and respect in the workplace. One participant allowed a difficult and tough culture to be predominant by declining to intervene.

Novice and expert nurses created challenges for two participants. The other two participants faced challenges stemming from the ingrained practices of nurses who had organizational longevity. J. S. Brown and Duguid (2001) and Vitala (2004) described knowledge development in organizations as bound to individuals' identity, the practice patterns of the particular unit, and the ability to move knowledge through the organization. Conflict in communities-of-practice develops from situational experiences (Fox, 2000).

An important function of the nurse manager is engagement in the workplace (Gullo & Gerstle, 2004; Stordeur et al., 2001). In the current study, relationship development proved significant for developing a cohesive practice community. Two participants focused on workplace practices involving working with staff members and modeling practice patterns that eliminated the challenges from difficult staff members. The other two participants demonstrated limited engagement with staff members, restricting the development of a cohesive team environment.

Key word: Setting direction. The focus of Question 84 (i.e., Do you have personal and professional goals for your unit), Question 85 (i.e., Do you have personal and

professional goals for the practice of nursing on your unit), and Question 86 (i.e., How do these goals align with the goals of the organization) was depth of leadership development. Three participants discussed goals and organizational expectations associated with Press Ganey scores, cost-effectiveness, quality, and excellence in service delivery. One nurse manager did not have personal or professionals goals reflecting an unawareness of the relationship between goals and organizational expectations. The setting of goals stimulates self-motivation with the connection of goals to expectations advancing the leadership capacity of individuals (Barbuto, 2005).

Quality in the workplace is based on leadership setting goals, creating vision, and generating infrastructures to support quality processes (Anderson et al., 2007). Goals motivate staff to improve through education, increasing the quality of nursing practice. One participant integrated the concept of shared goals and expectations into daily work practices with the use of frequent team meetings. Two participants indicated that the discussion of goals and expectations occurred but not as a shared decision-making process.

Hughes (2003) and Parsons (2004) presented innovation and visioning as qualities important to leadership in organizations. Gullo and Gerstle (2004) found reciprocity mediated the effects of change. One participant in the current study valued using visioning in mutual conversations as a means of communicating with staff members. Two participants described innovative behaviors. The other two participants did not provide examples of innovative leadership behavior.

For one participating nurse manager, daily activities included interacting primarily with the patients instead of staff members. A second manager focused on

keeping the staff nurses at the bedside, decreasing integration into care planning, adaptability, and critical thinking. The third manager described frustration with spending the majority of her time functioning as a staff nurse because of staffing shortages. Such a situation inhibited personal leadership growth. The fourth nurse manager spent the day interacting with the staff, managing unit flow, and directing care delivery.

Johansson et al. (2007) identified that nurse managers had difficulty going beyond the core identity of nurse to attain a leadership identity. Johns (2003) agreed that early first-tier clinical managers focused more on care delivery issues than leadership goals. Traditional modes of care delivery restrict the innovation capacity of leaders (Green et al., 2009; Sarros, Tanewski et al., 2002). McAlearney (2006) maintained the newness of leadership development in healthcare required innovative models to increase leadership capacity.

Theme: The Influence of Others

Supportive administrators who communicate effectively contribute positively to the leadership capacity growth of nurse managers (Parsons & Stonestreet, 2003; Ponte et al., 2007). The purpose of Question 13 (i.e., What has been your perception of support for you in this role) and Question 14 (i.e., Has anyone been of influence to you in this role) was to explore supportive processes. Sanders et al. (1996) ascertained a knowledge gap existed concerning the relationship of mentoring and supportive relationships to leadership development in nursing.

Each participant knew an individual who influenced role development. In each case, the person who had the most influence was a director in the organization. Organizational changes that influenced the leadership development of three participants

involved director change (see Figure 3). Each participant experienced organizational changes differently based on self-perspective, identity formation, and unit culture. Educational level was a significant factor in the ability of participants to cope with change.

Scoble and Russell (2003) surveyed expert nurse managers and found that individuals with a master's degree of science in nursing and business acumen adapted more effectively to changing role responsibilities. Donaher et al. (2007) demonstrated that nurse managers with higher educational attainment showed an ability to move easily from novice to expert in competency mastery. The experiences of all participants in the current study paralleled results obtained by Scoble and Russell and Donaher et al. with one exception. One participant who had a master's degree focused on interaction with patients instead of staff development.

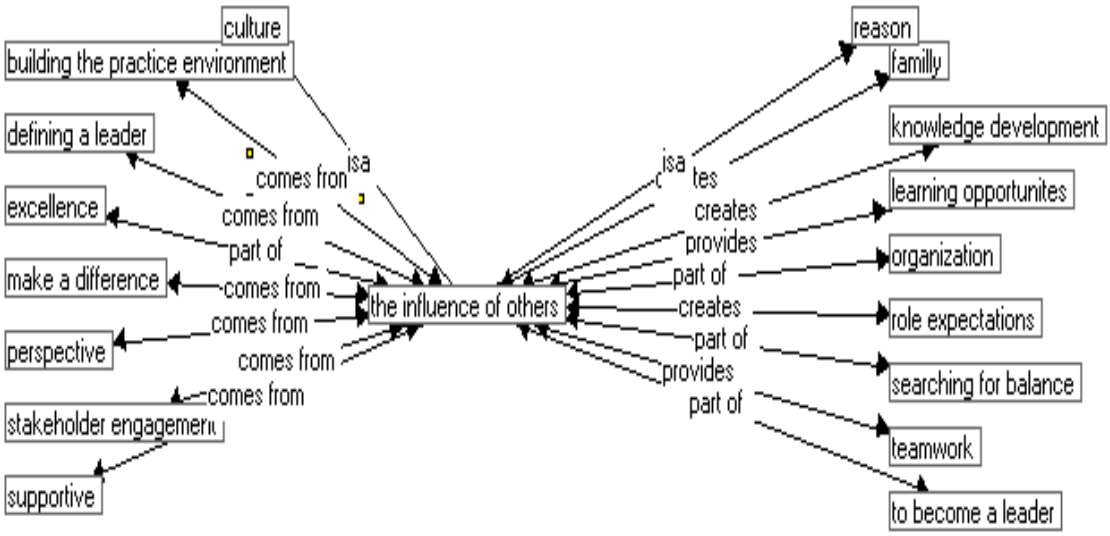


Figure 8. Linkage for the theme: Influence of Others.

Leadership style influenced the ability of the nurse managers to form a cohesive team environment. Despite a supportive director relationship, the laissez-faire style of one participant reversed team dynamics, resulting in a confrontational environment. The other participants worked toward improving staff interaction and developing harmonious relationships in a team environment. Figure 8 illustrates the linkage of the theme of influence of others.

Key word: Supportive. Support and resources improve the effectiveness of nurse managers during change (Bligh & Carsten, 2005). A significant factor influencing leadership development in the participating organization concerned the ability of the director to supply adequate support. Patrick and Laschinger (2006) found that director support depended on the availability of organizational resources. The participants in the current study revealed that leadership development resources were plentiful and were enhanced by an extremely supportive administration. The result supports findings by Berger (1992) and Wiggins (2006).

Lack of resources did not explain the variation in director support perceived by the nurse managers in the present study. One participant believed a lack of knowledge, critical thinking skills, and innovative capacity by the particular directors explained the lack of director support. Ferguson et al. (2007) explained that the connection between knowledge and application required intervention from experienced leaders to develop leadership capacity in new nurse leaders. Two participants found mentors outside their direct chain of command as resources and support.

New nurse managers view peer support as significant to understanding role requirements and developing leadership (Hawkins et al., 2009). The purpose of the

question asking, *Do you consider yourself and the other nurse managers as a team,* and the question asking, *How do you interact with the other managers in the organization,* was to identify the peer relationships of the nurse managers. One participant emphatically answered *no* to team inclusion and interaction with other nurse managers. Three participants stated they were part of a team, but in-depth questioning revealed a series of brief interactions instead of a commonality of experiences. A depiction of the nurse managers as members of a team failed to emerge from the data.

Previous researchers (Hall, 2007; Koberg et al., 1999; Neves & Caetano, 2006) found that the job satisfaction and self-efficacy of nurse managers correlated with the degree of supportive relationships in the organization. One participant revealed a sense of aloneness in the managerial role, triggering uncertainties concerning competency and leadership fitness. Performance validation and development of relationships with staff members alleviate and strengthen a bond with a supportive director. Personalization of relationships in organizations strengthens communication, effectuating the development of common norms, goals, and expectations (Green et al., 2009; Hoffman et al., 2005).

Meraviglia et al. (2009) ascertained a link existed between length of employment and perception of positive support from executive leadership. For three participants, organizational longevity corresponded with a sense of connectedness that augmented the capacity for critical thinking. Fagerberg (2004) determined the quality of care delivered in the organization depended on the degree of relationship building and organizational connectedness.

Key word: Teamwork. Slater (2006) believed that effective change coincided with the use of collaboration in organizations. The purpose of the question, *Who is on the team*

in your workplace, was to identify team membership in the organization. One director formed a critical care team consisting of a subset of nurse managers, establishing a supportive peer structure for one participant. A spirit of camaraderie existed within this unique team. Through shared experiences, the team members developed a bond of fellowship.

Kalisch et al. (2009) emphasized that effective communication and shared mental models existed in functional work teams of nurses, aides, and secretaries. Each participant in the present study described a core work team of nurses and ancillary workers with other individuals based on specialty. The development of relationships with team members demonstrated the difference between coping and managing in a stressful environment. The incentive to succeed originates from leadership motivation, shared knowledge, expectations, and goals (Quigley et al., 2007).

Previous researchers (IOM, 2001; Kvarnström & Cedersund, 2006; Leipzig et al., 2002) have recommended the use of multidisciplinary teams in healthcare workplaces. Sluss and Ashforth (2007) maintained an organization consisted of a network of interdependent roles based on the relational identities of the individuals in the organization. In the participating organization, meetings, conferences, and educational opportunities helped connect the nurses with each other. None of the participants listed all available organizational professionals, disciplines, or departments in team membership (see Figure 9).

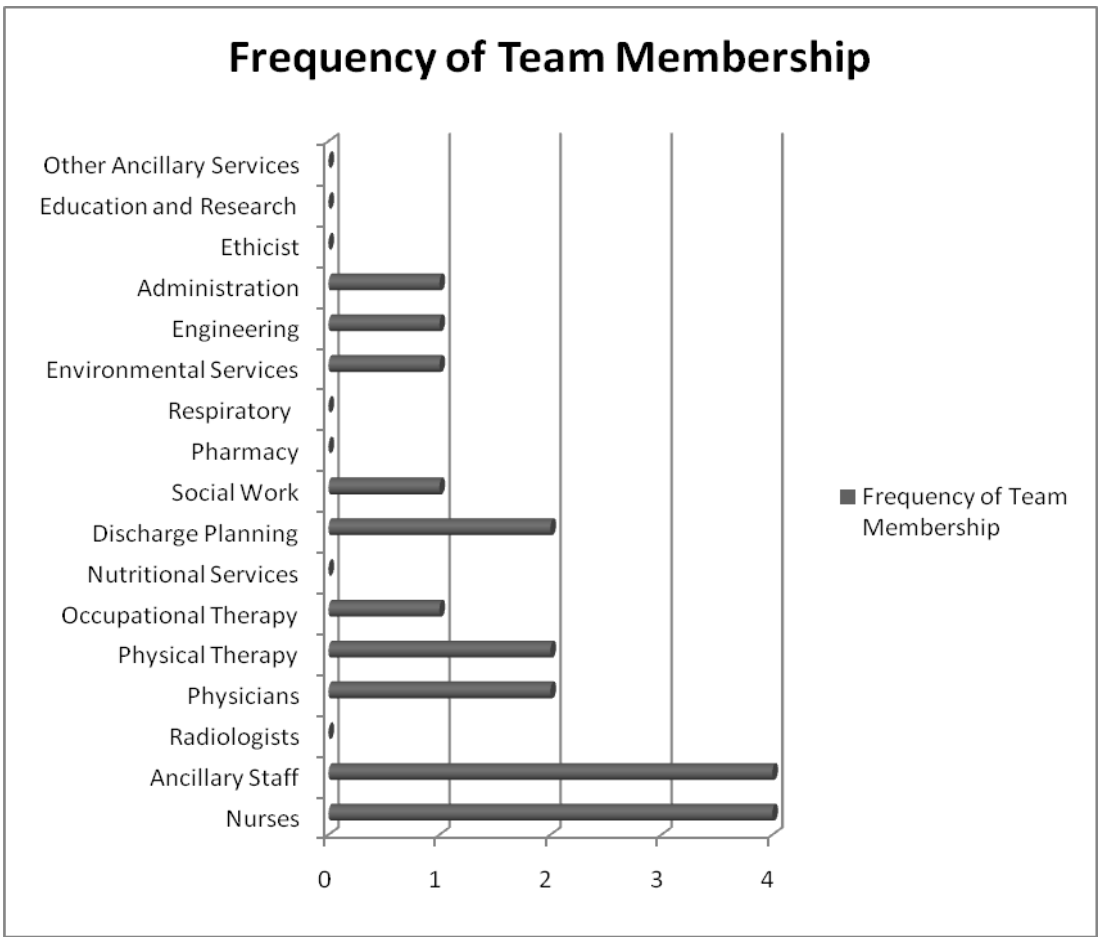


Figure 9. Frequency of team membership.

The question asking, *What qualities does the nurse manager need to develop an effective team,* generated varied responses. Hope was the first word one participant used. The union environment limited the ability to change team members without justification, a result supporting findings by Allen (2004), Beil-Hildebrand (2002), and Cody (2003) that boundaries and hierarchical constructs restrict the ability to change nursing practice.

The nurse managers in the current study mentioned that strong and disruptive personalities remained in their positions because of union restrictions, which challenged the team building capacity of the nurse managers. Effective team leadership involves managing people with various personalities and guiding members in working together. A

focus on channeling divergent personalities toward the development of quality practices through standardization provides a means for collaboration. Effective organizational leaders develop environments of accountability with clear role delineation, identifiable mission, goals, and vision, and a culture of trust, responsiveness, and quality performance (Leslie et al., 2006; Rowe & Hogarth, 2005).

The participants in the present study used the terms listener, communicator, facilitator, helper, mentor, resource person, and leader to describe qualities important to effective team building. Godkin and Godkin (2004), Ponte et al. (2007), and Rafferty and Griffin (2006) noted that mentoring, learning, and knowledge advancement through leadership development changed power structures from hierarchical to collaborative. Power filters through restrictive union parameters, constraining the ability of leaders to reorganize teams in which members with difficult personalities hamper the effectiveness of the teams. The interaction of individuals in the workplace determines the culture of the organization (DiMeglio et al., 2005; Ogbonna & Harris, 2000; Sánchez & Yurrebaso, 2009; Savolainen, 2000; Wenger, 1998; Westerman & Cyr, 2004).

Theme: Make a Difference

Key word: Identity. Among the participants in the current study, the ability to make a difference ranked first in reasons for pursuing a career in nursing (Duffin, 2009; Sherman, 2005). Two participants stated they always wanted to be a nurse, and the other participants stated they became nurses on the advice of family. The nurse managers gave a clear depiction of nursing not as a job but a calling with a focus on striving for excellence in practice. Such perspective translated into high expectations in the

workplace, and the participants modeled behavior that emphasized caring, connectedness, and patient advocacy.

Values associated with nursing included responsibility, honesty, dignity, hope, compassion, integrity, and achievement (Horton et al., 2007). One participant believed a bureaucratic top-down administration limited leadership potential. Leadership connected to identity involved setting an example, being accountable, assisting the staff to meet performance goals and expectations, helping the staff to grow, being a role model, and solving problems. Each participant in the present study perceived the role of the nurse manager as striving to provide quality care.

The identity of the participants as caring nurses balanced the bureaucratic functions of the nurse manager role. Trust underscored the connection between the participants and staff members, emphasizing the belief that the nurse manager would set reasonable performance tasks and goals. Job satisfaction derives from the ability to maintain a nursing sense of identity in workplace processes (Rountree & Porter, 2009). Goal self-efficacy and a clear progression toward goal attainment correlate positively with job satisfaction (Pornaki, Karoly, & Maes, 2009).

Three nurse managers stated the significance of nursing work and their identity as nurse managers matched their goals and vision. Experienced nurse managers divide goals into personal and professional categories (Manfredi, 1996). Morrison et al. (1997) asserted that nurses' perception of greater meaning in their role as healthcare professionals complicated leadership development. The role of the nurse is meaningless without leaders' emphasis on a nursing identity associating caring, empathy, and compassion with the profession (Gallagher-Lepak & Kubsch, 2009).

Key word: Knowledge development. The nurses in the study described the culture of the organization as accountable, open, and accessible. Three participants underscored the importance of understanding role expectations and adapting leadership methods to organizational needs. The fourth participant focused on issues related to patient care. The nursing leaders held staff members accountable for practice patterns, using leadership methods that emphasized flexibility and adaptability. Accountability positively influences the development of excellence (Casida & Pinto-Zipp, 2008).

Manfredi (1996) found that nurse managers lacked foresight and promoted short-term mentoring and goals instead of futuristic visioning. The purpose of Question 80 (i.e., Do you have a personal and professional vision for your unit), Question 81 (i.e., Do you have a personal and professional vision for the practice of nursing on your unit), Question 82 (How do you share this vision with your staff), and Question 83 (i.e., How does this vision align with the vision of this organization) was to examine the ability of the nurse managers to project their understanding of their managerial responsibilities beyond individual units. For two participants, professionalism emerged as significant in developing staff members and the work environment. Both participants promoted educational advancement as central to developing quality environments through professionalism. Leadership capacity in nursing results from the realization that learning generates knowledge. Leaders without vision lack the ability to influence and motivate teamwork (Alarcon et al., 2002).

Answers to Question 79 (i.e., What influence do the other nurse managers have on your nursing practice as a leader) showed differences in knowledge acquisition. Two participants focused on what they could gain from the other nurse managers. The other

two participants delved into how working together with the other nurse managers increased leadership knowledge and capacity. The participants believed that professional knowledge expanded on a daily basis, derived from a drive toward excellence, created an understanding of the job, increased performance, and involved listening.

Theme: Building the Practice Environment

Individuals' interactions in the workplace vary based on the degree of cohesion and relationship dynamics in relation to leadership functionality (Janson, 2008). Laschinger et al. (1999) and Lacey et al. (2009) connected staff satisfaction and empowerment to the qualities of the nurse leader in the unit. The purpose of the questions, *What concepts do you think need to be included in the model of leadership* and *What qualities do you think need to be included in a model of leadership*, was to connect leadership to the perceptions of the participants (see Figure 10).

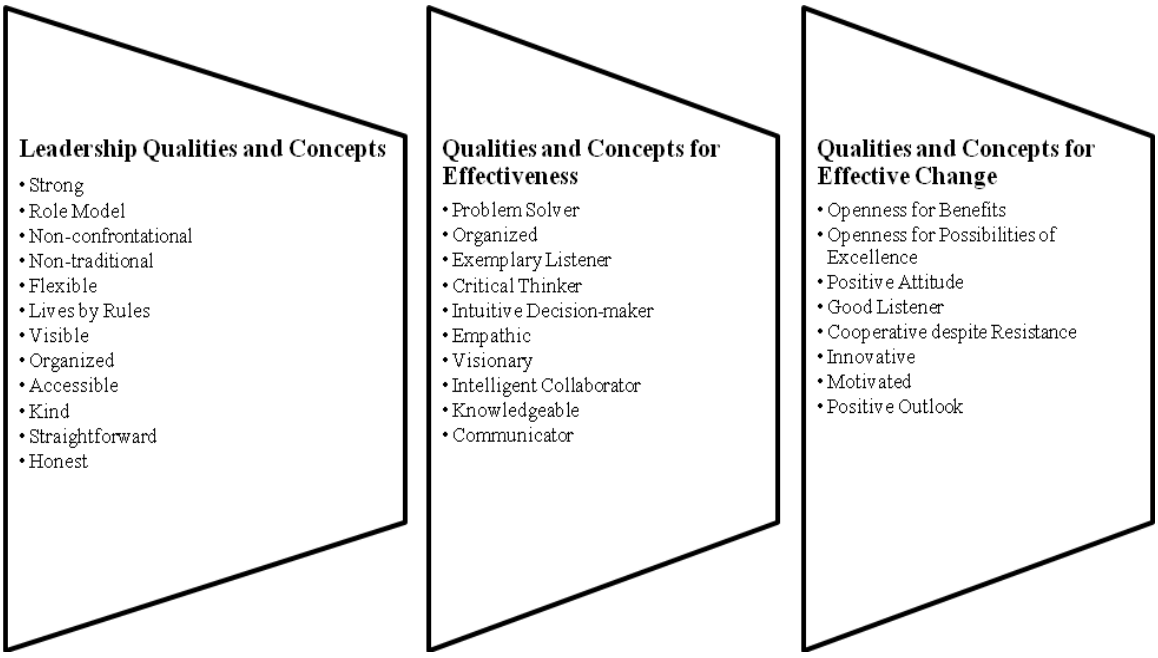


Figure 10. Leadership qualities and concepts.

Key word: Challenges. The purpose of Question 11 (i.e., Please describe any positive and/or negative aspects of this role), Question 17 (i.e., What qualities are needed by the individual to be effective in this role), and Question 18 (i.e., What does the nurse manager need from the individuals in their unit to be effective in this role) was to examine the functional capacity of the role. The participants viewed second-tier leadership as supportive because the leaders provided adequate resources and tools for successful role development. Continual problem solving, the union culture, and preconceived expectations of the role complicated role development.

The effective use of trust and directness matched second-tier leadership rather than nurse managers (Johnson, 2005). Honesty and directness in communication (Bligh & Carsten, 2005; Horton et al., 2007; Sias, 2005; Stanley, 2006) characterized one participant as an honest and truthful leader. The laissez-faire leadership style of the participant meant the nurse avoided interaction with staff members and marginalized staff member participation in goal and vision development. Cultural transformation fails without commonality of goals and a vision, which is essential to creating cohesive workplace communities (Billett & Somerville, 2004; Ravasi & Schultz, 2006).

Harshman and Harshman (1999) discovered staff members viewed communicated information as less credible in hierarchical organizations. For one participant in the current study, anticipation of challenges strengthened her critical thinking skills. Two participants relied on effective listening and communication skills. Effective change depends on the degree of connectivity between informal and formal communication channels in organizations (Goodman & Truss, 2004; Meynell, 2005).

Sias (2005) connected accurate communication with the development of relationships in the workplace. Three participants formed relationships with staff members, utilizing communication techniques despite the union culture and perception by one participant of a toxic culture. The relationship and workplace experiences of the three participants incorporated visibility, modeling, visioning, and sharing into the building of community. J. S. Brown and Duguid (2001) and Habermas (1981/1984, 1981/1987) asserted the identities of individuals in the workplace community helped overcome the challenges of integration through communicative practices.

Key word: Culture. Recognition in the workplace increases job satisfaction (Meraviglia et al., 2009). Question 48 (i.e., Are there any individuals who particularly stand out) and Question 49 (i.e., How do they influence the functioning of the team) elicited examples of excellence. Three participants visualized each individual in the workplace as capable of excellence. The perceived culture of the organization as open, collaborative, autonomous, and supportive vied with the perception of toxic units and tough, antagonistic, and difficult staff members.

One participant needed to identify with a perception of self in specific staff members. Mackoff and Triolo (2008) and Sluss and Ashforth (2007) described the relational identity of seeing oneself in subordinates as a higher-level leadership function. I. Graham (2003) and Stets and Burke (2000) agreed that self-categorization created expectations in the development of organizational cultures. For one participant in the current study, self-identification with the individuals in the workplace generated a more cohesive team environment.

Otani et al. (2009) found that patient satisfaction related to the care provision of the unit staff. One participant looked toward job standardization, task mastery, and role clarification (Lave & Wenger, 1991; Lichtenstein et al., 1997; Slater, 2006) to meet the challenge of developing a cohesive team. Improving the safety of the workplace was the main criterion for excellence for two participants. A focus on safe environments determined that individuals who stood out contributed to the safety focus. Challenges to developing a safety culture remained pervasive throughout the participating organization because of the union culture and the difficult personality types of some staff members.

Desivilya and Eizen (2005) argued a degree of conflict contributed to the effective functioning of teams. The participants agreed that discussion and compromise worked effectively to manage conflict. One participant shared that high unit acuity brought arguing staff members together to work for the benefit of patients. Another participant believed the rigid attitude of senior staff members limited team effectiveness.

Skjørshammer (2001) determined that common conflict resolution techniques in the workplace included avoidance, forcing, and negotiation. Listening, compromising, and mediating described the approaches to conflict management used by three participants. One participant avoided conflict by refusing to mediate problems between staff members. Collinson (2006) found that resourceful, engaged, innovative, and effective leaders who communicated by showing enthusiasm motivated staff members.

The union environment restricted the ability of the nurse managers to change staff members. Despite dysfunctional staff members, two participants believed every individual had a potential for excellence. Ensley and Pearce (2001), Jehn (1997), Sarros, Gray et al. (2002), and Senge (1990/1994) emphasized shared cognition as a team

building strategy. In the current study, an organizational focus on workplace standards of excellence in service delivery and professional standards of excellence in practice served to unite staff members in care provision that made a difference.

Two participants placed emphasis on the individuals who stood out to improve the functionality of the workplace. A need to keep the unit functioning smoothly led to placing strong individuals as the models who improved the skills and performance of the other team members. While one participant was visible and accessible, the other participant valued staff members who followed direction and kept the unit functioning without interrupting management functions. Lin et al. (2007) and McMurray and Williams (2004) found the same separation of practice limited leadership development.

The purpose of Question 27 (i.e., Please describe your relationship with your staff members) was to examine workplace dynamics. Two participants underplayed the importance of team building concepts. Two participants believed leaders gained the respect of staff members by showing their technical expertise. The practice of one participant to focus on patient interaction instead of staff interaction limited the formation of cohesive teams.

Organizational expectations position clinical nurse managers as experts in practice, pivotal in team formation, and accountable for resource management (Hawkins et al., 2009; Schryer, 2004). Shared mental models, closed loop communication, and mutual trust support the development of cohesive teams (Kalisch et al., 2009; Senge, 1990/1994; Wenger, 1998). Estryn-Béhar et al. (2007) found a lack of cohesive teamwork increased intent to leave. Three participants in the present study believed relationship building is based on the development of mutual respect, trust, and meanings

that generate a sense of belongingness and facilitate the challenges of organizational change in a union culture.

Answers to Topic Question 2 (i.e., Please describe what leadership means to you) revealed perspectives aligned with setting an example. Trust underscored the connection between the participants and staff members, emphasizing the belief that the nurse managers would set reasonable performance tasks and goals. Trust development was linked with each participant's sense of identity as a compassionate leader who had the best interests of the staff members at the crux of every decision. Compassion, support, and transparency in decision making enables trust and moral reasoning to develop in work environments (Lincoln & Johnson, 2009; O'Connor, 2008; Snell, 2001).

The focus of organizational culture is working together as a family. Shivers-Blackwell (2004) theorized that cultures with a sense of family demonstrated alignment with transformational leadership. All participants in the present study viewed their unit cultures as supporting a sense of family, but self-perceptions of leadership behavior varied. Terms used to describe types of leadership included directive, non-confrontational, organized, strict, fair, communicator, and laissez-faire.

The participants viewed the nurse manager as a parent and the relationship of the unit as a family. Hierarchical structuring equated the staff member with the child in the family. Sarros, Tanewski et al. (2002) maintained organizations based on hierarchical models of leadership amplified workplace dissatisfaction. The participants relied on second-tier leadership for direction and answers rather than use a collaborative approach contributing to leadership capacity growth. Reliance on second-tier leadership indicates the existence of paternalistic structures (Harshman & Harshman, 1999).

E. Miller (1999) stressed the importance of leadership over management. Only one participant in the present study equated leadership with role modeling and mentoring. Hawkins et al. (2009) found a significant correlation between the availability of peer support and mentoring and the leadership growth of nurse managers. Nurse managers in the study favored peer mentoring because they needed to develop interpersonal relationships (Sanders et al., 1996).

D. Buchanan, Caldwell, Meyer, Storey, and Wainwright (2007) and Hawkins et al. (2009) put forth the concept of each staff member as a potential leader with the support and mentoring of the nurse manager. Identification with the nursing identity at the expense of the leader identity forecasts limited involvement in developing cultures that support innovation and cohesiveness (Bondas, 2006; Johansson et al., 2007). An environment that restricts leadership growth decreases the recognition of innovation (Lageson, 2004; Patrick & Laschinger, 2006). The identity of first-tier leadership in the current research study corresponded to the role of a nurse instead of leader.

Key word: Role expectations. A focus on the technical requirements of the nurse manager role decreases leadership capacity development (Ferguson et al., 2007; Patrick & Laschinger, 2006). Question 23 (i.e., Tell me about an average day in your workplace) prompted the participants to describe the workplace routine. Only one participant detailed a balanced day divided between staff, patients, and technical role functions. The other three participants described patient interactions, paperwork demands, meetings, and functioning as a staff nurse.

The statement of one participant that the role of the nurse manager involved primarily problem solving demonstrated a focus on reactive management (Johns, 2003)

and a directive style of leadership. Diversification in leadership necessitates the capacity to be open, innovative, caring, non-judgmental, and creative (O'Connor, 2008). The participants in the current study lacked supportive structures that would allow the delegation of traditional management functions and limited work/life balance.

The words excellence, quality, and professional occurred multiple times during the conversations with all participants when describing the practice environment. Question 29 (i.e., What experiences have been significant for you over the time that you have been a nurse manager) and Question 30 (i.e., Looking back, are there any experiences that you would change) helped determine the nurse managers' focus. The participants believed that challenging experiences influenced the development of identity, especially when positive reinforcement corresponded to a sense of wellbeing and a stronger sense of self-worth. Leadership capacity developed through critical thinking supporting structures that allowed balancing stressors.

Key factors in developing leadership capacity include accessible knowledge, collaborative environment, and supportive structures (Gustafsson & Fagerberg, 2004; Newhouse & Mills, 2002). Dawson et al. (2005) discovered that placing the nurse manager over multiple units decreased available support and resources and restricted the development of excellence in practice. Leadership development necessitates the use of accountability, communication strategies, flexibility during change, and knowledge acquisition based on research (Rundall et al., 2007). The current study participants' understanding of role expectations depended on critical thinking, level of leadership development, and organizational support.

All participants relied on directors in the organization for support, knowledge, and direction. The type of interaction between directors and nurse managers influenced the leadership development of each participant. Two participants observed differences in leadership styles because of a change in directors. Both participants went from a supportive leader to a leader without the knowledge and experience to support leadership development, decreasing the effectiveness of leadership classes and eliminating gained confidence.

Supportive nurse managers spur the development of innovative behavior in staff members (Åmo, 2006; Länsisalmi et al., 2006). Innovation behavior emerges as significant to developing cultures of safety (Gil et al., 2005). The participants in the present study had to become change agents and be autonomous in developing staff to reach professional practice levels demonstrated excellence in service. Effective directors in the organization supplied positive feedback on the leadership activities of the nurse managers, supporting growth in leadership for three participants.

Key word: Knowledge development. Leadership development classes lacked relevance because of the timing of classes and lack of understanding of the nurse manager role. Reasons mentioned for lack of relevance included time constraints, role responsibilities, and limited opportunity for leadership growth and skill development during actual role performance. The focus of standardized nursing education is primarily on technical skills development (Hales, 2005; Johns, 2003; Kleinman, 2003; Sherman, 2005). McMurray and Williams (2004) found that higher levels of education and varied experience outside of healthcare increased innovative capacity.

The participants focused on educational advancement as a means to improve the utilization of best practices and quality of service delivery. While the organization provided shared governance as a vehicle for increasing quality and staff satisfaction, a lack of buy-in from three participants revealed limited integration into unit practice patterns. Shared governance efforts failed without the encouragement of the nurse managers (Apker, 2001; DiMeglio et al., 2005; Edmonstone, 2000; Frith & Montgomery, 2006; Hess, 2004; Hilburn et al., 2006; Jackson, 2000; Styer, 2007; Zuzelo et al., 2006). Bartunek et al. (2006) found that the degree of involvement in change depended on the interpretation and experiences of individuals with regard to the vision and expectations of the leaders in the organization.

Key word: Vision. Millward and Bryan (2005) agreed the ideal of a standardized leadership model was inconsistent with the need for flexibility in a changing healthcare environment. Doyle and Turkie (2006) expected some ambiguity to exist during change. Fairholm (2004) argued leadership perspectives and inherent worldviews change with the advancement of leadership capacity. Visioning that incorporates personal and professional objectives can strengthen the leadership capacity of individuals (Senge, 1990/1994; Walmsley & Miller, 2007).

The personal and professional visions elicited from the nurse managers in the study focused on service delivery quality. Central to the development of quality service delivery was the need to increase the knowledge of staff members through education. The finding parallels the experiences of the participants who increased their knowledge through education. Technical skill development in standard nursing education limits

applications to changing healthcare environments for lack of innovation (Kleinman, 2003; Mrayyan & Al-Faouri, 2008; Prybil, 2003; Russell & Scoble, 2003).

McMurray and Williams (2004) found leaders of healthcare organizations valued application of innovation at the bedside but devalued the importance of nurse managers in decision making. The participants in the current study revealed that inclusion in decision making was a low priority in their organization. The participating nurses placed a higher value on clear, accurate communication and involvement in implementation processes. Tools, resources, and support in the workplace to help move forward workplace changes emerged as significant to developing structures and practices for exemplary service delivery.

The Relevance of the Conceptual Framework

The conceptual framework for the research study included identity, culture, and organization as components in all healthcare organizations (see Figure 11). Illeris (2004) emphasized the importance of understanding the organizational relationship of individuals in relation to the position of the individuals in society. Cultural change in the workplace derives from the effectiveness of leaders and relationship development (Susnienė & Vanagas, 2006; Waldersee, 1997). Team-based processes require collaboration in the workplace (IOM, 2000, 2001, 2004; Leipzig et al., 2002).



Figure 11. Conceptual framework

Theory of Communicative Action

The development of a cohesive team environment depends on the ability of nurse managers to integrate divergent perspectives. Difficult personalities, tough unit cultures, and the union culture contributed to the challenges of changing the cultural environment of the participating organization. The leadership style of three participants included negotiation, accountability, and communication combined with the use of ethical standards and conflict resolution skills. One participant avoided interaction with staff members and refused to mediate staff conflicts.

The participants showed a partial commonality of norms, patterns, and expectations. Each participant believed a nurse makes a difference through interaction with others, demonstration of caring, and striving for excellence (i.e., the objective world). Inner meaning (i.e., the personal world) pertains to the identity of the participants

as nurses instead of leaders. A lack of cohesiveness limited the active participation of individuals in governance and change (i.e., the subjective world). A successful professional practice in nursing is dependent on a worldview that contains exemplary moral and ethical standards.

The worldview of individuals emerges from life experiences derived from the personal, objective, and subjective worlds. The participants in the present study placed importance on life experiences as preparation for leadership. Family, societal, and personal values emphasized caring, dedication, and responsibility. Higher goal expectations for the participants supplied a sense of achievement when support and resources aligned for goal completion.

The specific interaction of the personal, objective, and subjective worlds in the organization is based on the type of overall leadership. Table 4 illustrates the role of the nurse manager as an intermediary between second-tier leadership and the staff members. Unit cultures exhibit a sense of family. Open communication between directors and nurse managers fosters an organizational culture of accessibility and high expectations of excellence in service.

Two participants believed leadership was inherent, showing closed worldview perspectives. Popper et al. (2004) found that nurse managers with a belief in inherent leadership failed to develop adequate leadership capacity. The two participants modeled a systemic approach to leadership practice that encouraged staff members toward similarity in practice. The other two participants valued excellence in a practice connecting leadership to innovation and initiative. These two participants differed in leadership

practice with one participant setting practice standards while the other participant believed that encouraging knowledge acquisition would increase leadership.

Supportive organizations foster knowledge acquisition and leadership development through formal and informal learning. All four participants gained knowledge through supportive directors, classes, and workplace experiences. The participants prioritized knowledge development and acquisition as essential to the future of nursing in a changing healthcare environment. “Every institution has to adapt to changing boundary conditions by drawing on its own resources” (Habermas, 1981/1987, p. 242).

Community of Practice

An ideal healthcare organization consists of individual units connected by commonality of purpose. The participants demonstrated that service delivery quality drives the vision of nurse managers and the organization. Concepts of identity emerge through a process of participation, negotiation, engagement, and reification. All four participants experienced the process during their leadership development.

The second stage of leadership development includes visioning and visualization to involve staff members in setting professional and personal goals in the workplace. Three of the participants had an understanding that the staff members needed to participate in the process but lacked implementation skills. One participant had not reached the second stage of leadership development for lack of personal or professional goal development. The participants did not have the skills to develop a community-of-practice because of resistance to collaborative decision making.

Shared Governance

The principles involved in shared governance consist of learning, negotiation, understanding, accountability, communication, autonomy, and commitment. Two participants demonstrated higher-level communication skills and used strategies focused on a continuous exchange of information throughout the workday. The other two participants showed a one-way communication style from nurse manager to staff member in a monthly meeting format. Hierarchical organizational barriers limited the degree of shared information.

Slow cultural change in a union environment challenged the ability of the participants to set standards, change expectations, and eliminate barriers. The leadership development process of the participants revealed a need for a more collaborative structure between nurse managers. While teamwork was used to describe the organizational environment, team structures lacked completeness and limiting effectiveness (see Figure 7). The perceptions of the nurse managers revealed a need for further education and knowledge concerning practice parameters, responsibility, and accountability in a team environment.

Implications

The results of the study show that the degree of support and mentoring from second-tier leadership is a significant factor in the leadership development of new nurse managers. Directors were the most significant leadership example for the nurse manager population. Previous educational experiences did not influence the leadership development of the participants. Nursing education did not prepare the participants for leadership in the nurse manager role.

Significance of the Study

The use of a conceptual framework to guide the research study helped center the interview questions on identity, culture, and organization. The study results show a complete picture of the organization from the perspective of the participants. The six themes pertain to the identity of the participants, the culture of the organization, and the influence of the organization. The themes included defining a leader, become a leader, searching for balance, the influence of others, make a difference, and building the practice environment.

The inner identity of the participants as nurses strengthened the meaning of the nurse manager role. The participants demonstrated a sense of belongingness because of support of the directors in the organization. The participants used a team approach to the workplace environment, but there was no perception of the nurse manager group as a team except for one small subset of critical care managers. Each nurse manager acted independently in the workplace under the guidance of directors.

Nurse managers share knowledge, expertise, and perspective in organizational environments that encourage education, innovation, and initiative. Forward-looking healthcare organizations emphasize that successful quality service delivery requires the ability of organizational members to collaborate during change. In the participating organization, adequate organizational resources, an emphasis on excellence and professionalism, and standardization of processes started a change process that was challenged by a union culture. Despite a difficult culture, the change to a nurse manager role for first-tier leadership positively influenced the culture of the organization.

Significance of the Study to Leadership

There was a gap in research concerning leadership development of nurse managers. The present research study included the perspectives of four new nurse managers during the introduction of the managerial role in one healthcare organization. All participants stated their nursing education did not prepare them for a leadership position. Lifetime experiences at the personal and societal levels provided more preparation for a leadership role than nursing education and practice experiences.

The knowledge-based and innovation capacity of the director directly influenced the leadership development of the nurse managers. The three nurse managers who had more involved directors showed a greater level of leadership development than the other participant. These three nurse managers expressed personal and professional goals while the other participant could not think of goals. All the participants shared a vision of excellence in service delivery, but only two participants demonstrated the ability to engage staff members in this vision.

Recommendations for Nursing Leadership

The research revealed that nursing educational experiences lacked the component of preparation for leadership. A focus on technical aspects and skill sets specific to care modalities limits leadership development in nursing education. Universities and healthcare organizations need to provide leadership development opportunities through structured educational programs and classes. Limited available time during work hours require organizations to develop workplace models allowing flexibility in scheduling to meet the need for leadership education for all employees.

While the participants in the current study believed the organization functioned from a team perspective, the perception of the nurse managers as a team did not emerge from the data. The results reveal that the role of nurse manager was viewed as a complex and difficult role in the organizational structure. The nurse managers were responsible for creating a unit environment that utilized supportive and effective teamwork but lacked the benefit of a peer team framework. Nursing second-tier leadership should facilitate a peer team approach to the nurse manager role in the organization.

Directors in the organization were found to be significant to the leadership development of the nurse managers. Only one participant mentioned that the director was viewed as a role model or mentor. The expansion of leadership development strategies (see Figure 12) to include the use of role models and mentors will benefit nurse managers and organizations. A suggestion consists of providing formal and informal mentoring opportunities to advance the leadership development of nurse managers to a higher level.

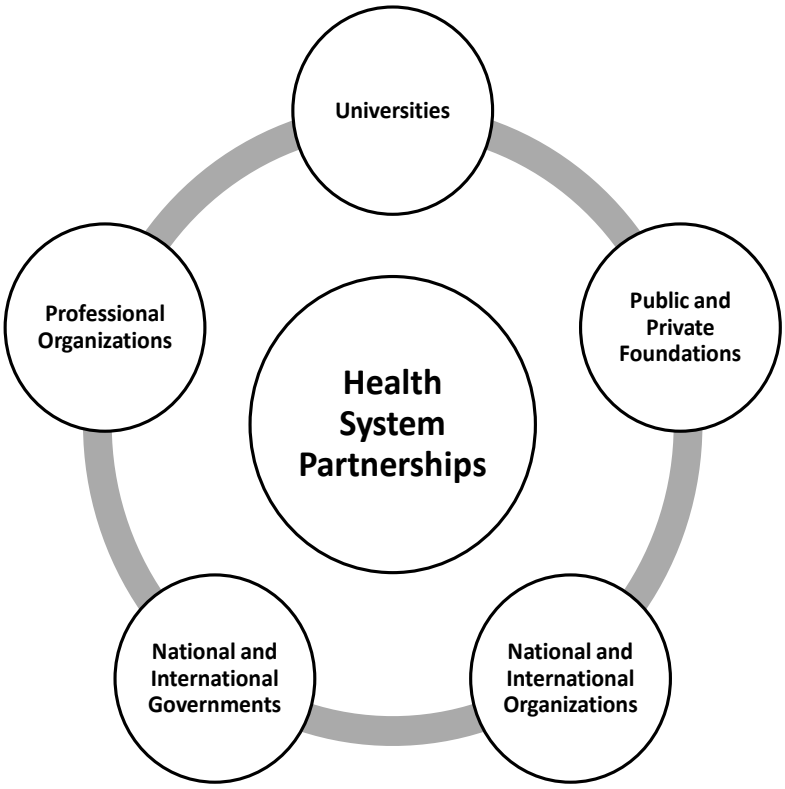


Figure 12. Leadership development strategies.

The health system of the participating organization provided numerous educational programs and courses for the leadership development of the nurse managers. Each participant took advantage of the structured education, but one participant revealed the educational programs came too soon in the nurse's managerial practice. The nurse manager had not enough experience to understand the complexities of the role. Another participant believed an orientation process that allowed working alongside an experienced nurse manager for a month would have provided a greater benefit to role development. A recommendation is to develop a standardized educational process that includes mentoring experiences, peer mentoring, working with experienced nurse

managers outside of the specific organization, fellowship opportunities, and educational programs to support nurse managers in reaching full leadership capacity (see Figure 12).

Conclusions

The purpose of the qualitative case study was to determine how healthcare leadership developed in a changing organization. A specific change from a hierarchical model of leadership using head nurses to a more autonomous model using nurse managers in one organization qualified the research as applicable for a case study method. The responses of four participants reflected the experiences of developing leadership and changing the practice environment toward excellence in service delivery. Document review of director/nurse manager meeting minutes confirmed the recollections of the participants.

The participants described a focus on patient quality and safety, educational advancement, professional practice, and safe environments. Integrating vision with practice involves educating and developing staff members through communicating nursing values based on improving the patient experience for every participant. Each nurse manager faced challenges in the workplace that included the union environment, the perspectives of the staff members, the perspectives of other leaders, and the realities of nursing practice. The visions identified by each participant ranged from simplistic and focused on unit-based expectations to complex and identified with becoming a center of excellence.

A primary finding from all participants was that prior educational experience left the participants unprepared for the complexity of the nurse manager role. All participants expressed an inner identity as a nurse rather than a leader. The belief that life experiences

provided more benefit than education aligns with Habermas' (1981/1984, 1981/1987) conceptualization of identity as a blending of objective, social, and subjective worlds. A conclusion drawn from the finding is that nursing education lacks relevance to leadership development in the practice environment.

The participating organization supplied extensive leadership development resources, but the most significant factor influencing role fit concerned the connection of the director to the nurse manager. A strong director presence with mentoring moved two participants beyond knowledge acquisition to knowledge application in some areas of leadership practice development. Two conclusions are drawn from this finding. First, mentoring instead of oversight allows relationships, respect, and camaraderie to benefit both director and nurse manager. Second, the application of knowledge requires supportive relationships to foster effective leadership development.

A surprising finding was that the nurse manager group lacked the perception of being a team. The focus of the organizational environment in healthcare is on teamwork as a model of workplace functioning. Full involvement in the community-of-practice requires effective communicative structures based on teamwork. Conclusions drawn from the finding are (a) a leadership role without a team perspective limits the growth of excellence in service delivery and (b) further development of team processes is needed in healthcare.

The use community-of-practice in the conceptual framework for the current research represented an ideal environment of practice. The model of leadership contained engagement, imagination, and alignment as a basis for the advancement of the individual into the team environment emphasizing a sense of belongingness to the community.

While the participants demonstrated through their responses that engagement occurred, further leadership growth is needed to develop environments of practice that align with a team perspective. The blending of a leadership identity into a nurse identity can connect participants to the concepts needed for cohesive team development.

The linkages between the 6 themes and 22 key words showed the complex relationship between the identity of the nurse manager, leadership development, and components of the practice environment as perceived by the participants (see Appendix I). The themes of defining a leader, to become a leader, searching for balance, the influence of others, make a difference, and building the practice environment represent the leadership development process of the participants. The research study filled a small portion of the gap in literature concerning leadership development of nurse managers.

Recommendations for Future Research

The study provided a platform for expanding the small population of four participants to a larger population with the conceptual framework, interview guide, and case study protocol. Potential participant groups include all levels of nursing leadership from assistant nurse managers to administrative directors of nursing. A comparison of new nurse managers and experienced nurse managers would benefit future research into leadership development needs. Future researchers might modify the interview guide and case study protocol to apply to other professional leaders, using qualitative and quantitative methods.

The use of a conceptual framework targeting identity, culture, and organization can facilitate the application of theory, ideas, and concepts that translate beyond healthcare and the hospital environment. The interrelationship of identity and culture

apply to every individual in an organization. An organization supplies a specific cultural and organizational identity that influences every individual. The conceptual framework of the current study is applicable for quantitative and qualitative research concerning leadership and organizations.

Suggested Questions

The following questions may be considered by future researchers:

1. How does perceived identity as a nurse influence leadership capacity?
2. How does perceived identity as a nurse influence leadership growth?
3. What is the value of mentors concerning leadership development in nursing?
4. How does unit culture influence the development of leadership?
5. How does organizational culture influence the development of leadership?
6. Does self-perception as a leader influence the development of leadership?
7. Does the level of interpersonal relationship between nurse managers influence the development of leadership?

Potential Hypotheses for Future Research

The following hypotheses may be considered by future researchers:

$H1_A$: The differences between new nurse managers and experienced nurse managers influence the development of teamwork in a unit.

$H1_0$: There is no difference between new nurse managers and experienced nurse managers concerning the development of teamwork in a unit.

$H2_A$: Experienced nurse managers have more complex leadership concepts and qualities than new nurse managers.

$H2_0$: There is no difference in complexity of leadership concepts and qualities when comparing experienced nurse managers and new nurse managers.

$H3_A$: There is a difference between teamwork at the nurse manager level and the director level.

$H3_0$: There is no difference between teamwork at the nurse manager level and the director level.

$H4_A$: Good interpersonal relationships between nurse managers influence the development of leadership.

$H4_0$: There is no difference concerning the development of leadership between nurse managers who have good interpersonal relationships and nurse managers who do not have good interpersonal relationships.

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APPENDIX A: CONCEPTUAL FRAMEWORK

TABLE A1

Table A1

Conceptual Framework

Theory	Identity	Culture	Organization
Community-of-Practice	Participation Negotiation Engagement Reification	Negotiated Experience Community Membership Learning trajectory Nexus of multimembership A relationship between local and global	Boundary Overlap Perspective Reflective Reifications Knowledgeability of practice A learning architecture
Shared Governance	Perception Role Responsibility Accountability	Changing Expectations Creating evidence Setting standards Developing relationships Collaborative practice	Integrating parameters of practice Creating a network of councils Eliminating barriers

			Equality in professional relationships
Theory of Communicative Action	Objective world Social world Subjective world Communicative Rationality Worldview forms and stabilizes identity	Interpretation Assimilation Consensual Validity of norms Communicative practice Reaching understanding Transmits and renews cultural knowledge Acting communicatively develops shared lifeworlds	Regulation of domains of action Autonomy is gained through neutralizing lifeworld structures Mutual understandings mediated by bureaucracy Fragmented consciousness blocks enlightenment via reification

APPENDIX B: KEY WORD SEARCH TABLE

TABLE B1

Table B1

Key Word Search Table

Key Words Searched	Peer Reviewed Articles	Germinal Works	Books	Studies
Social cognitive learning theory	8	1	2	6
Identity theory	13	3	0	20
Theory of communicative action	13	2	2	1
Culture and change	32	2	1	33
Environment and change	12	1	1	33
Organization and groups	8	0	0	16
Community of practice	8	2	2	6
Leadership	34	1	1	52
Leadership models	9	0	0	10
Nurse managers	8	0	0	47
Shared governance	17	1	1	14
Total Reviewed	174	13	10	282

APPENDIX C: CASE STUDY PROTOCOL

CASE STUDY PROTOCOL

Overview

1. The research study intended to explore the leadership development of nurse managers in a changing organization. Leadership set the tone for the practice and service provision of the employees of the healthcare organization. The main objective of this qualitative study was to determine how leadership developed in a changing healthcare organization.
2. Goals for this research study included exploring the change process as it related to leadership development; showing the relationship between leadership development processes and perceived growth as leaders; and determining the role of leadership in developing environments of care that supported excellence in service provision.
3. A series of reports on healthcare delivery in America (IOM, 2000, 2001, 2004) guided the research base of this case study. A conceptual basis for this research study used Etienne Wenger's (1998) book, *Communities of Practice: Learning, Meaning, and Identity*, for an organizational model. Jürgen Habermas' (1981/1984, 1981/1987) *Theory of Communicative Action* represented reasoning, culture, and society. Porter-O'Grady and Finnigan's (1984) book, *Shared Governance for Nursing: A Creative Approach to Professional Accountability*, represented governance practices in healthcare. Leadership development processes emerged from healthcare research (IOM, 2001).
4. Guiding this research study was the question, "How does leadership develop in a changing organization?" Sub-questions, "What has been the leadership

development process for the nurse manager in this organization?" and "How has the change effort influenced the leadership of the nurse manager?" targeted the leadership development of the nurse manager.

5. A choice of the hospital organization as the site for this research relied on the number of likely individuals that were available for study. A majority of hospitals had nurse managers as the first-tier leadership position in the healthcare unit.

Data Collection

1. Access to participants occurred with permission by the Associate Executive Director of Nursing Services and approval of Institutional Research Review Board.
2. Initial contact with nurse managers was an e-mailed solicitation message describing the research study. A signature on the informed consent document will confirm agreement by participants.
3. Participant decision of an organizational setting or a private setting for the two semi-structured interviews determined each participant's place for each interview sequence.
4. A semi-structured in-depth format guided data collection with the use of two 60-minute interviews. Each participant interview was separated by an approximately two-week interval based on participant availability. An interview guide provided initial questions with further direction emitting from participant engagement in the research process.

5. Each interview was audio recorded with initial data analysis occurring after each interview to determine direction for the second interview. Data analysis took place outside the organizational premises without the presence of the participant.
6. Research notes described the observations and reflections of the researcher during the interview and analysis process. Research notes were recorded in a notebook with opposing pages separated into observations and reflections. Research notes contributed to the development of questions for the second in-depth interview.
7. Review of Director / Nurse Manager meeting minutes followed completion of the interview process. The review of these documents contributed data concerning the internal activities of the organization. This data review took place outside the organization using copies of these documents.

Case Study Questions

1. What was the role of nurse manager background in the development of leadership skills? Collection source was each nurse manager, descriptive and reflective research notes, and prior existing research data and theory. What was the role of the nurse manager? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.
2. What did each nurse manager contribute to the role? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.

3. What influenced the development of the practice environment? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.
4. How did the preexisting culture of the organization influence the development of the practice environment by the nurse manager? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.
5. What was the leadership path of each nurse manager? What influenced this path? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.
6. How did the leadership development of this role influence the organization and the practice environment? Collection source was each nurse manager, descriptive and reflective research notes, Director/Nurse Manager meeting minutes, and prior existing research data and theory.

Case Study Report

1. An inclusive representation of each participant's nursing, educational, and organizational experience from each nurse manager, other nurse managers' perceptions, descriptive and reflective research notes, and Nurse Manager/Director meeting reports was developed.
2. An inclusive representation of each participant's path toward leadership from each nurse manager, other nurse managers' perceptions, descriptive and reflective research notes, and Nurse Manager/Director meeting reports was developed.

3. The relationship between leadership and organizational environments was described as demonstrated via the perceptions of the nurse managers. Analysis of data results was integrated with prior existing research and theory.
4. How a changing healthcare environment affected the development of leadership and organizational environments were described. Analysis of data results was integrated with prior existing research and theory.

APPENDIX D: PERMISSION TO USE PREMISES FORM

PERMISSION TO USE PREMISES FORM

University of Phoenix

INFORMED CONSENT: PERMISSION TO USE PREMISES, NAME, AND/OR SUBJECTS

North Shore-Long Island Jewish Health System Southside Hospital

I, hereby authorize Joan T. Mueller, student of the University of Phoenix, to use the premises, name, and or/subjects requested to conduct a study entitled Emerging Leaders: The experiences of new nurse managers in a changing organization.

Signature [signature] Date 12/12/07

Title
Associate Executive Director

Name of Facility
Southside Hospital

APPENDIX E: INFORMED CONSENT FORM

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM

STATE CAMPUS HERE: SOUTHSIDE HOSPITAL

CONSENT FOR PARTICIPATION IN A RESEARCH STUDY

Study Title: Emerging Leaders: The Experiences of New Nurse Managers in an Organization Undergoing Change

Principal Investigator: Joan T. Mueller, Doctoral Student

Introduction

You are being asked to join a research study. The following information will explain the purpose of the study, what you will be asked to do, and the potential risks and benefits. It will also explain that you do not have to be in this study to receive medical care. You should ask questions before deciding whether you wish to participate.

Purpose of Study

The purpose of this project is to study the role of the nurse manager. We would like to find out what your experiences are in this role.

You have been asked to participate in this study because you are a nurse manager with no prior experience in the nurse manager role.

Expected Duration of Subject's Participation

If you choose to participate in this study, the study procedures will consist of two 60-minute audio-recorded face-to-face interviews. There will be an interval of approximately two weeks between each interview. No additional procedures and visits are necessary.

Description of Procedures

If you choose to participate in this study, besides completing this consent form, you are being asked to:

Consent to two 60-minute face-to-face audio-recorded interviews.

Decide whether you wish to be interviewed in a private area of the organization (NSLIJ Southside Hospital) or a private area of your choosing outside the organization.

Possible Benefits

There will be no direct benefit to you in participating in this research; however, the possible benefit of your participation is to contribute to the knowledge base of leadership in healthcare and improve understanding of the nurse manager role.

Possible Risks/Discomforts

As with all research studies, there is a risk of a breach in confidentiality. Careful measures are in place to minimize this risk.

Alternatives To Participation

The alternative is not to participate.

Costs/Compensation

You will not have any added costs from being in this study. You will not be reimbursed for your participation.

Compensation For Research Related Injury

If you are hurt from being in the study, you will receive medical care and treatment as needed from the North Shore-Long Island Jewish Health System. However, you will be responsible for the costs of such medical treatment, directly or through your medical insurance and/or other forms of medical coverage. No money will be given to you.

Voluntary Participation

Your participation in this project is voluntary. If you do not join the study you will not be penalized or lose benefits to which you are entitled. If you join the study, you may withdraw at any time without prejudice to your future care at the North Shore-Long Island Jewish Health System.

The quality of your medical care will be the same, whether you join, refuse to join, or decide to leave the study.

Privacy/Confidentiality

If you agree to be in this study, we will collect information that identifies you. We will not collect information related to your health or from your medical record. Any study information about you will be kept private and will only be given out with your permission. If the results of this study are published, your name will not be used. Your research records will be private to the extent allowed by law. In order to make sure the research is done properly, the Institutional Review board (IRB – the committee that oversees research at this institution) may need access to information about your participation in this study.

Contacts For Questions/Access To Consent Form

If you have any questions about the study, you may call Joan T. Mueller at (631) 412-3041. For questions on your rights as a research subject you may call the Office of the Institutional Review Board (the committee that oversees research at this Institution) at (516) 719-3100. A signed copy of this consent form will be given to you.

Summation/Signature

You have been informed of the potential risks and benefits involved as a participant. Furthermore, you have been assured that the researcher will answer any questions that may arise. You acknowledge that the nature of the study and the means by which your identity will be kept confidential have been explained. You have had the opportunity to ask the researcher questions and have received satisfactory answers to these questions. You voluntarily agree to participate in this study and know that you can withdraw from the study at any time without penalty. By signing this form, you have not given up any of your legal rights, you confirm that you are 18 years old or older, and you have fully read this informed consent describing a research study.

_____	_____	_____
Research Subject's Name (Typed or printed)	**Research Subject's Signature**	**Date**
_____	_____	_____
Witness's Name and Title	**Witness's Signature**	**Date**

(A witness to the research subject's signature is required.)

Investigator's Statement

In addition to advising the above subject about the study, I have offered an opportunity for further explanation of the risks, which may be associated with this study and to answer any further questions relating to it.

_Joan T. Mueller Doctoral Student	_____	_____
Name and title	**Signature**	**Date**
(Typed or printed)		

APPENDIX F: TRANSCRIPTIONIST CONTRACT

TRANSCRIPTIONIST CONTRACT

Joan T. Mueller and J*S Martin Transcription Resources (‘Supplier”) are entering into an arrangement in which the Supplier will provide transcription services. It will be necessary for Joan T. Mueller to provide the Supplier information Joan T. Mueller considers confidential. The Supplier shall maintain in confidence all interview information disclosed by Joan T. Mueller . The Supplier shall not disclose any such information to any third party for any purpose other than providing services under the agreement between _Joan T. Mueller and the Supplier.

The Supplier shall return all interview information, tapes and data to Joan T. Mueller upon request or upon termination of the relationship between Supplier and Joan T. Mueller. Included in the information to be returned to Joan T. Mueller shall be any documents created by Supplier that incorporates _Joan T. Mueller’s information.

The Supplier’s obligations of non-disclosure and non-use shall not apply to any information or data disclosed to it by _Joan T. Mueller which (i) was known to the Supplier or to the public prior to the disclosure of the information by Joan T. Mueller; (ii) becomes known to the public from a source other than the Supplier; (iii) is disclosed to the Supplier by third party having a legal right to make such disclosure; or (iv) is independently developed by or for the Supplier by persons, including employees of the Supplier who have not had access to information or data disclosed by Joan T. Mueller to the Supplier or to documents created by the Supplier that incorporate such interview information or data.

IN WITNESS THEREOF, this Confidentiality Agreement has been executed by an authoried representative of the Supplier on

J*S Martin Transcription Resources

By: Jay H. Martin

Name: Jay H. Martin

Title: Proprietor

Address: 11042 Blix Street, W. Toluca Lake, CA. 91602

Phone: 818-760-2791

E-mail: jay@jsmartintranscription.com

Client name:

By:

Name: Joan T. Mueller

Title: Researcher

Address : 511 Scudder Avenue Copiague NY 11726

Phone: 631-412-3041

E-mail: jmueller147@yahoo.com

APPENDIX G: INTERVIEW GUIDE

INTERVIEW GUIDE

Overview

The purpose of the research study is to discuss the role of the Nurse Manager in this organization. This research study concerns your experiences in this role. Your participation will involve participating in two audio-recorded 60-minute interviews. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. The results of the research study may be published. Your data will be combined with other participants in this study. The published results will not include your name or any other information that will personally identify you. Participant identity will be protected by the assignment of a random number from 1a to 10b by the researcher for each interview.

Demographic Questions

1. How long have you been a nurse manager?
2. How long have you been in nursing?
3. Why did you decide to become a nurse?
4. What has been your educational background?
5. What type of nursing have you practiced?

Topic Questions

6. Please describe what it means to be a nurse manager.
7. Please describe what leadership means to you.
8. Please describe what you consider an optimal workplace environment.
9. What can you tell me about shared governance?

Nurse Manager Role Questions

10. What motivated you to decide to accept the nurse manager role?
11. Please describe any positive and/or negative aspects of this role.
12. Is there anything in your background that you feel prepared you for this role?
13. What has been your perception of support for you in this role?
14. Has anyone been of influence to you in this role?
15. Is the role of the nurse manager defined by the organization?
16. What do you see as the role of the nurse manager?
17. What qualities are needed by the individual to be effective in this role?
18. What does the nurse manager need from the individuals in their unit or team to be effective in this role?
19. What does the nurse manager need from the organization to be effective in this role?
20. What does the nurse manager need from educational opportunities to be effective in this role?
21. What does the nurse manager need from professional organizations to be effective in this role?
22. What do you see as the role of the nurse manager in the future?

Organization, Culture, and Environment Questions

23. Tell me about an average day in your workplace.
24. What types of relationships do you have in the workplace?
25. What about your relationships with the other nurse managers?

26. What do these relationships mean to you?
27. Please describe your relationship with your staff members.
28. Please describe your staff members' relationships with each other.
29. What experiences have been significant for you over the time that you have been a nurse manager?
30. Looking back, are there any experiences that you would change? Why? How would you change them?
31. Please describe an experience where you have changed a negative outcome to a positive outcome.
32. Please describe an experience where you have been unable to change an outcome.
33. How does the unit that you are managing compare to other units that you worked on as a staff nurse?
34. How would you describe the culture of your unit?
35. Does the organization have a specific culture?
36. How would you describe the culture of other units in the organization?
37. How do individuals work together in this organization?
38. How do individuals work together in your unit?
39. Is teamwork a component of how units function in this organization?
40. Is there a type of team that is specific to nursing compared to other types of organizations?
41. Who is on the team in your workplace?
42. How is the team on your unit the same or different from the team on other units?
43. What qualities does a nurse manager need to develop an effective team?

44. What components in the workplace do you need to develop an effective team?
45. What components do you need in the organization to develop an effective team?
46. What components exist in the workplace and the organization to assist in the development of an effective team?
47. What are the dynamics of the teams in your workplace?
48. Are there any individuals that particularly stand out?
49. How do they influence the functioning of the team?
50. How do the individuals on the team interact?
51. How do you interact with the team in your unit?
52. How much guidance do they need? If any?
53. What challenges exist in the management of the team on your unit?
54. How do you introduce new people into the team in your unit?
55. How do you handle conflict in your team?
56. What is the interaction between your team and other teams in the organization?
57. Do you consider yourself and the other nurse managers as a team?
58. How do you interact with the other managers in the organization?
59. What is your relationship with other departments in the organization? Do you consider them part of your team?
60. In what way is this organization changing?
61. What do you see as effective or not effective?
62. What would you change or not change in this organization? Why?
63. What qualities does a nurse manager need to be effective during change?

64. What components or aspects need to be present for your unit to be effective during change?
65. What components do you need to have from the organization for you to be effective during change?

Leadership and Governance Questions

66. Describe your participation in leadership in the organization.
67. How do you think leadership develops in a person?
68. How do you build professional knowledge?
69. What are the resources available to you in your workplace to build professional knowledge?
70. Describe the role of shared governance in the organization.
71. How is shared governance working?
72. Do you identify with being a leader? Why or why not?
73. Do you think that you have a particular leadership style?
74. Is there a specific model of leadership in the organization?
75. Do you think that there should be a specific model of leadership for nursing?
76. What concepts do you think need to be included in a model of leadership?
77. What qualities do you think need to be included in a model of leadership?
78. Can you see any differences and/or similarities between leadership in nursing and other types of professions?
79. What influence do the other nurse managers have on your nursing practice as a leader?
80. Do you have a personal and professional vision for your unit?

81. Do you have a personal and professional vision for the practice of nursing on your unit?
82. How do you share this vision with your staff?
83. How does this vision align with the vision of this organization?
84. Do you have personal and professional goals for your unit?
85. Do you have personal and professional goals for the practice of nursing on your unit?
86. How do these goals align with the goals of the organization?

Topics

1. Leadership qualities
2. Communication strategies
3. Mentoring
4. Empowerment
5. Autonomy
6. Educational programs and development
7. Organizational meetings
8. Corporate culture
9. Retention
10. Recruitment
11. Individual growth
12. Workplace qualities
13. Community in the workplace
14. Sense of belongingness

Prompts and Probes

1. What happens?
2. Could you tell me a little more?
3. What can you tell me about that?
4. What is important about that?
5. Could you describe that further?
6. How did you react to that?
7. What do you mean?
8. Such as . . .?
9. Could you give me an example?
10. Can you clarify that?
11. Please explain further.
12. Let's explore . . .
13. How did you feel about . . .
14. Why do you think that happened?

Conclusion

Is there anything else that I can take away from the interview that will provide me with a better understanding of the nurse manager role? Is there anything else that I should have asked? Please do not hesitate to contact me if you have any questions and/or concerns. You will be sent via e-mail a copy of the completed interview transcript for verification prior to final data analysis. If indicated, please review and return with corrections and/or clarifications. I would be happy to give you a copy of the completed dissertation if you would like one. Thank you for your time and participation.

APPENDIX H: E-MAIL SOLICITATION LETTER

E-MAIL SOLICITATION LETTER

Dear Nurse Manager,

I am a student at the University of Phoenix working on a Doctoral of Health Administration degree. I am conducting a research study entitled Emerging Leaders: The Experiences of New Nurse Managers in an Organization Undergoing Change. The purpose of the research study is to discuss the role of the Nurse Manager in this organization. This research study concerns your experiences in this role.

Your participation will involve participating in two audio-recorded 60-minute interviews. The interviews will be conducted face-to-face in a mutually agreed setting of the participant's choice in the organization or an alternative private setting. Your participation in this study is voluntary. Please be assured that the organizational relationship between the nurse manager and the assistant director will not factor into choosing to decline to participate. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself.

The results of the research study may be published. Your data will be combined with other participants in this study. The published results will not include your name or any other information that will personally identify you. Participant identity will be protected by the assignment of a random number from 1a to 10b by the researcher for each interview. Your results will be maintained in confidence with a coded identifier to ensure anonymity. Research data will not be shared with organizational members**.** Research data will be kept confidential and will not be shared with any individual.All audio-recorded data, research notes, and transcripts will be stored in a password-protected computer separated from identifiers. In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, the possible benefit of your participation is to contribute to the knowledge base of leadership in healthcare and improve understanding of the nurse manager role.

If you have any questions concerning the research study, please call me at 631-412-3061. I can also be reached via e-mail at jmueller147@yahoo.com.

If you wish to participate in this research study, please e-mail a reply to this e-mail request. Thank you for your interest in this research study.

Sincerely,

_____

Joan Mueller

APPENDIX I: IRB APPROVAL LETTERS

IRB APPROVAL LETTERS

UNIVERSITY OF PHOENIX INSTITUTIONAL REVIEW BOARD

On behalf of Dr. Bill Pepicello, Chair of the Institutional Review Board, your doctoral research proposal has been reviewed and deemed "exempt."

Your progress report for this study is due one year from the date identified below.

Dissertation Title: Emerging leaders: the experiences of new nurse managers in an organization undergoing change.

By

Joan Mueller

DR. BILL PEPICELLO

Bill Pepicello
Provost of Academic Affairs
University of Phoenix

University of Phoenix

1/20/2009

North Shore LIJ
North Shore-Long Island Jewish Health System

Institutional Review Board
FWA #00002505
Office of the Institutional Review Board
6 Dakota Drive, Suite 207
Lake Success, New York 11042
Phone 516-719-3456
Fax 516-719-3110

3/4/2009

Joan T. Mueller
Nursing Administration
Southside Hospital
301 E. Main Street
Bay Shore, NY 11706

RE: **IRB #:** 08-324
Protocol Title: Emerging Leaders: The Experiences of New Nurse Managers in an Organization Undergoing Change
Expiration Date: 3/3/2010

Dear Ms. Mueller:

The above referenced project meets the criteria outlined in 45 CFR 46.110 and 21 CFR 56.110 for EXPEDITED REVIEW and has been approved. The following category(ies) apply(ies) to the project:

45 CFR 46.110 (7): **(7) Research on individual or group characteristics or behavior or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.**

Pre Meeting Action. Expedited Approval. Approval of this project includes:
1. Protocol (version 3.3.09).
2. Consent (version 3.3.09).

Please note:

The Institutional Review Board - Committee will be notified of this action at its meeting on 3/19/2009.

Subject recruitment methods are appropriate, there is equitable selection of subjects, and there are provisions to protect and maintain the confidentiality of data and research participants.

Investigators are reminded that research must be conducted in accordance with all applicable Department of Health and Human Services regulations 45 CFR 46, Food and Drug Administration regulations 21CFR 50, 21CFR 56, 21 CFR 312, and the Health Insurance Portability and Accountability Act (HIPAA).

All studies are subject to audits by the Office of Research Compliance and/or Institutional Review Board to confirm adherence to institutional, state, and federal regulations governing research. All research studies are expected to conform to Good Clinical Practice (GCP) guidelines.

NOTE: This approval is subject to recall if at any time the conditions and requirements as specified in the IRB Policies and Procedures are not followed (see next page and web site: http://www.northshorelij.com/body.cfm?ID=2804)

Sincerely,

Hiaun T. Neal, CIP, PMI-B
Assistant Director, Office of the Institutional Review Board

Internet # 9472

The Office of the IRB no longer sends a hard copy of documents which have been electronically transmitted. These are the only copies of the regulatory documents you will receive.

Revised: November 2008

APPENDIX J: THEMES AND KEY WORDS

TABLE J1

Table J1

Theme and Key Word Frequency

Theme	Frequency	Key Word	Frequency
Building the practice environment	174	Challenges	317
Defining a leader	172	Culture	240
Searching for balance	105	Organization	191
To become a leader	76	Knowledge	138
The influence of others	44	development	
Make a difference	34	Stakeholder	122
		engagement	
		Strategies	117
		Setting direction	111
		Perspective	109
		Learning opportunities	101
		Role expectations	91
		Identity	87
		Participation	77
		Excellence	74
		Teamwork	74
		Change	72
		Reason	69

	Supportive	48
	Vision	44
	Sensemaking	43
	Fears	27
	Sense of belongingness	20
	Family	14

APPENDIX K: SIGNIFICANT EXPERIENCES

TABLE K1

Table K1

Significant Experiences

Identity	Culture	Organization
Acknowledgement of a job well done	Acknowledgement of excellence in practice	Emphasis on completion of goals with rewards and praise
Created a strong sense of belief in leadership capacity	Valued individual achievement	Strength in achievement occurred due to successful peer training
Firmness balanced role stressors	Learned that change created enablers	Change provided positive learning experience
Learned how to work more collaboratively	Stressing individual accountability mitigated enablers	Non-punitive learning encourages leadership growth
Negative feelings garnered supportive intervention when shared	The sharing of negative and positive stressors developed a culture of mutual support	Nurse manager effectiveness relied on supportive administrative mentoring
Knowledge is needed to achieve and sustain change	Union culture limits direct communication and constructive criticism	Organizational resources
Questioning leads to a greater understanding of expectations	Fast based environment	
Critical thinking based on knowledge enhances problem solving		
Higher expectations for self than		

for staff members	leads to positive outcomes only by involving all team members in effective problem solving	are needed to achieve and sustain change Organization supports autonomous practice Human Resource Department significant to determination of policy and processes Top expectations set as goal for Nurse Managers

APPENDIX L: THEME AND KEY WORD LINKAGES

THEME AND KEY WORD LINKAGES

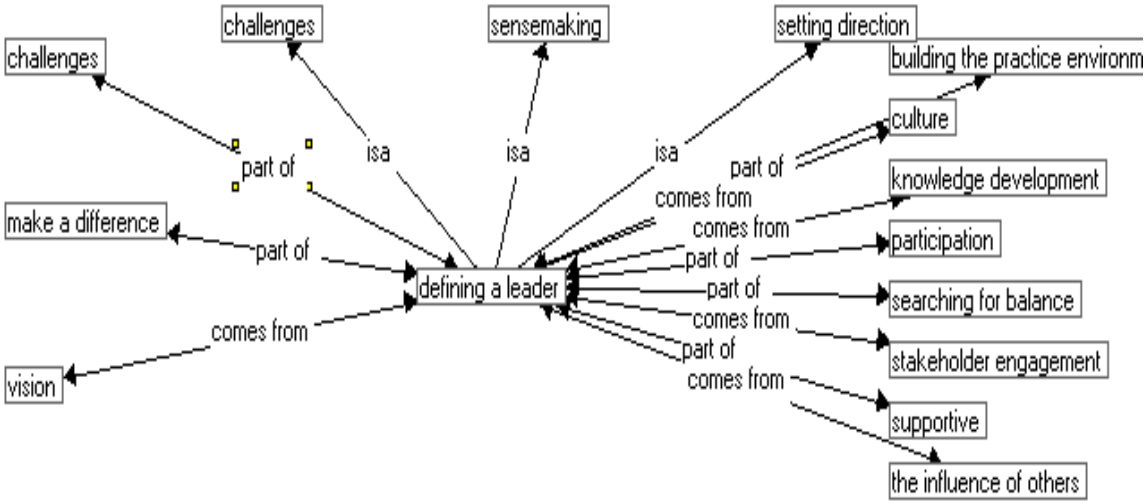


Figure L1. Linkage for the theme Defining a Leader.

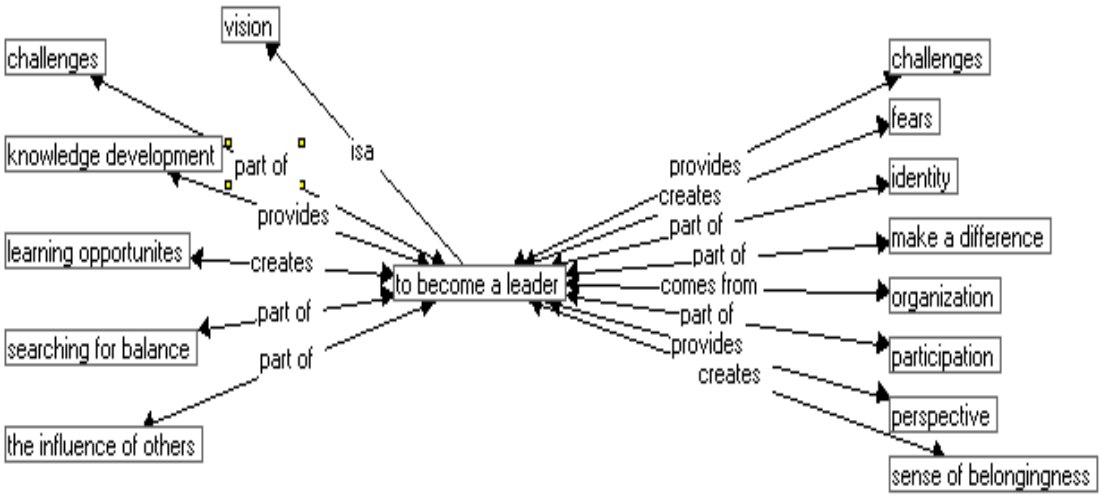


Figure L2. Linkage for the theme To Become a Leader.

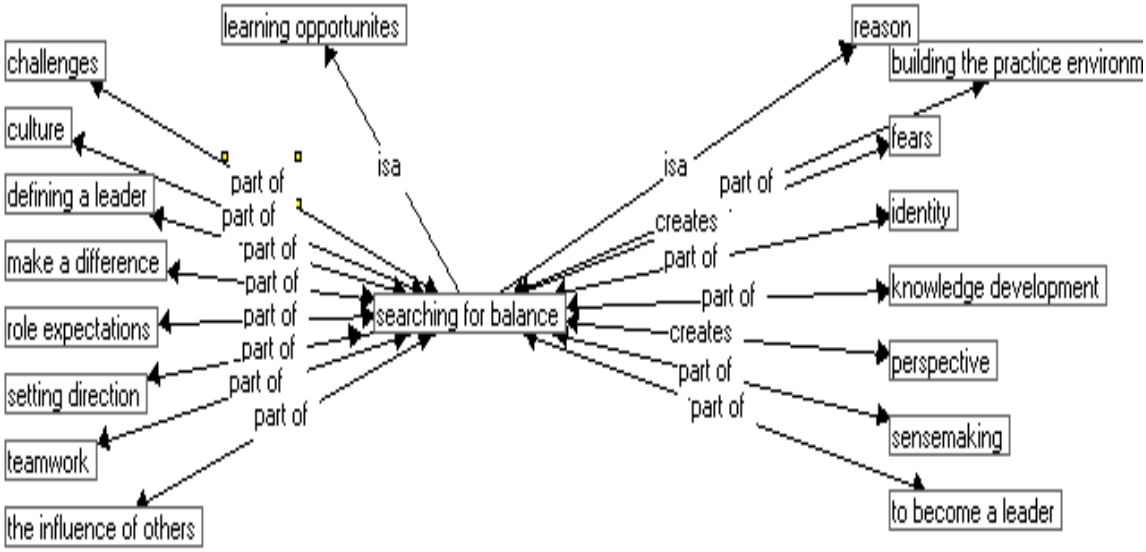


Figure L3. Linkage for the theme Searching for Balance.

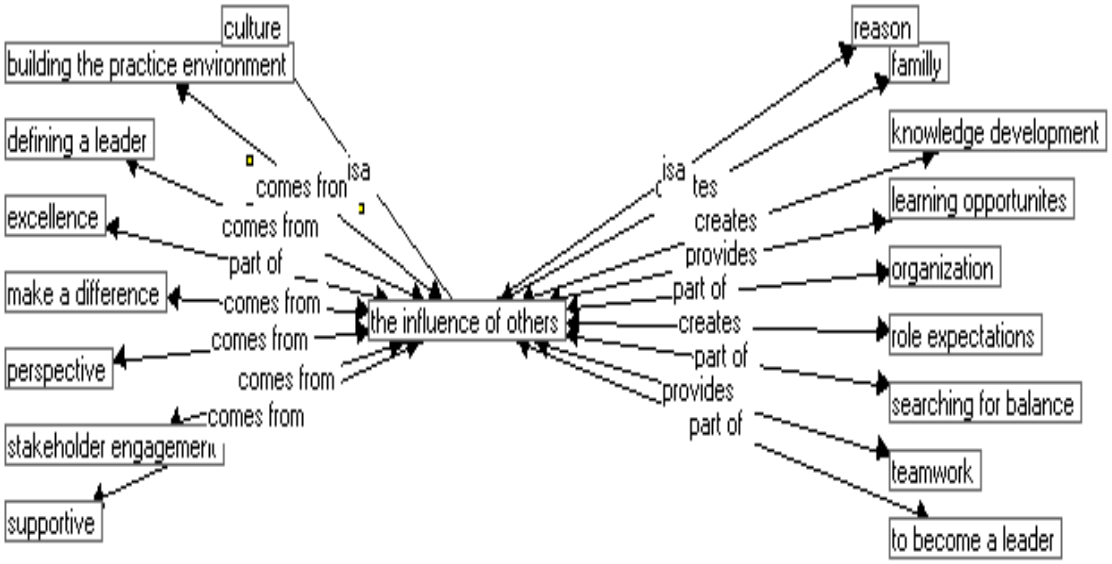


Figure L4. Linkage for the theme The Influence of Others.

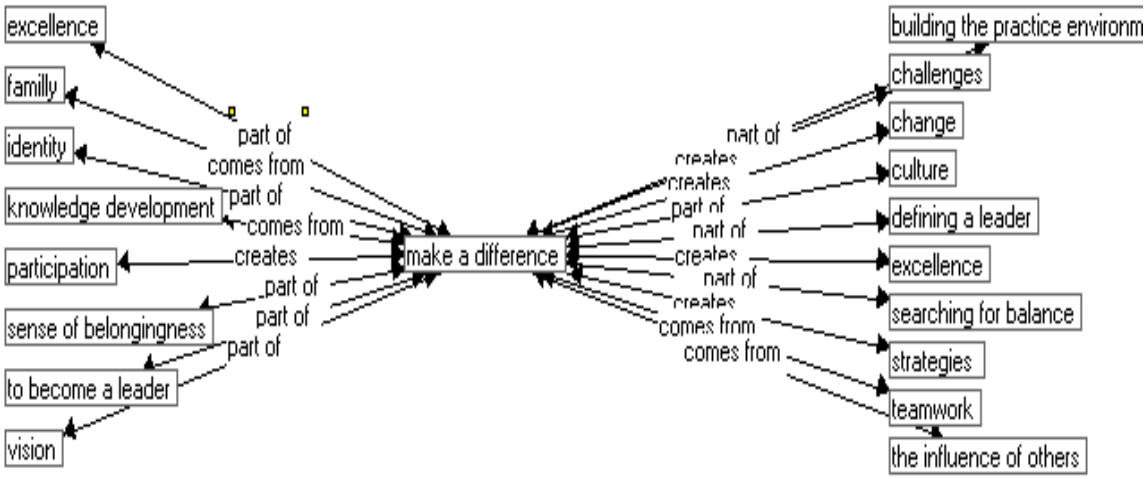


Figure L5. Linkage for the theme Make a Difference.

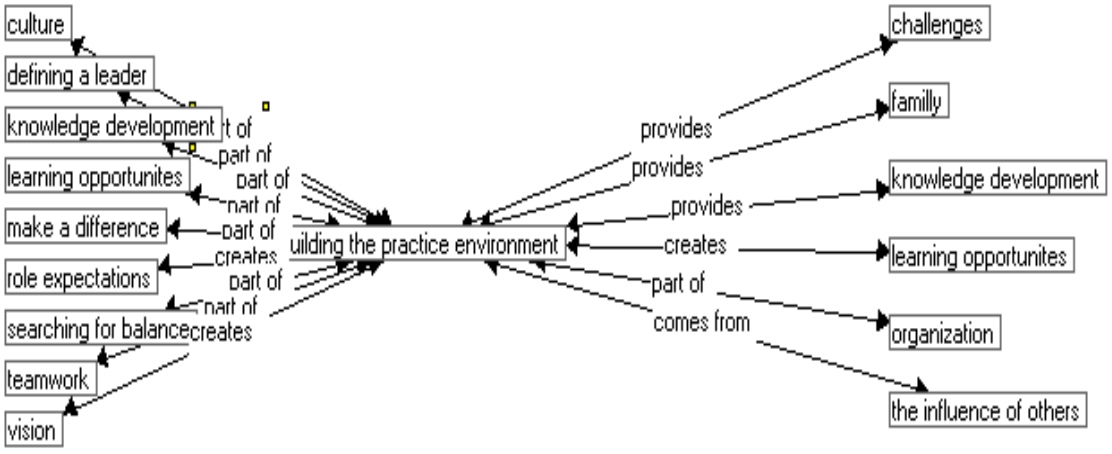


Figure L6. Linkage for the theme Building the Practice Environment.

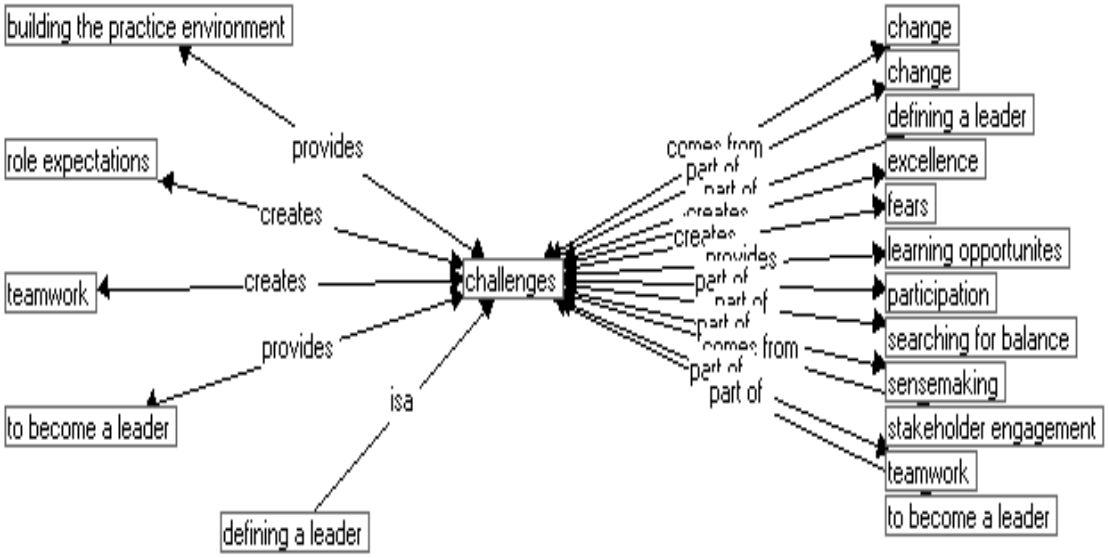


Figure L7. Linkage for the theme Challenges.

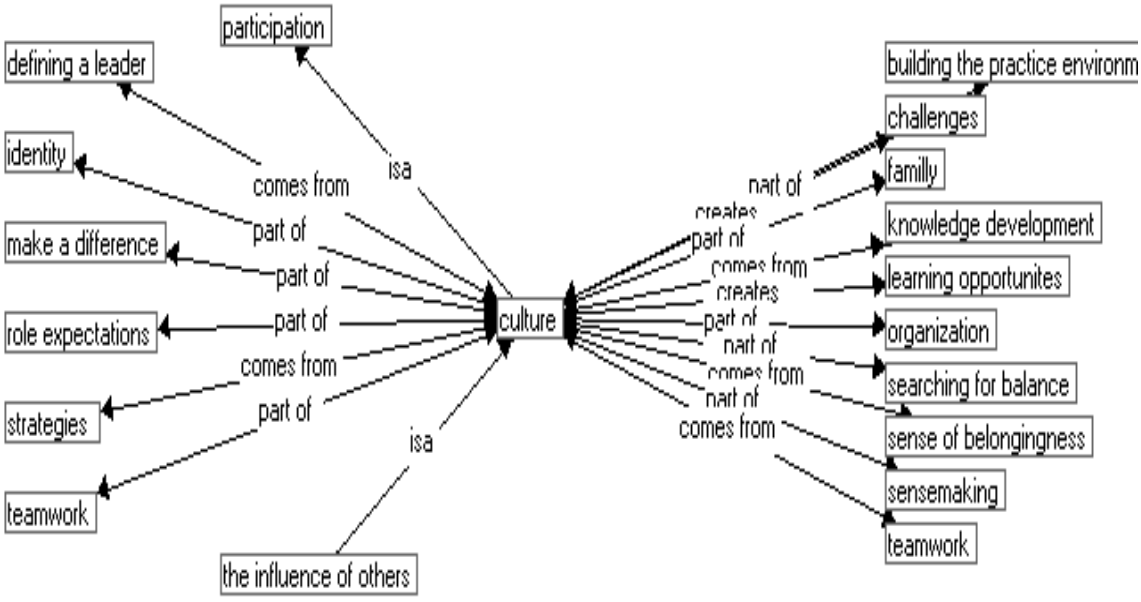


Figure L8. Linkage for the theme Culture.

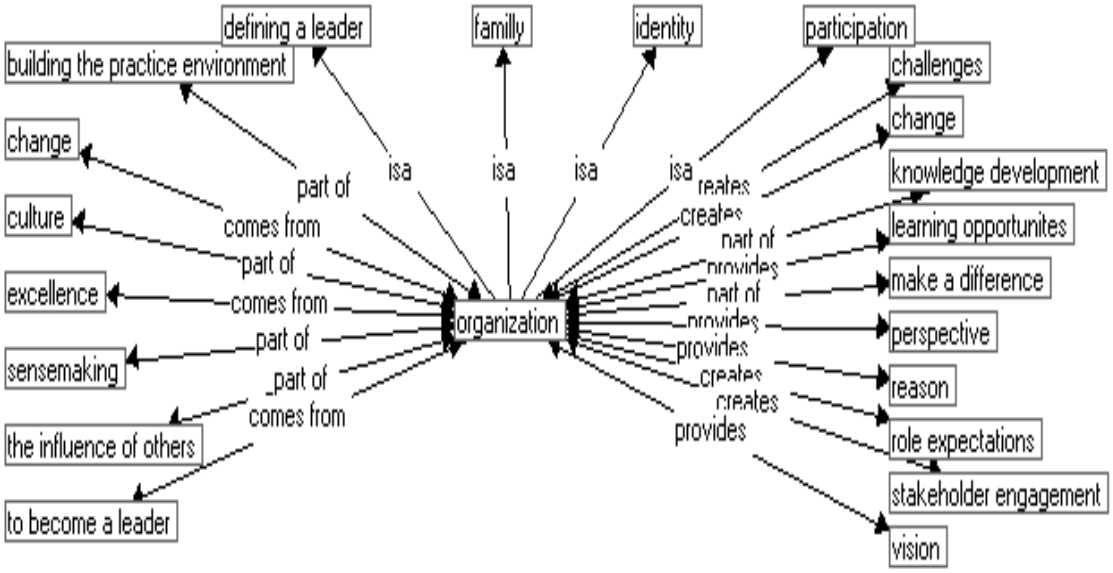


Figure L9. Linkage for the theme Organization.

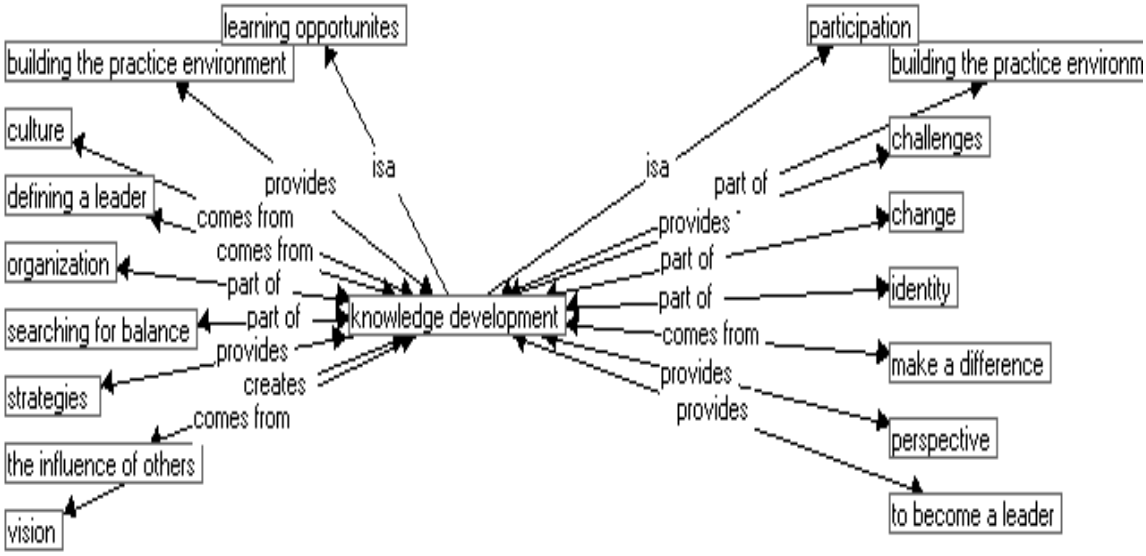


Figure L10. Linkage for the theme Knowledge Development.

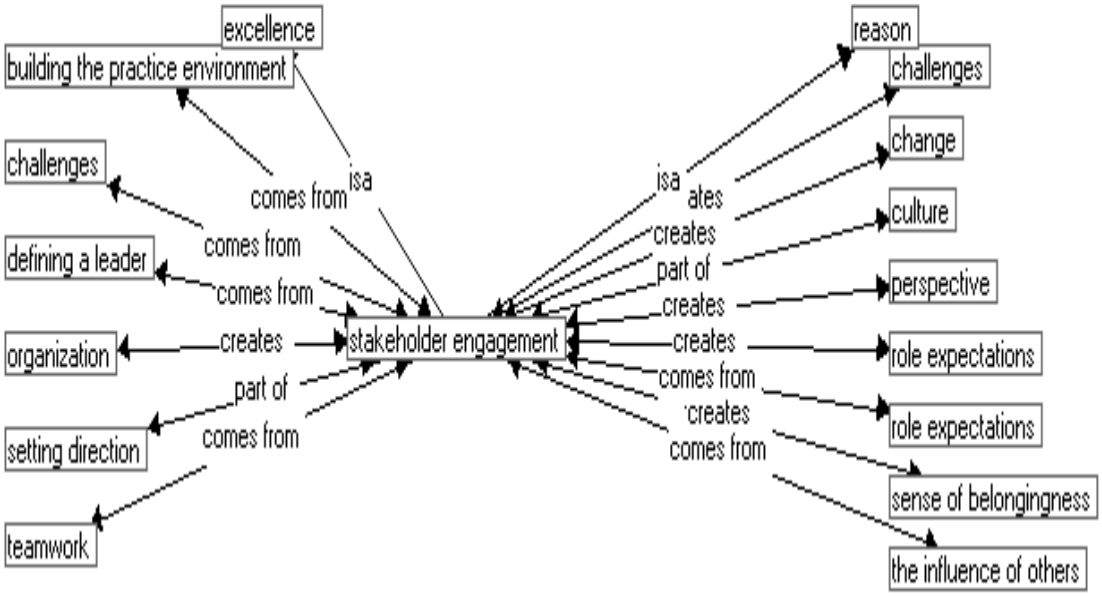


Figure L11. Linkage for the theme Stakeholder Engagement.

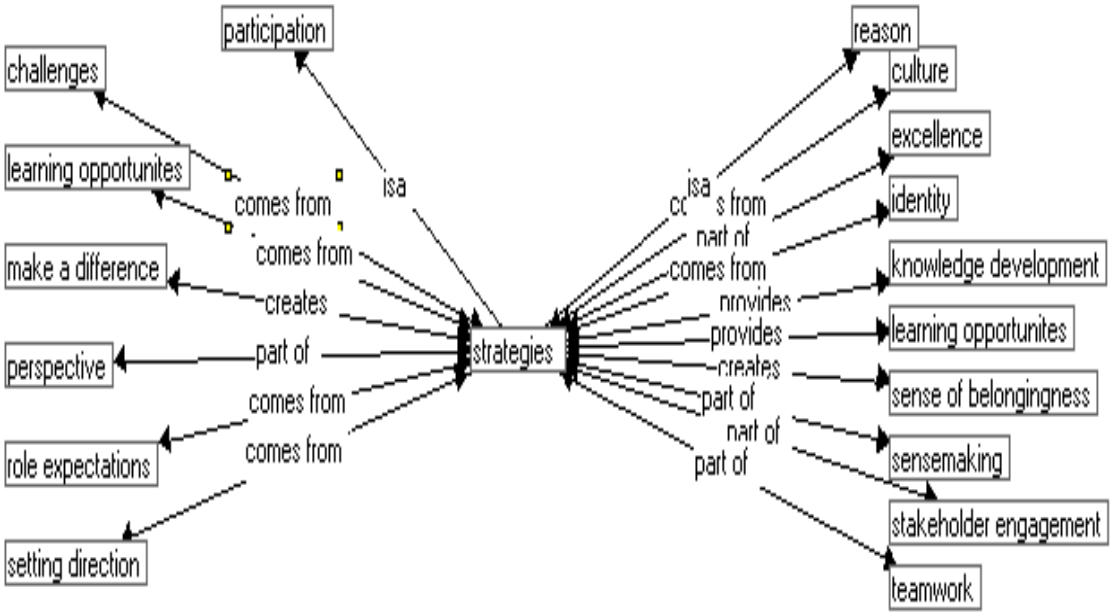


Figure L12. Linkage for the theme Strategies.

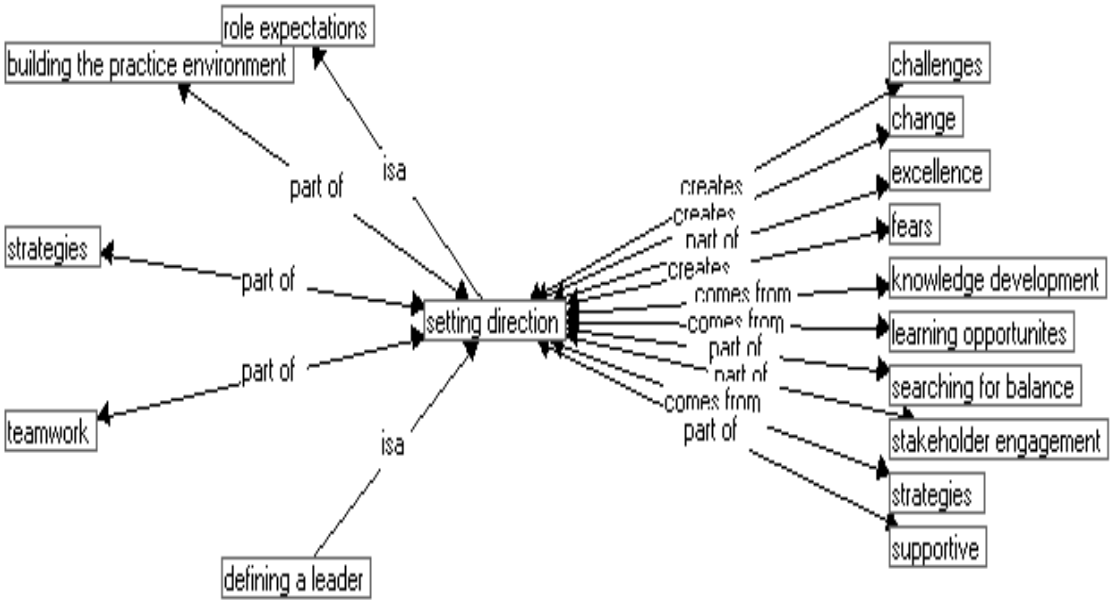


Figure L13. Linkage for the theme Setting Direction.

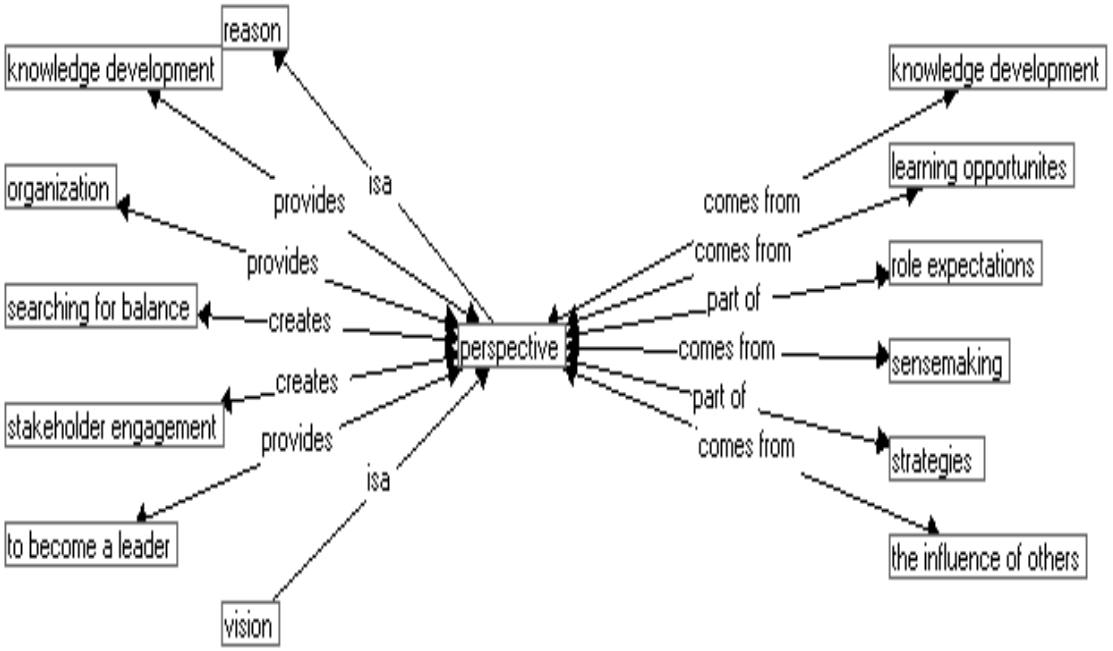


Figure L14. Linkage for the theme Perspective.

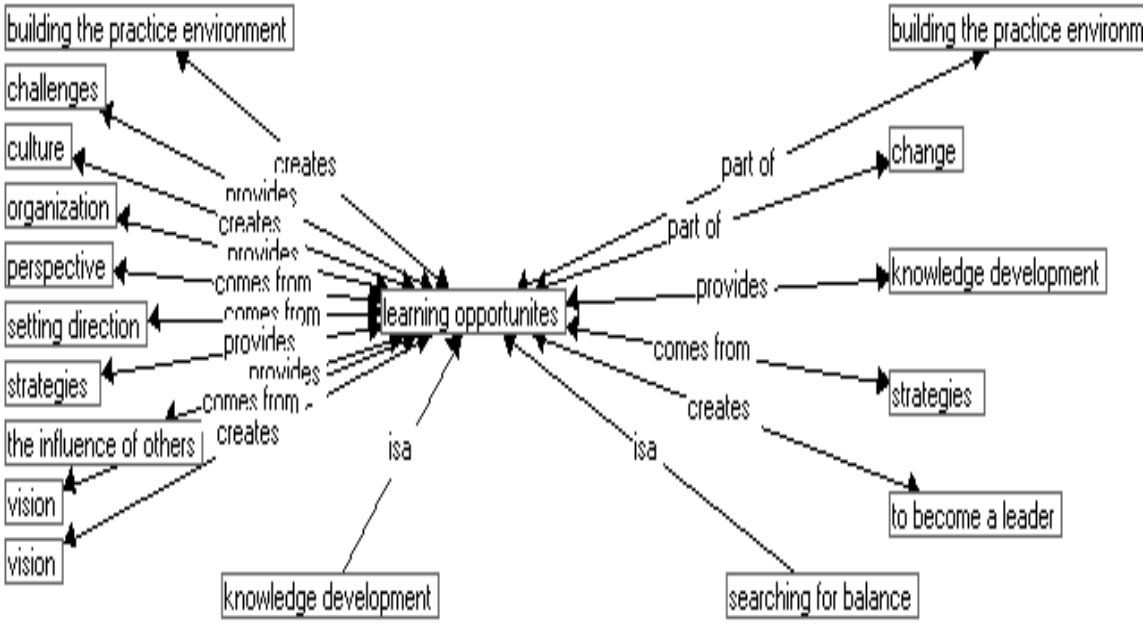


Figure L15. Linkage for the theme Learning Opportunities.

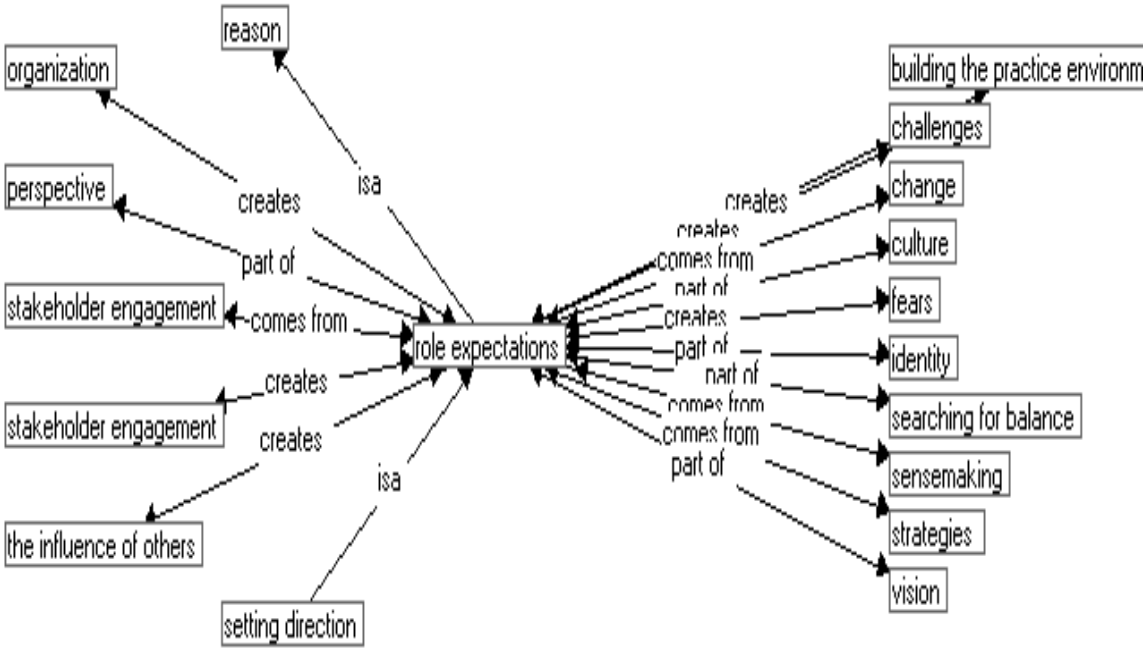


Figure L16. Linkage for the theme Role Expectations.

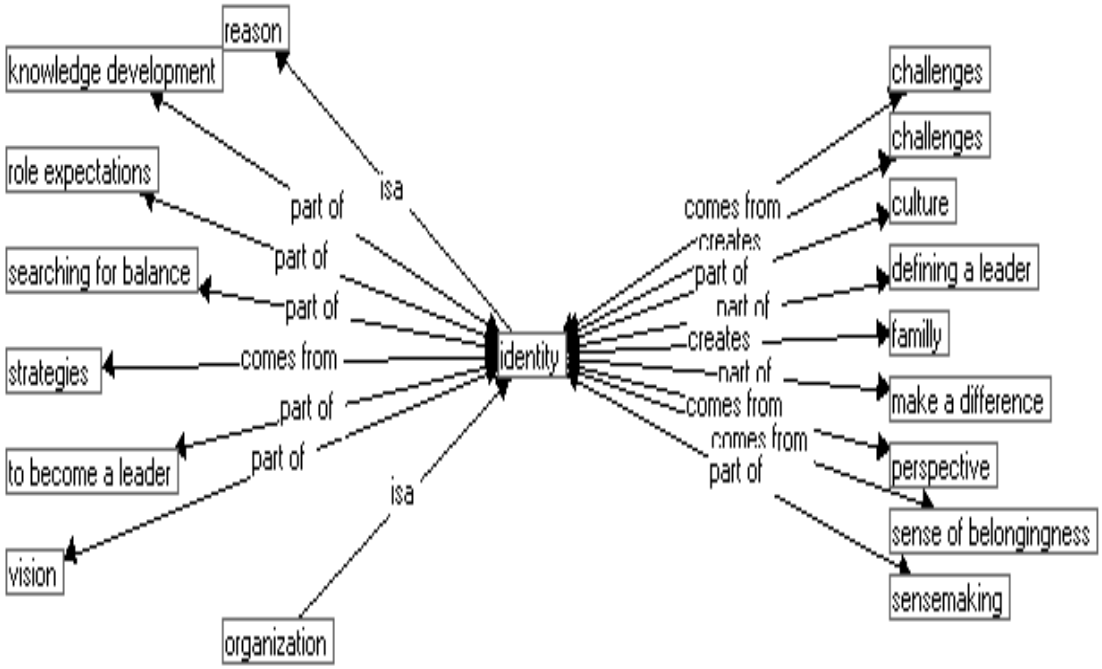


*Figure L17.*Linkage for the theme Identity.

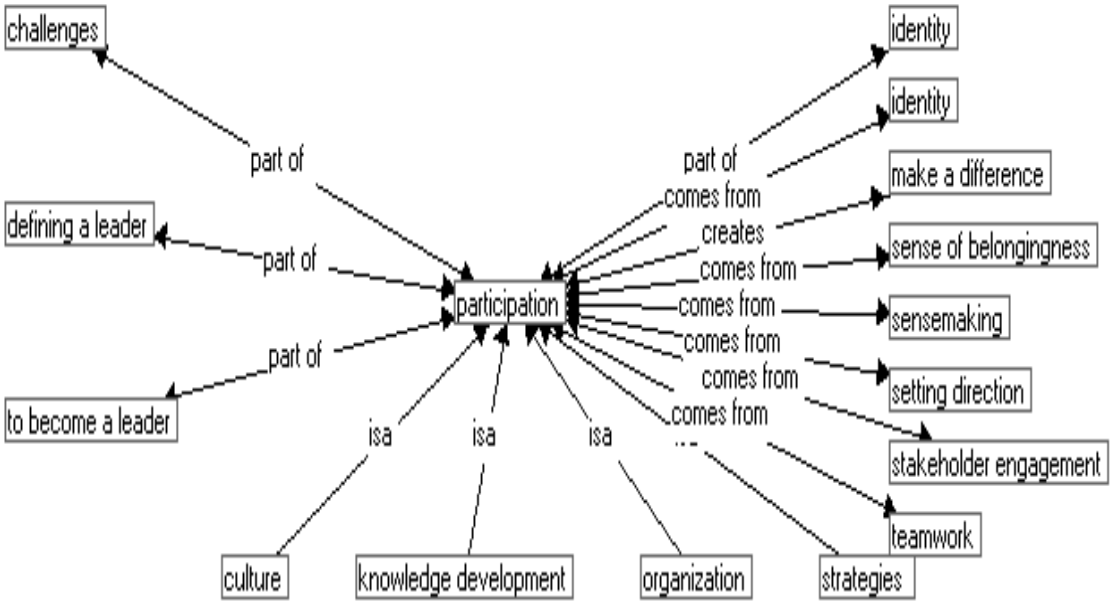


Figure L18. Linkage for the theme Participation.

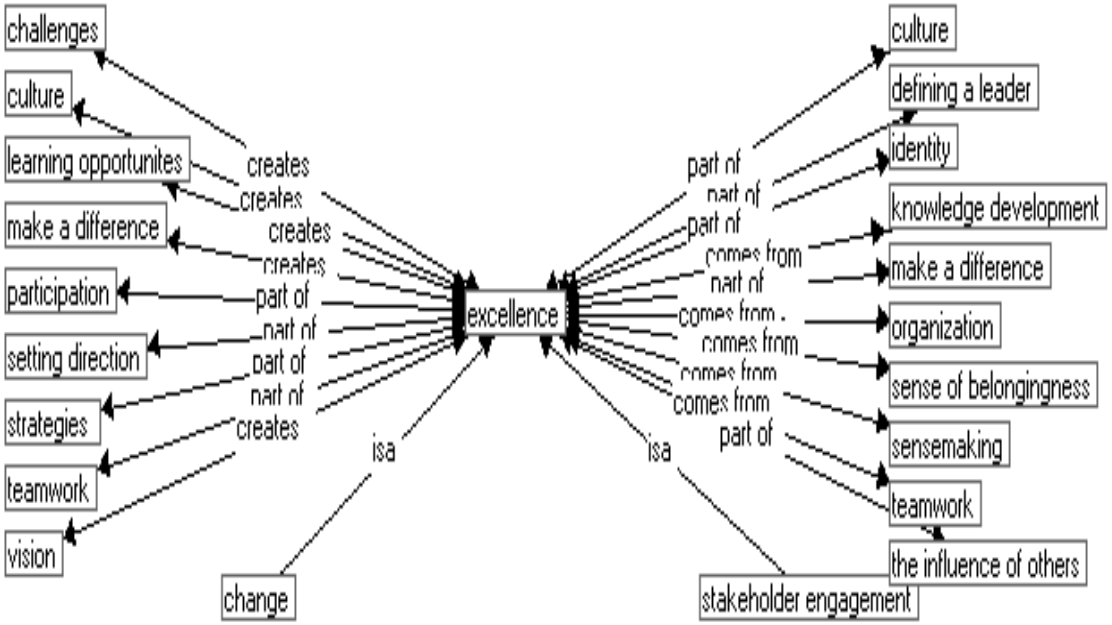


Figure L19. Linkage for the theme Excellence.

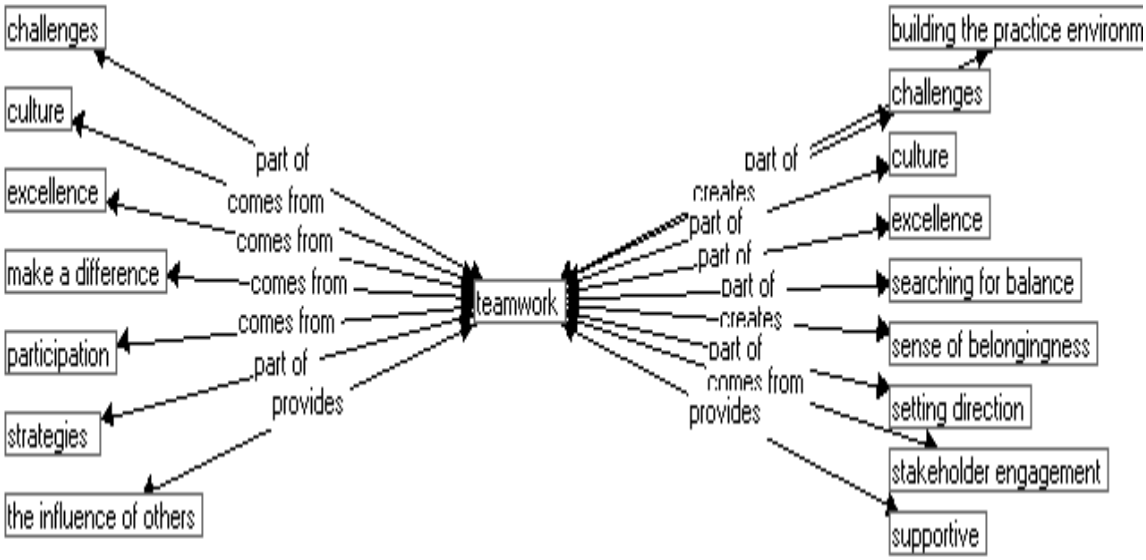


Figure L20. Linkage for the theme Teamwork.

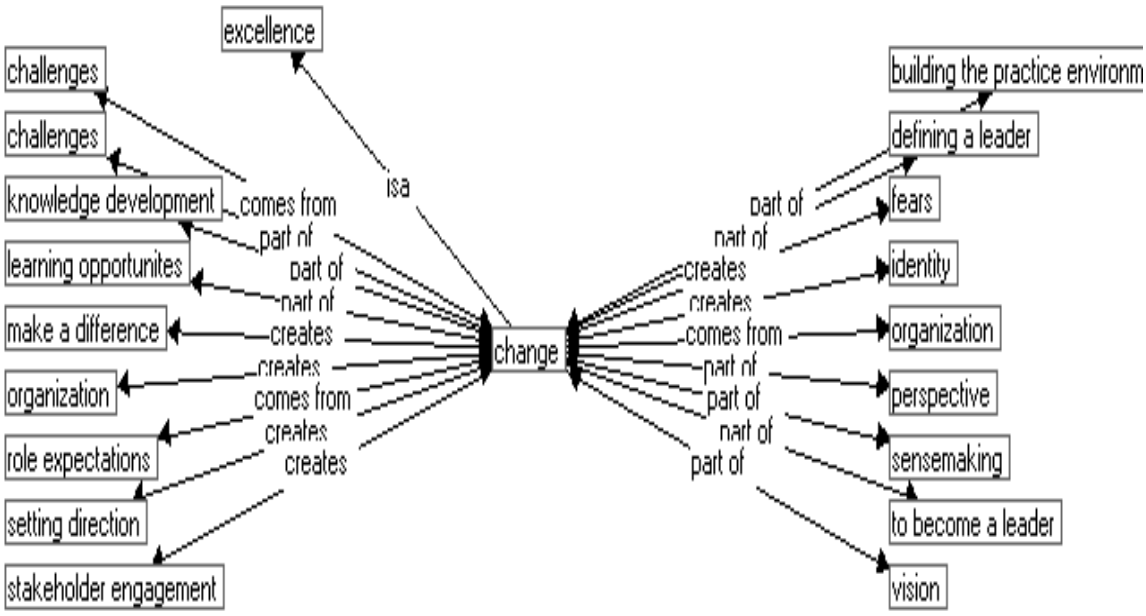


Figure L21. Linkage for the theme Change.

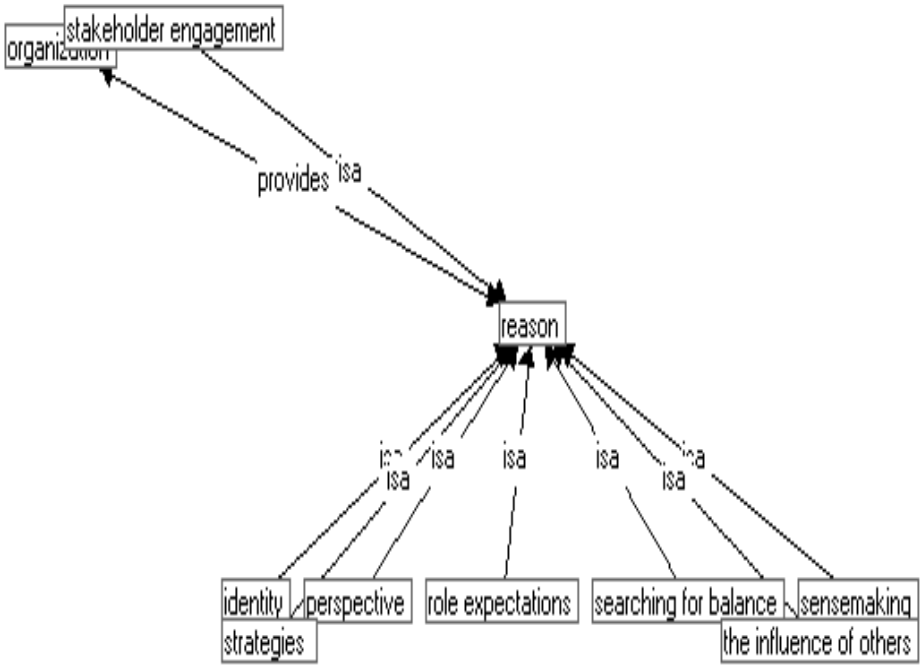


Figure L22. Linkage for the theme Reason.

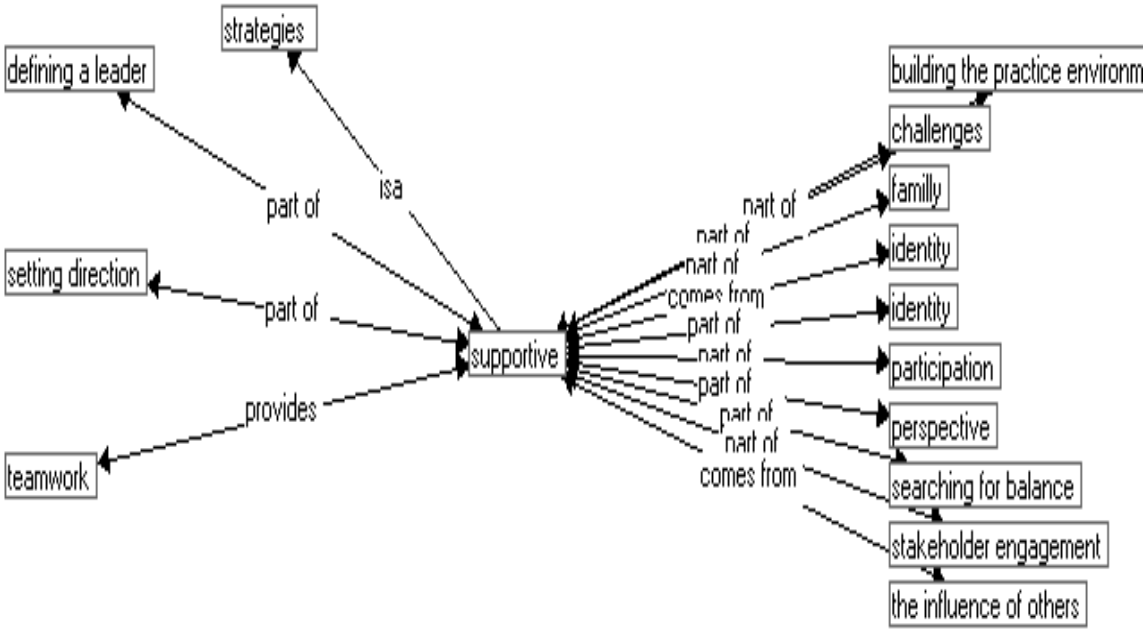


Figure L23. Linkage for the theme Supportive.

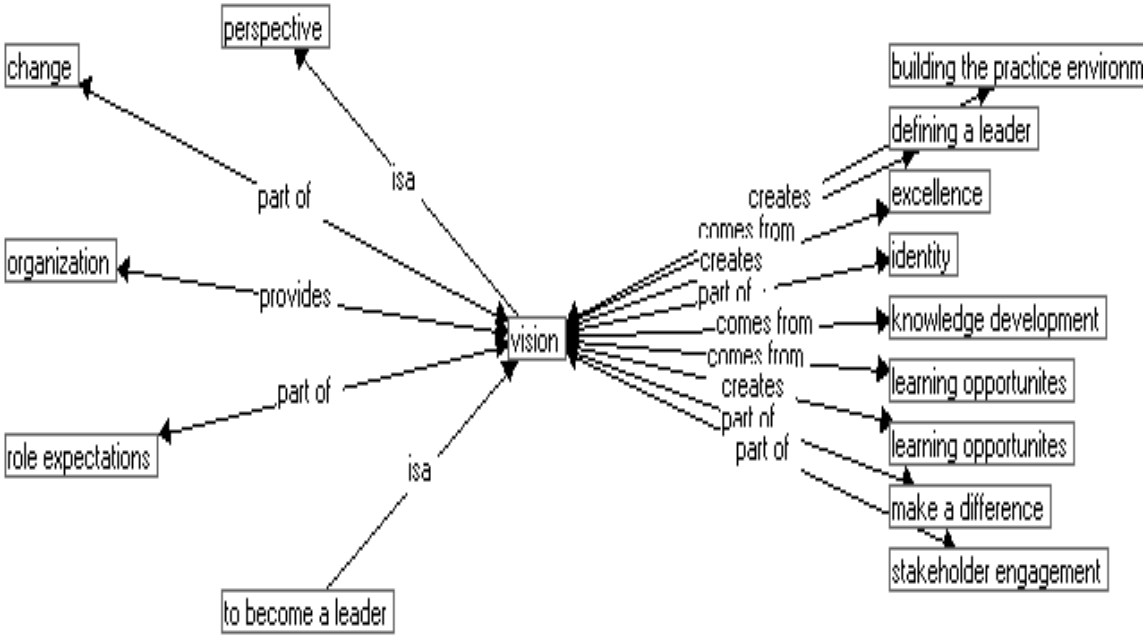


Figure L24. Linkage for the theme Vision.

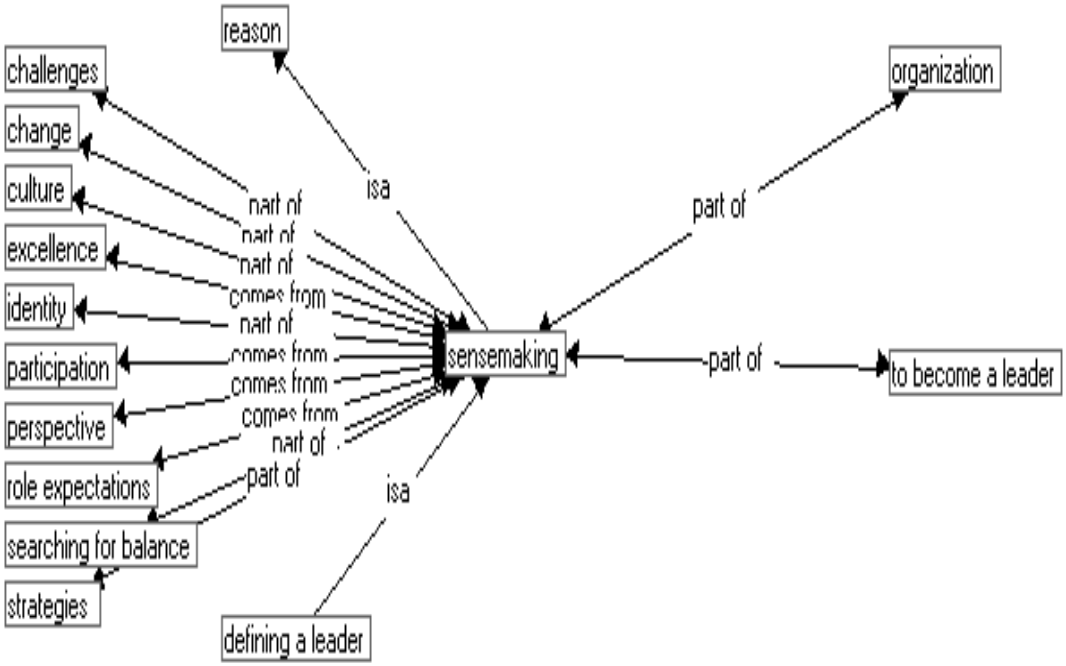


Figure L25. Linkage for the theme Sensemaking.

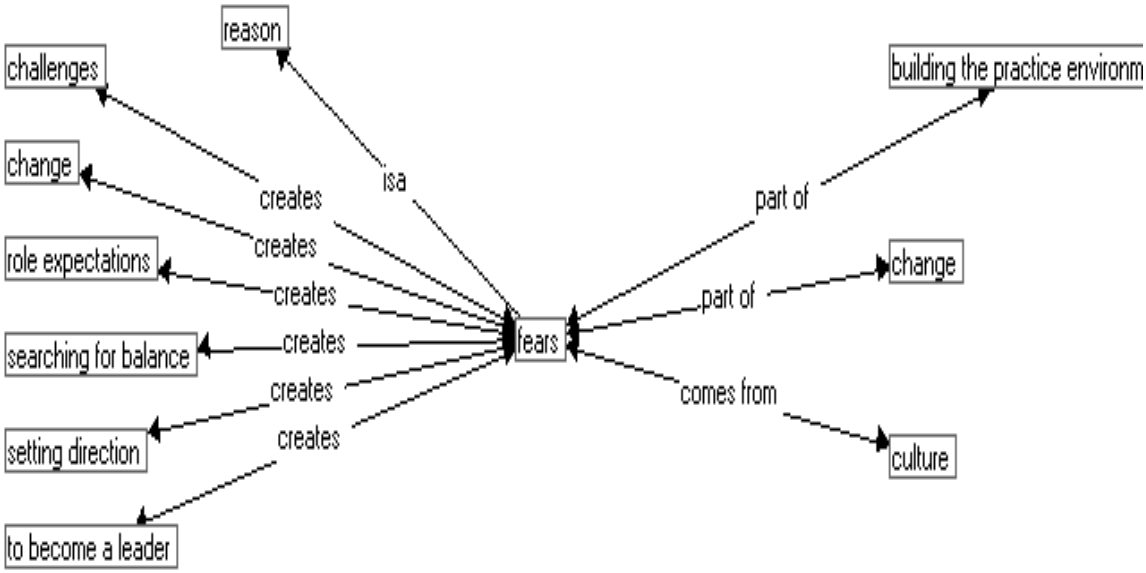


Figure L26. Linkage for the theme Fears.

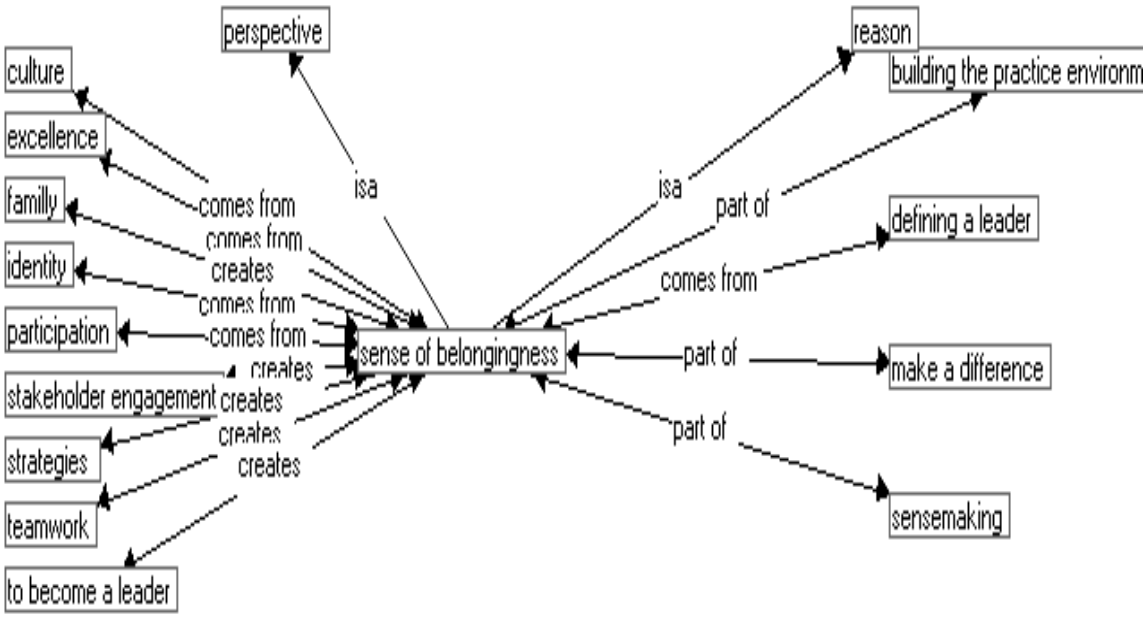


Figure L27. Linkage for the theme Sense of Belongingness.

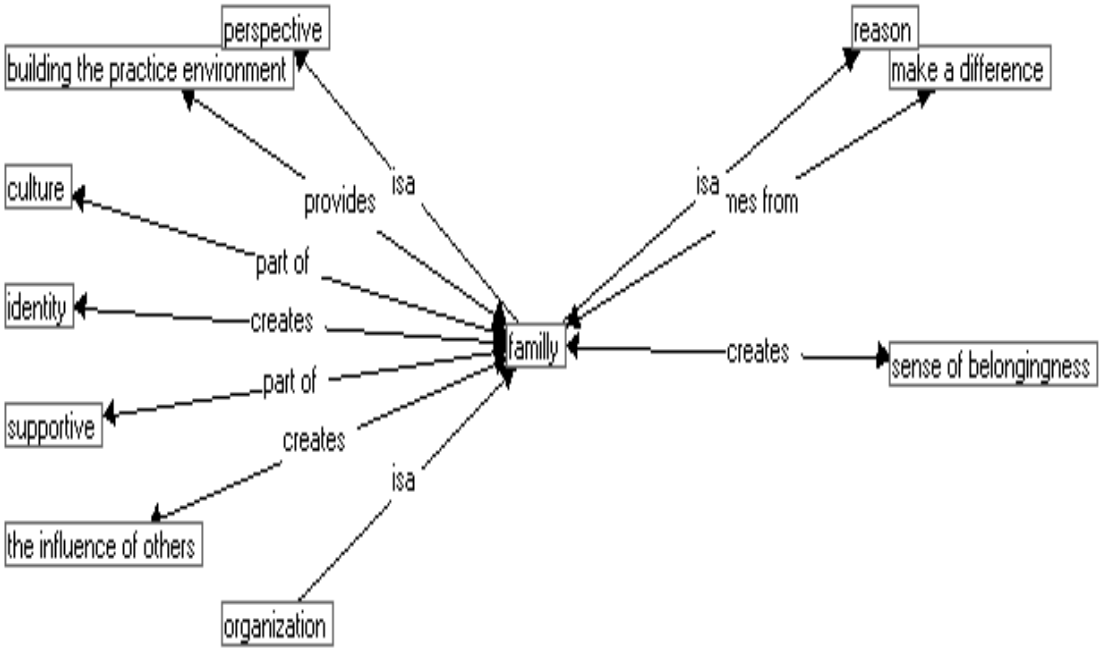


Figure L28. Linkage for the theme Family.