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LEADER AT THE BEDSIDE: A MIXED METHODS STUDY ESTABLISHING CLINICAL STAFF NURSE LEADERSHIP COMPETENCIES

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LEADER AT THE BEDSIDE:

ESTABLISHING **C**LINICAL **S**TAFF **N**URSE **L**EADERSHIP COMPETENCIES

(THE CSNL STUDY)

by

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Dedication

I dedicate this success to my husband, Wesley. In my opinion, his name should be included as honorary in earning the PhD degree since he sweated, toiled, and labored beside me in every class, every project, and for every grade. In every way that counts, he worked for this success as hard as did I.

Thank you, my love, for your unfailing support and efforts on my behalf.

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Abstract

LEADER AT THE BEDSIDE: ESTABLISHING CLINICAL STAFF NURSE LEADERSHIP COMPETENCIES (THE CSNL STUDY)

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Significance and Background

Leadership competencies were established for formal nursing roles (i.e. nurse executives), but not for informal nurse leader roles (i.e. clinical staff nurse leader). A set of comprehensive clinical staff nurse leader (CSNL) competencies would facilitate evaluation of the CSNL role in providing safe, quality, and efficient patient care.

Purpose

The purpose of this pilot was to establish a preliminary set of CSNL competencies with associated set of knowledge, skills, and attitudes (KSAs) for each competency identified through the CSNL's voice.

Theory & Design

Underpinned by the Authentic Leadership Theory, this pilot was a multiphase sequential explanatory mixed methods design utilizing an online survey and focus groups to explore CSNL competencies, followed by a final set of preliminary competencies established using a Delphi technique.

Methods

This was a pilot evaluating the feasibility of implementing a nationwide three-phase research protocol to establish CSNL competencies. Registered Nurse (RN) CSNLs were the target population. Various sampling techniques recruited participants to specifically address the research question(s) for each phase of the pilot. In Phase 1, the recruited sample responded to an online survey using a stratified, random selection of acute care hospitals. In Phase 2, volunteers were recruited for a virtual focus group to explore and explain the survey results. Finally, the Phase 3 CSNL subject matter experts (SMEs) were identified by Phase 2 participants' recommendations and recruited to engage a Delphi procedure to review, revise, and confirm a final set of preliminary CSNL competencies.

Keywords: *leader, competency, clinical staff nurse leadership, bedside nurse leader, leadership competencies, mixed methods*

Chapter One: Overview of the Dissertation Research Focus

The importance of nursing leadership was recognized across the healthcare industry with the Institute of Medicine's (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (2010). In the 2010 report, the IOM connected nursing leadership at every level to improved patient outcomes, both individually and communally. Other experts supported the IOM's report with further evidence that nurse leaders contribute to effective, quality patient care outcomes and improved organizational financial successes (Ezziane, 2012; Garner, 2011; Grindel, 2016). Soon after, one of the nursing leadership organizations, the American Organization of Nurse Executives (AONE), now known as the American Organization of Nurse Leaders (AONL), established valid and reliable leadership competency measurements for both nurse executives (NE; AONE, 2015a) and for nurse managers (NM; AONE, 2015b). However, the IOM's report indicated that nursing leadership was important *at every level*, making the next level at the bedside, the clinical staff nurse leader (CSNL), an equally important role in successful patient outcomes, and by extension, organization success.

Chapter 2 is a literature search conducted in 2017 that explored nursing science's understanding of CSNL leadership characteristics and competency. The search revealed that much of the information used to educate, train, and evaluate CSNLs was identified and defined by nurses in leadership roles such as nurse manager or nurse executive, not the role to which such education and training applied. Wright (2015) stated that the people for, and to whom, the competencies applied *must be intentionally integrated* into the development and validation of the work product. The identified CSNL competencies

had not included the CSNL community's voice during production. Clinical staff nurse leaders are different from other, more formal nursing leader roles (Patrick, Laschinger, Wong, & Finegan, 2011), but the difference(s) were not fully explored by the nursing profession nor articulated through the perspective of the CSNL, that is, by the CSNL's voice, which was a gap in the literature.

Chapter 3 discussed the rift that exist when trying to recruit staff to participate in nursing research. This rift was identified during the recruitment of participants into the CSNL pilot Phase 1, which involved a cross-sectional questionnaire, in both electronic and hardcopy formats. Using the *CSNL Study* pilot as an exemplar, registered nurses' understanding of the research-practice connection between the nurse scientist and the bedside nurse was explored in the literature. Potential opportunities to improve bedside nurses' comprehension and application of, as well as participation in original nursing research were explored and discussed. The ability of nurses to recognize the research-practice connection between original nursing research and bedside practice was identified as a gap in the science, which needed further exploration in future research efforts.

In Chapter Four, the CSNL pilot addressed this identified gap in nursing science by asking the CSNL community what were its CSNL competencies, and their associated knowledge, skills, and attitudes (KSAs). The *CSNL Study*© hypothesized that the result of including the CSNL community in establishing their leadership competencies would be a valid and reliable set of CSNL competencies, which could be used to train, educate, and objectively evaluate the leadership behaviors of the CSNL at the bedside.

Definitions

Leadership

Leadership is "an interpersonal process in which a leader influences followers" toward a common goal (Dansereau, Seitz, Chiu, Shaughnessy, & Yammarino, 2013, p. 799). Traditionally, the term 'leadership' was often used interchangeably with 'management' in healthcare (Cook & Leathard, 2004), but was not the same conceptually, nor were they mutually exclusive (Grossman & Valiga, 2013).

Chavez and Yoder (2015) used the term "staff nurse clinical leader" (p.9) to describe the CSNLs as clinical staff nurses who "exert significant influence over other individuals in the healthcare team, and although no formal authority had been vested in them facilitate individual and collective efforts to accomplish shared clinical objectives" (p. 92). Nursing leadership is a phenomenon derived from the individual nurse's personal values, beliefs, and corresponding behaviors and is a fluid, dynamic interpersonal interaction process that involves using power to influence groups to move toward common goals (Northouse, 2016). Effective leaders were not required to be in management roles (Grossman & Valiga, 2013).

CSNL's Voice

The Oxford Living Dictionaries website (2019, definition #2) defined 'voice' as "a particular opinion or attitude expressed" explained as a "point of view" or "right to express an opinion" of a person or people. Recording the voices of a people carries "indigenous meanings and experiences" (Madison, 2012, p. 7). Work derived directly through the voice of a culture, people, or group had intrinsic value as an expression of their empowerment (Combaz & McLoughlin, 2014). When a group used its voice to

develop group standards (i.e., norms, values, and expectations), the community was better able to objectively judge its members' actions (Sharma, 2008). Clinical staff nurse (CSN) leader competencies identified, defined, and approved by the CSNL subcommunity have inherent, intrinsic value because they were developed by the CSNL voice – an expression of the CSNL role expectations for a bedside leader.

Clinical Staff Nurse Leader

Registered nurses engaged in direct nursing care activities for more than 50% of their work time were CSNs, as defined by the American Nurses' Association (ANA) Nursing Database of Nursing Quality Indicators (2012). Therefore, the *CSNL Study*© incorporated the ANA definition for CSN (e.g. bedside nurse, frontline nurse, staff nurse, or point of care nurse) with the additional distinguishing characteristic of intentionally practiced leadership behaviors that influenced other members of the healthcare team to individually, or collectively, accomplish common goals (e,g. optimized patient outcomes and organizational financials).

Learning CSN leadership requires time. Benner's Novice to Expert Theory (1982) explained how nurses' maturation process in practice required on-the-job experience to progress from beginner to competent or proficient nursing practice. Additionally, clinical leadership experience at the bedside required between 12 and 18 months to develop (Al-Dossary, Kitsantas, & Maddox, 2014). While work experience cannot guarantee nurses developed or employed leadership skills, Benner's theory helped understanding that the newly graduated, practicing RN would not likely meet the expectations of a CSNL role.

The CSNL was not a manager, but successfully influenced patient outcomes and organizational financials (Grindel, 2016). The CSNL earned distinction as a leader from peers (Chavez & Yoder, 2015) through specialized KSAs, including clinical excellence (Picker-Rotem, Schneider, Wasserzug, & Zelker, 2008) outwardly exhibited, in many cases, as a nationally recognized nursing practice certification.

While a direct relationship between nursing certification and leadership was not established, nurse peer and patient perception(s) of clinical excellence accompanied a professional certification (Neibuhr & Biel, 2007) beyond the minimum requirements of licensure (Elwell, 2017; Krapohl, Manojlovich, Redman, & Zhang, 2010). Furthermore, nurses who hold a nursing certification were more likely to engage in continuing education opportunities designed to improve their knowledge base, which would be expected to improve patient outcomes (Coleman et al., 2009).

Competencies

Competencies were observable, measurable behaviors resulting from KSA synthesis applied to nursing practice (American Association of Colleges of Nursing [AACN], 2012) and evaluated objectively (ANA, 2013). A set of comprehensive competencies included a supporting set of KSAs that, together, substantiated the competencies' behavioral expectations.

Review of Literature

A literature search of the electronic databases Medline, CINAHL Complete, and Cochrane Database of Systematic Reviews was conducted for publications that identified, defined, or explained CSNL competencies. Search criteria filters applied were English language, peer reviewed, and publication dates between January 2000 and October 2016.

Keywords included were *nurse, clinical, leader, leadership,* and *frontline;* each of which returned more than 1,000 articles. Combining keywords *frontline AND nurse AND leader/leadership* yielded 35 articles; combining *frontline AND nurse AND clinical leadership* yielded 30 articles. These 65 articles were reviewed to determine if the publication included the CSNL's voice during data collection, manuscript preparation, or manuscript review, and article duplications. Articles that did not incorporate the CSNL's voice and duplicates across databases were eliminated, leaving four of the 65 initially identified articles. The four remaining articles were discussed below.

The articles retained from the search demonstrated commonalities within the CSNL role. In 2014, Jooste and Cairns reported a mismatch in perceptions among NMs and CSNLs regarding CSNL-exhibited leadership behaviors. Managers perceived the CSNLs were exhibiting higher levels of leadership behaviors than did the CSNLs, illustrating the gap between NM and CSNL expectations. The Jooste and Cairns' (2014) study offered a voice to CSNLs. In an integrative review of ten articles, Mannix and colleagues (2013) provided CSNL expectations of leadership that were defined through their voice, which included a clinical focus (e.g. decision-making, clinical knowledge, goal setting, and advanced nursing practice; i.e., knowledge and skills), a follower/team focus (e.g. role modeling, effective communication, relationship building, motivator, and knowledge sharing; i.e., knowledge and skills), and a personal qualities focus (e.g. professional conduct, emotional maturity, flexibility, personal insight, and non-judgmental; i.e., attitudes).

Stanley (2006) interviewed both CSNLs and NMs, identifying commonly recognized CSNL attributes. These CSNL attributes included the following:

approachable, clinically competent, a motivator, supportive, able to inspire confidence, able to cope well with change, flexible, able to set direction, able to direct and help, and ethical (Stanley, 2006). Cook and Leathard (2004) reported a qualitative study, which they then used to develop an educational program for clinical leaders with the intent to improve leadership interactions. From the study, the researchers identified five clinical leadership attributes: 1) creativity, 2) highlighting, 3) influencing, 4) respecting, and 5) supporting. These attributes were used to design the program, which was expected to enhance the participants' personal leadership experience through case scenarios with guided inquiry. In 2006, Cook and Leathard reported the clinical leader training program's recruitment process, programmatic design, and completion rates of the participants. There were no defined outcomes to demonstrate completion of the program. The CSNL attributes common to all four studies reviewed were clinical excellence, communication, collaboration, professionalism, and role modeling.

Theoretical Framework/Philosophical Underpinning

The theory guiding the development of the *CSNL Study*© was the Authentic Leadership Theory (ALT; Luthans & Avolio, 2003). This theory explained how authentic leadership evolved over a lifetime and was influenced by the life events, a positive psyche, and strong ethical convictions leading to genuine (i.e., authentic) interpersonal interactions (Northouse, 2016). Authentic Leaders, as described by Northouse (2016), through the experience(s) of critical life events, examined their internal motivations resulting in heightened personal awareness. Additionally, Authentic Leaders learned from every interaction, ultimately changed by each experience (Northouse, 2016). The leadership domains described in the ALT were heart, purpose,

values, relationships, and self-discipline (Northouse, 2016). Figure 1 described the ALT development process, while Figure 2 depicted ALT domains, or characteristics.

Authentic CSNLs successfully lead the healthcare team through relationships (i.e. connectedness) and self-discipline (i.e. consistency). According to ALT, a heightened awareness of attitudes, understandings, and personal history allowed CSNLs to effectively manage how their core values (i.e. behaviors) and beliefs influenced interactions. Clinical staff nurse leaders possessed a strong internal moral compass regulating their reactions to external stimuli (i.e. self-discipline). Clinical staff nurse leaders' passion and heart allowed them to explore and examine all options before selecting the best situational intervention. Clinical staff nurse leaders, as authentic leaders, exhibited sincere, scrupulous interpersonal interactions expected to increase levels of trust by others, and therefore, their leadership's effectiveness.

Chapter Two: Clinical Staff Nurse Leadership: Identifying Gaps in Competency Development

(as published in Nursing Forum, 2017)

See *Appendix A* for Nursing Forum permission to use publication.

Abstract

Background

Nursing neglected to develop a complete, applicable inventory of clinical staff nurse leader (CSNL) competencies through a valid and reliable methodology. Furthermore, the CSNL was not engaged in the identification, definition, nor development of their own leadership competencies.

Objective

Identified and highlighted gaps in clinical staff nurse role leadership competency development and validation.

Method

Literature Review

Results

The CSNL did not participate in the development of CSN leadership role competencies, nor were CSNL role competencies validated through a rigorous evaluation process. Finally, CSNL role competencies were incomplete and not reflecting the CSNL viewpoint.

Keywords: clinical staff nurse leadership; leadership competencies

Introduction

Nurses in all roles have performance requirements that were developed and designed to ensure their practice meets organizational healthcare delivery excellence expectations. Nurses meet these expectations through skills, knowledge, and attitudes (QSEN, 2014), (i.e. competencies) specific to each nurse's role (Wright, 2013). Comprehensive competencies for nurse executives (NE) and nurse managers (NM) were identified and validated as reliable application measurements for personal, professional, and organizational outcomes (AONE, 2015a; AONE, 2015b). However, a comprehensive list of leadership competencies (i.e. identified, validated, and reliable role expectations) for the CSNL was not developed. Most CSNL literature was written through the lens of management expectations by nurse experts (e.g. nurse executives, nurse educators, and nurse managers), but not filtered by the CSNL expert (i.e., the nurse providing direct care, the informal nurse leader). This literature review highlighted gaps between formal leaders' (i.e. nurse executives and nurse managers) and informal leaders' (i.e. CSNL) role-based competency development, as well as analyzed and compared differences in competencies for each discussed role.

Definitions

An effective discussion required common use of language; therefore, a few sentences devoted to common language were in order. First, leadership was one person (i.e. the leader) persuading at least one other person (i.e. the follower) to work in concert to accomplish a common goal (Dansereau et al., 2013) and, second, all nurses were leaders (Carr, 2013). Nursing leaders influenced other members of the healthcare team to work in tandem accomplishing shared goals (Chavez & Yoder, 2015) and was one of the

most important qualities a nurse can develop (Garner, 2011). Effective nursing leadership ensured optimal patient outcomes with fewer errors and higher satisfaction scores (Garner, 2011), which, in turn, improved organizational financial success (Ezziane, 2012; Grindel, 2016).

Second, for the purposes of this article, a CSN was defined as a registered nurse (RN) who spends more than 50% of his/her worktime in direct care activities (ANA, 2012). A CSNL was a direct care nurse, a care coordinator, or clinical manager depending on the amount of time spent in direct care activities but excluded management roles spending less time in direct care duties such as nurse managers, nursing directors, or nurse executives.

Third, the Quality and Safety Education for Nurses (QSEN) project defined competencies as the knowledge, skills, and attitudes (KSA) required for nurses to provide safe and effective care (2014). Competencies were observable, measurable behaviors that meet organizational and supervisory expectations (ANA, 2013). Competencies should be developed through a collaborative effort (Wright, 2013). The people for whom the competency will be applied *must* be the center of all aspects of competency development (Wright, 2013). Wright stated that an effective competency was built through a collaborative process that deeply involved the people for whom the competency was designed (2015). Essentially, for a community to readily accept the accountability and responsibility associated with newly developed professional competencies, their point of view must be fully integrated into development and validation.

Competency Development

Nurse Executive Competencies

Since 2004, nurse executive (NE) role competencies were recognized as measurable, observable behaviors meeting organizational and supervisory expectations for the NE, when the Healthcare Leadership Alliance (HLA) produced *Nurse Executive Competencies,* which were subsequently revised and refined (AONE, 2015a). In keeping with Wright's premise, the nurse executive's point of view was solicited and integrated into the competencies developed for the NE role. Their presence was evident by AONE's inclusion in the HLA that developed the NE competencies; AONE was listed as one of the members (AONE, 2015a). The NE competencies were tested for reliability and validity through rigorous evaluation (i.e. periodic job analysis/role delineation studies; AONE, 2015a). Nurse executive role competencies were developed with, by, and for the NE.

Nurse Manager Competencies

Since 2006, when *Nurse Managers Competencies* was published by AONE, the NM's observable and measurable organizational and supervisory expectations, like the NE's, were based on published standards developed by the Nurse Manager Leadership Collaborative (AONE, 2015b). While a NM organization was not specifically included in the Collaborative, the AONE was considered by many to represent formal nurse leadership (i.e. nurse managers). The Collaborative engaged the NM viewpoint during the document's development (AONE, 2015b). The NM competencies were subjected to rigorous evaluation for reliability and validity through periodic job analysis and role

delineation studies (AONE, 2015b). Nurse Manager competencies were developed with, by, and for the NM.

Clinical Staff Nurse Competencies

Unlike the NE and NM, a single leadership competency inventory publication for the CSNL's observable and measurable competencies was not readily available. In October 2016, the nurse scientist performed a literature search via the electronic databases Medline, CINAHL Complete, and Cochrane Database of Systematic Reviews, looking for publications that identified, defined, or explained CSNL competencies. Search criteria filters applied were English language, peer reviewed, and publication dates between January 2000 and October 2016. Keywords included: *nurse, clinical, leader, leadership,* and *frontline;* each of which returned more than 1,000 articles. Combining keywords *frontline AND nurse AND leader/leadership* yielded 35 articles; combining *frontline AND nurse AND clinical leadership* yielded 30 articles. These 65 articles were reviewed to determine if the publication included the CSNL viewpoint during data collection, manuscript preparation, or manuscript review. Four of the 65 articles incorporated the CSNL viewpoint. The exercise illustrated the limited numbers of publications reporting CSN competencies, particularly competencies from the CSN viewpoint.

The Academy of Medical-Surgical Nurses (AMSN) published a CSNL curriculum developed by what were referred to as nurse experts (Grindel, 2016); however, 'nurse expert' was not defined. A concept analysis identified domains of clinical excellence, relationship management, and effective communication as a foundation for CSNL competencies by nurse authorities (Chavez & Yoder, 2015), but,

again, excluded CSNL inclusion during manuscript development. In 2014, Jooste and Cairns reported a mismatch in perceptions among nurse managers and staff nurses regarding staff nurse exhibited leadership behaviors. Managers perceived the staff nurses were exhibiting higher levels of leadership behaviors than did the staff nurses. This publication directly measured the CSNL viewpoint and illustrated the gap between NM and CSN expectations. An integrative review of ten articles featured CSN leadership expectations by listing CSNL responses, recognizing the CSNL voice (Mannix, Wilkes, & Daly, 2013). Downy and colleagues (2011), though describing the benefits of nurturing the informal leader (i.e. CSNL) did not include the CSNL perspective. Stanley's study attempted to identify commonly recognized CSNL attributes by interviewing both CSNL and management leaders during data collection (2006). Cook and Leathard reported on an educational program designed to improve CSNL applications (2004). This program was developed for, and applied to, the CSNL.

Analyzing and Comparing Nurse Executive, Nurse Manager, and Clinical Staff Nurse Leader Competencies

Competency expectations were compiled for a comparison, available in Table 1, of NE, NM, and CSNL roles. The *Nurse Executive Competencies* (AONE, 2015a) was used as the gold standard for the leadership role comparisons. Each competency had supporting, explanatory sub-competencies that delineated specific expectations for observable, measurable behaviors. The comparisons and analysis conclusions were discussed in the following sections.

Communication and Relationship Building Competencies

The communication and relationship building competency included the following sub-competencies: effective communication; relationship management; influencing behaviors; diversity; community involvement; medical/staff relationships; and academic relationships (AONE, 2015a). Communication was a basic element of leadership (Grossman & Valiga, 2013). A leader must be able to convey ideas and vision to, or hear concerns and recommendations from, the followers (Grossman & Valiga, 2013; Kouzes & Posner, 2012). For the CSNL, effective communication was a required competency (Chavez & Yoder, 2015; Grindel, 2016; Mannix et al., 2013; Stanley, 2006). For the NE, communication focused on group or mass communication practices (AONE, 2015a), while the NM had no specific communication competency but did have communication techniques included as a requirement in Strategic Management's section (AONE, 2015b).

Relationships were the result of trust building and experiences in collaboration (Grossman & Valiga, 2013; Kouzes & Posner, 2012). The CSNL was expected to exhibit relationship management through coordination and influencing behaviors (Chavez & Yoder, 2015). The AONE nurse manager competencies were itemized relationship management and influencing behaviors (see the next subsection) as independent competencies (i.e. not listed under communication and relationship building like the NE competencies). The NM relationship management competency included conflict management, situation management, relationship management, influencing others, and promoting professional development (AONE, 2015b).

Communication and relationship building also included interactions with medical staff and academic leaders. Relationships were based on trust (i.e. influencing behaviors;

Kouzes & Posner, 2010) and were concerned with leader-follower interactions (Northouse, 2016). Clinical staff nurse leader competencies did not include medical staff interactions nor academic relationships, though the CSNL worked closely with the medical staff daily and served as preceptors for student nurses in many organizations. Both the nurse manager competency (NMC) and nurse executive competencies (NEC) included relationship management and influencing behaviors (AONE, 2015a; AONE, 2015b). Influencing behaviors was a core competency for the CSNL (Chavez & Yoder, 2015; Grindel, 2016; Mannix et al., 2013; Stanley, 2006), as was relationship management (Chavez & Yoder, 2015).

Knowledge of the Healthcare Environment

The knowledge of the healthcare environment competency included the following sub-competencies: clinical practice knowledge; delivery models and work design; healthcare economics and policy; governance; evidence-based practice/outcome measurement; patient safety; performance improvement/metrics; and risk management (AONE, 2015a). Clinical expertise was important in all nurse leader roles (Davidson, Elliott, & Daly, 2006). Clinical staff nurse clinical expertise was a primary CSN leadership domain (Chavez & Yoder, 2015). The NEC delineated expectations for current practice, care standards, professional association participation, development of individual organizational policies and procedures, nursing ethics, and research protections for subjects (AONE, 2015a), while the NMC stated that nurse manager clinical competencies were individual role- and institution-specific (AONE, 2015b).

Patient safety was a national initiative supported by Centers for Medicare and Medicaid Services (CMS) and accrediting agencies like The Joint Commission (TJC) or

Det Norske Veritas (DNV). Patient safety was identified as an NEC and CSNL competency, but not specifically as NMC. In NMC, performance improvement had a patient safety subheading, but no independent patient safety competency. Performance improvement was one competency common to all leader roles. Risk management was only listed as a NEC, not an NMC or CSNL competency.

Leadership

The AONE NEC leadership competency had foundational thinking skills, personal journey disciplines, systems thinking, succession planning and change management listed as supporting competency expectations (2015a). Interestingly, foundational thinking skills were listed in each nursing leadership role, as were personal journey disciplines. Both NMC and CSNL competencies listed human resource as a competency (AONE, 2015b; Cook & Leathard, 2004; Grindel, 2016; Mannix et al., 2013; Stanley, 2006). The NMC had human resources as an independent competency (AONE, 2015b). The nurse executive competency did not have human resource as an independent competency (AONE, 2015a). The NMC had human resource management in The Science domain, and human resource leadership skills in The Art domain (AONE, 2015b). Both sections were focused on staffing management and interactions.

Systems thinking was part of the NEC and CSNL competency, but not the NMC. Systems thinking meant mental processes that integrated vision, problem-solving, and organization-wide considerations (AONE, 2015a). Systems thinking was listed as a sub-competency under foundational thinking skills for the nurse manager (AONE, 2015b). Succession planning was part of the leadership competency (AONE, 2015a), which was

not included in either the NMC or CSNL competencies. Interestingly, change management was listed as a CSNL competency, like the NEC, but not in the NMC.

Professionalism

Professionalism included personal and professional accountability, career planning, ethics, and advocacy (AONE, 2015a), none of which were included in the CSNL competencies. The NMC included personal and professional accountability and career planning, but not ethics or advocacy as independent competencies (AONE, 2015b). Ethics was a sub-competency of personal and professional accountability, while advocacy was not specifically mentioned in any of the competencies of the NMC (AONE, 2015b). The ANA had produced a code of ethics for nursing professionals implying that ethics was a core competency for all nurses (2015).

Business Skills

Business skills, as defined by the *AONE Nurse Executive Competencies* (2015), included financial management, human resources management, strategic management, and information management and technology as individual competencies. All of competencies were included in the NEC and NMC, but none were included in the CSNL competencies.

Comparing CSNL Competencies Developed With and Without the CSNL Perspective

Successful and applicable competency development required full participation with, and from, the object of the competency development (Wright, 2013). When comparing publications that address CSNL competencies, many of the publications were written without including the CSNL viewpoint. A review of Table 2 revealed that many

important competencies were assigned to the CSNL, but fewer were identified by the CSNL as a clinical staff nurse competency. Effective communication and influencing behaviors were found in both columns, as was clinical practice knowledge, verifying that these three were important to the CSNL from their own viewpoint. Another, evidence-based practice (EBP) or outcome measurements was also identified by the CSNL as a KSA requirement. Human resources, personal journey disciplines and change management were sub-competencies in the leadership competency were designated as important by the CSNL. Some competencies assigned to the CSNL by management-written publications were relationship management, patient safety, performance improvement, foundational thinking skills, and systems thinking. Professionalism and business skills competencies for the CSNL have not been addressed by any author. These competencies may also be identified by the CSNL as important, but no literature included in this article had solicited that opinion from the CSNL.

Discussion

The AONE publications were based on the consensus of stakeholders, specifically, the nurse executive for the NEC, and the nurse manager for the NMC. These competencies were subjected to rigorous evaluations designed to ensure applicability across settings. However, CSNL competencies were not subjected to rigorous examination, were neither concise, nor based on the CSNL viewpoint. In fact, many were identified and designated by management as important to CSNL performance without including the CSN perspective.

Competencies should be role-based. For example, elements of the NE competencies had no comparable NM attributes lending credence to an assumption that

vital role differences exist requiring divergent role competencies. A review of Table 1 illustrated the differences between the executive's and nurse manager's role expectations. For example, many important NMC were integrated into overarching relationship or management competencies that could be priority competencies (i.e. patient safety, risk management, medical/staff relationships) for *every* nursing role. Risk management and performance improvement together ensure quality care delivery but were scattered through the NM competencies and completely missing from the CSNL competencies. Unit-based care delivery improvement initiatives were focused on CSNL activities and performances (i.e. risk management, performance improvement, evidence-based practice) leading to a belief that these were core competencies for the CSNL. However, the *used internal and external benchmarking data to evaluate performance and support best practices and decision-making* competency was not included in the self-identified CSNL competencies. Therefore, for future studies, it may be beneficial for the nurse's role to guide the final core competencies that are required for the CSNLs.

Many of the NM competencies dealt directly with human resources in the form of staffing practices, which indicated the NM spent extensive time and effort in staff management (i.e. human resources). Human resources were an independent NM competency but were not an independent NE competency. Another human resource competency was succession planning. Succession planning was important at all levels but was not part of the NM or CSNL competencies. However, CSNLs who precepted and mentored novice nurses were performing succession planning and human resources management.

Conclusion

Nurse roles adapted to meet the profession's evolutional needs. Leadership was not a new role in nursing but was recently identified as one of the most important competencies a nurse can display. The NE and NM had valid, reliable tools developed for evaluating work production providing for an opportunity to objectively meet industry expectations; however, nursing had failed to provide a valid, reliable tool to evaluate the CSNL's competencies. Clinical staff nurse leaders needed concrete guidelines to measure their strengths and opportunities for improvement, allowing for personal or professional enhancement action plans. Scientifically supported competencies for CSN leadership could be the basis for training, education, and evaluations of the CSNL in both the academic and clinical settings.

At best, the CSNL had been taught, trained and evaluated on limited, and perhaps, inaccurate information. Potentially, and worse, unrealistic expectations may have been imposed on the CSNL, based on competencies designed and validated for a different role.

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Chapter Three: Nursing Research Participation: We Can Do Better

(as accepted for publication by Nursing2019)

See *Appendix B for Nursing2019's permission to list manuscript.*

Abstract

Purpose

Potential drivers and barriers to clinical staff nurse leader (CSNL) research participation was explored through a recruitment exemplar description that highlighted how nurses' understanding of the connection between research and practice influenced their attitudes toward research participation.

Keywords: nursing research, nurse research participation, nurse research

Introduction

Even before nursing 'became a profession', the nursing community worked diligently to identify, examine, and support current nursing practice (Berthelsen & Holge-Hazelton, 2016). The whole nursing community, together, was responsible for fully understanding why, how, when, to what extent, and who's responsible for each intervention as nursing interacted with other disciplines delivering multifaceted, multifactorial care that influenced and optimized patient outcomes. Without research perpetuating nursing as a profession, nursing practice would not be what it is today (Carneval, 2014; Yoder, 2017). Continuous cooperation and collaboration in scientific inquiry among all levels of the nursing community was required to produce research that when translated can lead to optimal, high-quality patient outcomes. Members of the

nursing community enhanced the profession through participation in the various aspects of scientific inquiry, from nurse scientists and nurse executives to nurse leaders, which included the clinical staff nurse leader (CSNL) at the bedside.

Therefore, to explore the concept of collective partnership among the nursing community, this article presented a recruitment exemplar describing one nurse scientist's efforts to conduct original research designed to better understand the CSNL role's contribution to optimum patient outcomes. Describing a research recruitment exemplar offered a unique perspective on the potential drivers and barriers to nursing community participation in research, highlighting how a potential participant's understanding of the connection between research and its application to practice may influence nurses' participation. Understanding how nursing research explained patient outcomes, whether they were familiar or obscure, was necessary for nurses; understanding of their important contributions to research and, thereby, improved participation in nursing studies (Nkrumah, Atuhaire, Priebe, & Cumber, 2018). For example, in the recruitment exemplar description below, although clinical staff nurse leader (CSNL) competency was perceived as integral to patient care outcomes, without staff participation in research and the subsequent understanding of the role of staff nurse leadership in the healthcare team and in improving patient outcomes, the impact of leader competency on organizations' financial status could not be realized (Franks-Meeks, 2017b).

Literature Review: CSN Leadership and Patient Care

The Institute of Medicine's report *The Future of Nursing: Leading Change, Advancing Health* (2010) stated that nursing leadership was necessary at every level to improve patient outcomes. The effectiveness of a CSN's bedside leadership competency

directly impacted quality patient care outcomes (Ezziane, 2012; Garner, 2011), while influencing organizational financial stability (Grindel, 2016). According to Al-Dossary, Kitsantas, and Maddox (2014), CSNL competency required between 12 and 18 months to develop. In the *Clinical Staff Nurse Leadership Competencies* research proposal (CNSL, 2018), Franks-Meeks discussed the connection between the CSN leadership's influence on patient care outcomes as well as its financial impact.

In the *CSNL Study*© proposal (2018), Franks-Meeks proposed that if newly graduated nurses (NGN) could master CSNL competency more rapidly, patient outcomes would be improved without a lag time of 12 to 18 months that NGNs experienced, further improving an organizations' financial position. However, no CSNL competencies existed that were developed and validated by the CSNL's voice (Franks-Meeks, 2017a). Thus, the gap in nursing science was identified and potentially addressed by the *CSNL Study*©. Since the research was designed to capture the voice, or perspective, of the clinical staff nurse, the *CSNL Study*© depended directly on clinical staff nurses' participation in the research.

While CSNLs demonstrated a lack of attention to participating in original nursing research; most agreed that research was important (Scala, Price, & Day, 2016; Yoder, 2017). When nurse scientists asked nurses why they did not participate in nursing research, many respondents indicated that 'time' or 'too busy' was a major limiting factor (Hagen & Walden, 2015; Yoder, 2017). Other commonly listed barriers were a lack of resources and/or supporting organization culture toward nursing research participation (Berthelsen & Holge-Hazelton,

2016; Scala et al., 2016). Barriers listed that focused on the staff nurses were prioritization of and interest in research by the nurses, educational basis for understanding literature and research methodology (Berthelsen & Holge-Hazelton, 2016), and the ability to leverage existing supportive networks (Scala et al., 2016).

Moulton, Wilson, Plazas, and Halverson (2018) stated "… all nursing research should eventually impact patients in the practice setting. This does not mean that all research must be directed at a patient…" (p. 4). Perhaps this was one of the difficulties of nursing research. Potential nurse participants did not make the connection between how nursing research focused on nurses eventually impacted the patient care delivery. Nkrumah et al., (2018) demonstrated evidence of clinical nurses' perceived lack of benefit by research on bedside practice. Participating respondents indicated ($p = 0.01$) there was minimal association of benefit to professional nursing practice from research participation (Nkrumah et al., 2018). Nurse scientists and nurse educators must make the connections between nursing research and its impact on the practice setting (Moulton et al., 2018), and practitioners must be willing to investigate and evaluate the connection when asked to participate.

Recruitment Exemplar: The *CSNL Study*

For the purposes of this article, 'system failure' was used when the supporting healthcare system did not support the CSN in research participation. Next, 'participant failure' referred to examples of when the potential participants did not take advantage of the opportunity. The following described a research recruitment exemplar report conducted by a nurse scientist candidate. The research was multiphase, observational,

mixed methods methodology that included a survey, focus groups, and a Delphi validation process (Franks-Meeks, 2018).

For Phase 1, the recruitment exemplar survey was conducted between October 2018 and April 2019, the nurse primary investigator (NPI), a nurse scientist, offered more than 80 U.S. hospitals an opportunity to participate in original nursing research. In keeping with scientific requirements, the NPI obtained permission from each organization's leading nurse executive before recruiting nurse participants. Contact between the NPI and the organization was through chief nursing officers (CNO)/directors of nursing (DoN) or their first contact – in many cases, the administrative assistant. One administrative assistant, after the NPI briefly explained the research, said before concluding the conversation, "We don't do that. We are not interested in research." Assuming the potential CSNL participants would have completed the research activities, they were not given the opportunity. This was an example of a healthcare organization that did not provide the potential registered nurses (RN) participants a research opportunity.

Out of the originally 80 selected hospitals, only 23 agreed to allow the nursing research to be conducted. The research methodology required the CNOs/DoNs to forward an invitation email to the RNs employed by their acute care organizations. The RN invitation email included the recruitment exemplar survey url. The NPI was unable to get significant numbers of participation surveys using this method.

To better understand the lack of RN participation in the survey, the NPI contacted one of the CNOs/DoNs, who was willing to speak with the NPI. The NPI discovered that the CNO had forwarded the RN invitation email to the directors for distribution to the rank and file CSNLs, but the directors had not forwarded the invitation email. Again, the RN participants were not given the opportunity to participate in the research. This was another example of system failure in that the organization's leadership culture did not support RN participation in nursing research.

The original survey had an individual .url provided to potential participants in the RN invitation email. The online survey was expected to take between 10 and 20 minutes to complete. Between October 2018 and December 2018, only eight nurses started the survey, and, of those eight, only two fully completed it. Between December 2018 and January 2019, the NPI accessed individual champions at a few select hospitals attempting to improve survey participation at the champion's organization. The champions were able to get two more RN participants to access the survey, but neither fully completed it. The NPI contacted a participating DoN to better understand why the nurses were not participating in the survey. The DoN stated, "I have repeatedly sent the email to them. I have talked to them repeatedly. I don't know why they won't do the survey" (S. N. personal communication, March 29, 2019). This was an example of participant failure to take advantage of the research opportunity.

In March 2019, the NPI switched to a hardcopy survey distributed to several local acute care hospital champions, where an additional 23 surveys were completed before the survey data collection of Phase 1 closed at the end of April 2019. It was important to note that the hardcopy surveys were delivered by a voluntary survey champion from the

organization to members of the RN staff who were, in the champion's opinion, most likely to complete the survey.

Discussion

Nurses at every level, in every position must be committed to contributing to fully understanding nursing practice (ANA, 2015), but participation in nursing research requires effort and consumes resources. To ensure optimum resource utilization, each member of the nursing community must make efforts to understand the connection between the proposed research and patient outcomes (i.e. how the research will impact nurses in their practice and how it will benefit the patient). First, the nurse scientist must ensure that expected connections between the research results and patient outcomes were included in marketing materials and during the recruitment process. Second, the nursing executives and their first contact representatives must be willing to spend the time to understand the research-practice connection(s) when offered research opportunities. Third, research participants (i.e. practicing nurses) must seek to understand the research-practice connection when opting in or out of a research opportunity. Finally, the nurse scientist-participant relationship should be developed early in the nurse's career.

Many nurses did not appreciate how accessing the nurse scientist can improve and enhance the nurses' practice. In the clinical setting, the nurse scientist can provide insight into statistical data, particularly quality improvement (QI) activity results, evaluation of National Database of Nursing Quality Indicators (NDNQI) reports, identification of root causes using statistical tests,

and report writing to validate staff utilization. As new policies and interventions are implemented, the nurse scientist would be able to assist in evaluation of the practices for improvements using scientific methodology. A nurse scientist could assist in the Magnet journey for the Force: New Knowledge, Innovations, and Improvements with gap analysis, as well as study design and conduction. Finally, a nurse scientist would be a necessary addition to an Institute Review Board (IRB) hosted by an organization that conducts, or desires to conduct, original research.

A *multimodal approach* may be effective in solving recruitment issues (Broyles, Rodriquez, Price, Bayliss, & Sevick, 2011; Heath, Williamson, Williams, & Harcourt, 2018). Adding alternate venues of recruitment and survey distribution may improve organization participation. Broyles et al. (2011) recommended onsite and/or peer-to-peer interaction(s), scheduling flexibility which could include stakeholder planning/involvement, and sensitivity to the investigational research topic, while Heath et al, (2018) reported that flexibility in data collection methods increased participation, such as face-to-face interviews, text messaging, and email interviews.

In the recruitment exemplar, the NPI did not include an explanation of the connection between patient outcomes and CSN research participation during marketing and recruitment efforts. Multimodal approach variations for the *CSNL Study*© may include any or all the following: during initial contact with the approving nurse executives, a description of expected connections between the research and patient outcomes and potential financial benefits should be discussed; marketing materials to be used at the executive's discretion, addressed to members of the management team, describing the connection between the expected research end results and patient benefits

could improve leadership support of the organization's participation; and finally, ensuring the organization had access to organization-based email with an RN distribution list would be helpful to ensuring the research design meets the needs of the organization.

More importantly, as described above, the nurse scientist should have emphasized the importance of clinical staff nurse participation in the research, making the connection between the CSNL practice and patient outcomes, but the CSNL participants should have investigated and evaluated the research-practice connection. In the recruitment exemplar, the research was designed to capture the *voice of the CSNL*, to engage them in nursing science, to identify bedside nurse leadership competencies that could be used to improve nurse education and training, and most importantly, potentially improve patient outcomes. While keeping the recruitment materials brief and succinct was important, it was equally important to emphasize the research-practice connection(s). Alternately, the nurse participants could have been diligent in examining the research-practice connection.

Like nursing practice, the nursing CSNL Pilot recruitment exemplar was a multifactorial, multifaceted process with multiple potential points of failure. The difficulties in engaging every nurse in nurse research were myriad and getting data collection participation was difficult. The American Nurses Association (ANA, 2015) had included in the Code of Ethics for Nurses, Provision 7, an expectation that "in all roles and settings, [*the nurse scientist with the nursing community*] advances the profession through research and scholarly inquiry…" (p.

27) [*italics added by author*]. Members of the nursing community must embrace and participate in research. In both examples provided, the literature review and the experience of the original research recruitment exemplar, the nurse scientist, healthcare industry (i.e. the system), and the nurses (i.e. participants) failed to meet minimum expectations for compliance with the Registered Nurse's Code of Ethics' (ANA, 2015) recommendations.

Conclusion

In conclusion, more research is needed to overcome the barriers between the nurse scientist and the nurse participant. More research is needed to understand the drivers and barriers to research participation by all nurses. Improved healthcare industry support for nursing research was needed to allocate time and resources. Improved understanding by practicing nurses of the research-practice connection was needed, which in turn, should improve participation rates.

Nurses at every level, in every position, voiced the importance of nursing research – to participation in, and support of, nursing research; however, when push comes to shove – few engaged. Nurses *knew* in their hearts that the only way to continually improve nursing practice and the patient experience was to learn more about how, why, what, by whom, and when nursing interventions were best implemented. Research participation was, therefore, mandated to ensure nursing practice remains relevant to, supportive of, and actively protecting our most important asset, that was our patient(s).

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Chapter Four: The *CSNL Study*© Pilot: Feasibility Assessment of Leadership Competencies for Bedside Nurses

Abstract

Background

Leadership competencies have been established for formal nursing roles (i.e. nurse executives), but not for informal nurse leader roles (i.e. clinical staff nurse leaders). A set of comprehensive clinical staff nurse leader (CSNL) competencies would facilitate evaluation of the CSNL role in providing safe, quality, and efficient patient care.

Purpose

The pilot examined the feasibility of nationwide research engaging the CSNL voice to establish a set of CSNL competencies substantiated by supporting knowledge, skills, and attitudes (KSAs) by identifying pitfalls, barriers and options to success.

Methods

The pilot was a multiphase, sequential explanatory mixed methods design targeting clinical staff registered nurse (RN) leaders utilizing an online survey, focus groups to explore and explain the survey results, followed by a Delphi technique ensuring accuracy and validity of the results.

Results

The pilot results were an initial set of four CSNL competencies, accompanied by associated KSAs. The pilot identified multiple opportunities to improve the process and participation rates, while underscoring the importance of a nationwide study.

Keywords: leadership, competencies, clinical staff nurse, clinical staff nurse leader, leadership, mixed methods

Problem and Significance

Competencies were observable, measurable behaviors resulting from the synthesis of knowledge, skills, and attitudes (KSAs) applied to nursing practice (American Association of Colleges of Nursing [AACN], 2012), and evaluated objectively (ANA, 2013). Comprehensive leadership competencies were validated for the nurse executive and nurse manager roles, incorporating the voice of those to whom the competencies were intended (AONE, 2015a; AONE, 2015b); however, clinical staff nurse leader (CSNL) leadership competencies were not subjected to the same rigor (Franks-Meeks, 2017). Some leadership competencies were designated as appropriate for CSNLs by members of the nursing leadership team, however, none were identified and validated by the CSNL community (Franks-Meeks, 2017).

A literature search, published in Nursing Forum by Franks-Meeks (2017), see Chapter 2, identified a gap in the nursing science regarding CSNL competencies. Wright (2015) stated that competency development required the deep integration of the voice of the applicable community, in this case, CSNLs. Work derived directly from the voice of a community had intrinsic value as an expression of their empowerment (Combaz & McLoughlin, 2014). When the community developed standards (i.e. group norms, values, and expectations), evaluation of member actions was more objective (Sharma, 2008). The CSNL competencies' assignment had not included the voice of the community for whom they were intended.

The *CSNL Study*© addressed the identified gap in nursing science by engaging the CSNL voice to answer its research questions (Franks-Meeks, 2018). Phase 1 surveyed CNSLs determining a preliminary set of competencies; Phase 2 involved validation of the competencies identified in Phase 1, and Phase 3 further validated the four CSNL competencies through a Delphi process. The specific aim of the *CSNL Study*© was to establish a comprehensive set of CNSL competencies with associated knowledge, skills, and attitudes (KSAs) identified and verified by the CSNL voice. Through the CSNL pilot design process, advantages, successful procedures, improvement opportunities, and improved implementation planning were uncovered.

Literature Review

Leadership was identified as an essential nursing competency at all levels by the Institute of Medicine (IOM), in 2010, necessary to excellence in healthcare delivery and optimum patient outcomes (Ezziane, 2012; Garner, 2011; Grindel, 2016). By definition, leadership was the process of moving others toward a common goal (Dansereau et al. 2013). In nursing, the terms ‘leadership’ and ‘management’ were used interchangeably; however, in action, the behaviors were distinct and not confined to management roles (Grossman & Valiga, 2013), but included informal roles like clinical staff nurse leaders. Clinical staff nurse leaders demonstrated ‘leadership’ using influence without formal authority, achieving optimum organizational and patient outcomes, and recognized by their peers through exhibited leadership competency and associated KSAs (Chavez & Yoder, 2015).

Theoretical Framework and Philosophical Underpinning

The theory guiding the development of this study was the Authentic Leadership Theory (ALT; Luthans & Avolio, 2003). This theory explained the evolution of authentic leadership over a lifetime, influenced and refined by life's events, a positive psyche, and strong ethical convictions leading to genuine interpersonal interactions with heightened personal awareness (Northouse, 2016). The ALT domains were heart, purpose, values, relationships, and self-discipline (Northouse, 2016). Figure 1 described the ALT development process, while Figure 2 depicted ALT domains, or characteristics.

Figure 3 depicted the dynamic process of the ALT's influence on CSNL competencies. The authentic CSNL successfully led the healthcare team through relationships (i.e. connectedness) and self-discipline (i.e. consistency). According to how the NPI applied ALT, a heightened awareness of attitudes, understandings, and personal history was expected to allow CSNLs to effectively manage behaviors and beliefs, influencing interactions using their strong internal moral compass. Clinical staff nurse leaders' passion and heart was expected to allow them to explore and examine all options before selecting the best situational intervention. Based on their responses, CSNLs exhibited sincere, scrupulous interpersonal interactions leading to increased levels of trust by others, and therefore, effective leadership (Northouse, 2016).

Conceptual & Operational Definitions

The *CSNL Study*© constructs and conceptual definitions were included in Table 3. Survey items, as NE competencies, were assigned to ALT domains *A priori* by the NPI; however, final domain assignment for identified CSNL competencies was completed in Phase 3 by the CSNL subject matter experts (SMEs). Operational definitions were

proposed by Phase 2 focus group interview participants, discussed in subsection Phase 2 below, and validated during Phase 3's Delphi technique.

Research Questions and Hypotheses

Mixed Methods Research Hypothesis

Leadership competencies, identified, defined, and evaluated by the CSNL voice for the CSNL were specific to the CSNL role, and were different from those identified, defined, and evaluated by, and for, the formal nurse leader role (i.e. nurse executive or nurse manager).

Research Questions

To achieve the specific aim of the study, to establish a preliminary comprehensive set of CSNL competencies with associated KSA identified by the CSNL voice, a specific set of research questions (RQ) were answered within each study phase. See Table 4 for a visual of RQ divided into Phases.

The following RQ were answered in Phase 1: RQ #1: Of the existing established NE leadership competencies, which associated KSAs did CSNLs identify as essential to the CSNL role? and RQ #2: What other leadership KSAs did CSNLs identify as essential to their role competencies?

The following was answered in Phase 2: RQ #3: How was the CSNL voice actualized in terms of relevance, practicality, and meaningfulness in the CSNL competencies identified in Phase 1?

Finally, Phase 3 answered the following: RQ #4: How complete, accurate, appropriate, and meaningful were the final CSNL competencies as evaluated by CSNL

subject matter experts (SME)? and RQ #5 How do CSNL SME associate the final CSNL competencies with the Authentic Leadership Theory domains?

Design

The *CSNL Study*© pilot employed a multiphase sequential exploratory mixed methods design. In Phase 1, a descriptive survey was used so that CSNLs identified a proposed set of leadership competencies, which answered RQ #1 and RQ #2. In Phase 2, a focus group of CSNLs reviewed the proposed competencies identified in Phase 1 and verified that these were CSNL competencies, which answered RQ #3. In Phase 3, a two-round Delphi technique was used to solicit from subject matter experts refined and confirmed competencies identified in Phase 1 and 2, which answered RQ #4 and RQ #5.

Protection of Human Subjects

The *CSNL Study*© was reviewed and approved by the University of Texas, Tyler (UT Tyler) Institutional Review Board (IRB) before participants were enrolled. Protocol revisions, addendums, and additions were approved by the same IRB prior to implementation. Phase 1 participants were provided an opportunity to exit the survey before completing any questions with instructions that to continue implied consent to participate in the pilot. Phase 2 participants were provided a brief overview of their responsibilities and expectations via email, with an accompanying participation consent. Each returned the signed consent before they were included in the data collection. Phase 3 participants were contacted by the nurse scientist to provide an explanation of their responsibilities and expectations by email, text message, telephone, and face-to-face conversation(s). Questions and concerns were solicited and answered. Verbal consent to participate was obtained from all participants before data collection ensued.

Phase 1 *CSNL Study* Survey

Methods

sample. Phase 1's sample included Registered Nurses, employed by acute care hospitals, who spent more than 50% of their work time engaged in direct patient care activities. Furthermore, participant eligibility requirements included more than 18 months of direct care patient experience and employment by the sponsoring organization (i.e. not per diem or short-term traveler; See Table 5). The mean age for RN respondents was 35.7 years with a standard deviation of 11.54 years and all were female.

Participant recruitment occurred between October 2018 and April 2019. In September 2018, U.S. states were divided into regional subsets matching the original AONE leadership study, discussed in the *measurement* subsection of Phase 1. See Table 6 for regional state assignments. Possible sample hospitals were identified through a Google search with search parameters: "*hospitals in <name of state>'*. Google search filters were removed which would have identified hospitals closest to the NPI's location.

The names of the first 200 hospitals, or in some cases, all, of the hospitals in a state were collected. Hospitals included were community acute care hospitals, medical centers, university hospitals, and regional hospitals. A subset of 20 hospitals from each state were randomly selected. Of the final 20 hospitals from each state, 20 hospitals were identified from each region using the following method: the hospital names were printed on slips of paper, cut apart, mixed thoroughly, and 20 regional hospitals were selected randomly. The 20 regional hospitals were contacted by the NPI for potential participation in the pilot. A second subset of five alternate hospitals from each region was selected using the described method. It was important to note that a fifth region

solely for military hospitals was included in the regional designations, but the NPI was unable to contact the management of the military hospitals for permission to participate in the pilot; therefore, this region was discontinued as a possible venue for data collection.

The NPI offered the identified 80 U.S. hospitals an opportunity to participate in the pilot; of the 80, 23 hospitals agreed to participate. To identify participating hospitals, the NPI telephoned the hospital(s) to speak with the chief nursing officer (CNO) or director of nurses (DoN) [*for the purposes of simplicity called CNO*] requesting permission to access the organization's RNs. Chapter three described the process more fully. When the CNOs agreed to participate, the NPI provided them an email that further explained the pilot, their responsibilities, and an accompanying email to be forwarded to the organization's RNs. The email to be forwarded to the organization's RNs included a brief explanation of the pilot, its purpose, the eligibility criteria, and a hyperlink to the electronic survey. See Appendix D for the CNO engagement email, and Appendix E for the RN recruitment email. After two weeks, the NPI attempted to contact the participating CNOs to determine how many RNs to whom the CNOs had sent the recruitment email. None of the CNOs replied and one survey had been completed. In November 2018, the alternate hospitals list was accessed. The process described above was implemented, with no additional hospitals agreeing to participate.

Between December 2018 and January 2019, the NPI accessed champions at a few select local hospitals to improve participation rates; however, the effort brought little success. In March 2019, the NPI obtained permission from the UT Tyler IRB to switch to hardcopy surveys at a single local hospital. During April 2019, two champions at one

hospital solicited RN participation in the survey. It is important to note that the hardcopy surveys were delivered by a voluntary hospital employee champion to members of the RN staff who were, in the champion's opinion, most likely to participate. Data collection for the survey was closed at the end of April 2019.

Ultimately, 35 participant's surveys were collected via both electronic and hardcopy. Twelve cases were collected via the electronic survey and 23 cases were collected via hardcopy surveys. Of the 35, 22 were eliminated because the respondents had not progressed in the survey beyond the demographics section; they had not answered any of the competency items. Of the remaining 13 cases, three were eliminated due to eligibility criteria requirements (See Figure 4) leaving 10 cases for analysis.

measurement. The survey was developed using the AONE universally accepted NE leadership competencies identified and validated as reliable by the *2014 Nurse Executive Survey* in the *2014 Nurse Executive Exam (10) National Survey Tasks/Activities List Role Delineation Study* (ANCC, 2015). Permission was obtained to alter the NE survey instrument (See Appendix C). Specifically, the original survey's scoring strategy was revised to the following Likert scale: "*Please indicate how often you used these leadership activities/behaviors/competencies in the past six months?"* with scoring options ranging from 0 [*I never used this activity/behavior/competency*], to 4 [*I used this activity/behavior/competency frequently (almost every day)]* with options of 1 = *seldom (less than once per month)*; 2 = *sometimes (more than once per month, but less than weekly)*; or 3 = often *(more than weekly, but not daily).*

The survey was divided into demographic and competency subsections. The competency subsection included 78 potential CSNL competency items. The

demographic section included 17 questions. The NPI was concerned that the CSNL concept was new and not well known. The data accuracy was dependent on ensuring strict application of the eligibility criteria. The NPI intentionally included demographic questions to improve identification of eligible cases, such as age, level of education, gender, length time in nursing, previous formal or on-the-job leadership training, hospital bed number (i.e., size), and hospital designation (i.e. frontier, rural, or metropolitan). The NPI was concerned that RNs who were not eligible would complete the survey, and vice versa. In other words, the concept of CSNL competency is not universally understood, influencing RN interest in the pilot and its results (See Chapter 3). Table 7 is the pilot survey items, number of cases (N), frequencies, percentage(s) of total case responses, means, and standard deviations.

Survey items were examined to identify competencies with a mean greater than 2.4. A mean of 2.4 indicated that the respondents used the item more frequently than monthly. Five items (competencies #1-5 in Table 7) had a mean of at least 2.4. Histograms were examined for the five identified competencies; no skew or kurtosis was identified. Item frequencies were examined closely. Pearson's Correlation was performed on these five competencies (See Table 8). Two of the five competencies were identified as having a strong linear correlation (r = .866). They were the following: competency item #2 "*Created a practice environment of empowered decision-making, professional accountability, and autonomy*" and competency item #3 "*Facilitated active involvement of nurses in decision making related to professional standards of practice*". The items' frequencies and percentage(s) of total responses indicated that more than 50% of the CSNLs agreed they performed competency #2 'almost every day', while only 30%

agreed they 'frequently' practiced competency #3. As a result of this finding, the NPI elected to remove competency #3 from the Phase 2 competency list. The internal consistency of the survey was assessed using Pearson's product-moment correlation coefficient to examine linear correlation(s) between each item's mean-between-items, as well as the overall survey consistency using Cronbach's Alpha (*alpha =0.975*). It is important to note that Cronbach's Alpha may have been influenced by a strong linear correlation of multiple items.

Each item was examined for normal distribution using the Shapiro-Wilk test. The Shapiro-Wilk test was used for analysis instead of the Kolmogorov-Smirnov (K-S) test for normality of distribution due to the small sample size (n = 10) and was performed only on the competencies forwarded to Phase 2. An n = 10 limited the testing of reliability of the normality of distribution statistic. The results of both the K-S test and the Shapiro-Wilk test were included in Table 9. The NPI recognized that the above statistical tests were of limited value with the small *N*, but felt it was important to perform them to estimate their potential value with a larger sample size, as would be available should the *CSNL Study*© be performed as intended, nationwide.

data collection. Data were collected through both an electronic and hardcopy survey that included 17 demographic items and 78 competency items. The demographic section helped identify RNs who met eligibility criteria. The electronic survey was developed on the SurveyMonkey platform. Chapter 3 described the online data collection process in depth. The survey took, on average,15 to 20 minutes to complete. It was important to note that the hardcopy surveys were delivered by a voluntary hospital employee champion to members of the RN staff who were, in the champion's opinion,

CSNLs who would most likely participate. Data collection for the survey was closed at the end of April 2019 due to time constraints related to the NPI's dissertation timeline expectations.

Procedures to Enhance Control and Rigor

Threats to internal and external validity were evaluated. The NPI recognized that the pilot had low statistical power and the data outcomes violated the normality of distribution assumption; however, this was a pilot to evaluate the *CSNL Study*©'s possibilities with a large, nationwide participation. Most of the participants were employed by the same hospital. The hospital culture's influence on the results was beyond the scope of the pilot but was recognized as an important threat to the internal validity of the pilot. The multiphase design both built on previous data outcomes and results and validated them. Particularly, Phase 2 and Phase 3 validated the credibility and dependability of the results through the focus group interviews and CSNL SME verification and confirmation.

Data Outcomes

Analysis of pilot data was achieved using SPSS, Version 26. Electronic data were downloaded into an SPSS datafile from the survey software. The hardcopy data were added manually to the datafile, combining the data to 35 cases. After removing 22 incomplete cases, as described above, the remaining 13 cases were evaluated for eligibility criteria. Three more cases were removed due to ineligibility, specifically that all three had served in a manager position in the past 12 months, leaving 10 cases for analysis. Frequencies, means, and standard deviations were calculated and examined for each of the survey items (See Table 7). The 13 CSNLs identified five competencies in

Phase 1 as behaviors performed on a daily basis; based on the analysis, four were retained as CSNL competencies to advance to Phase 2 and 3, which answered RQ #1 and RQ #2 (See Table 10).

Table 7 contains a complete list of the frequencies and percent responses for each of the survey items, with the most commonly identified competencies listed as items #1-4. The most commonly used CSNL competency was competency item #1 which was answered as 'frequently, almost every day' by 100% of the respondents (n = 10, M=4.00, SD = 0.00). The second most commonly used CSNL competency was item #2 (n = 10, M = 3.00, SD = 1.33), which was answer as "reported more often than weekly, but not daily" by 100% of the respondents.

The competencies that were identified as not applicable to the CSNL role are competency items #6-20 with a mean less than or equal to .31 (M = or < 0.31). The cut-off was selected arbitrarily based on survey selection options. A mean less than or equal to .31 meant the respondents selected never (0) or seldom (1). CSNL participants skipped or responded with 'never' to two competencies indicating that they never perform the competency. The competencies that all respondents skipped was competency item #6 and item #7 (n = 0). The competency selected the least often was item #8 (n = 10, M = 0.00, SD = 0.00).

RQ #1: The competencies to be included in Phase 2 discussions were used 'almost every day' by more than 50% of the participants. Each of the included competencies scored a mean equal to or greater than 2.4 (M = or > 2.4). The four competencies were interpreted by the NPI as *essential* to the CSNL role. RQ #2: Phase 1 participants identified no additional CSNL KSAs.

Phase 2 Focus Group Interview

Methods

sample. Phase 2 participants were two self-identified CSNLs from Phase 1. They had the additional inclusion eligibility of 'must be acknowledged by peers as a leader' and be considered minimally competent as determined by the sponsoring hospital' clinical ladder or by a professional national certification. Table 11 contains the eligibility criteria for Phase 2 participants.

A champion from one participating organization was identified and volunteered to recruit potential Phase 2 participants. Using the Phase 2 eligibility criteria, the champion identified six potential participants and, after obtaining the potential participants' verbal permission, forwarded their contact information to the NPI. The NPI contacted the six potential participants via email and text messages. Four of the potential participants indicated an interest in the pilot. The NPI provided the four potential participants an email during the final week of May 2019 that contained a brief eligibility questionnaire and the Phase 2 participation consent (See Appendix F). This email was followed by a text message notification of the email's dispatch. The information and notification process were repeated during the first week of June 2019. The recipients were asked to answer the eligibility questions, complete, sign, and return the consent to the NPI via email within three days.

To facilitate a mutually agreeable meeting time, a Doodle Poll© was created and forwarded to the participants to identify the best time(s) for the focus group interview. Of note, identifying a common date/time was challenging, even for the small group used here as evidenced by three of the four agreeing to a common time. Ultimately, two

CSNLs participated in the focus group. One of the expected participants indicated that he could not attend due to unexpected personal difficulties.

A second recruitment was conducted during August 2019 to improve the generalizability, dependability, and credibility of the qualitative portion of the pilot since the first focus group interview included only two CSNLs. One of the Phase 1 champions was contacted for a list of potential Phase 2 participants, who met the eligibility criteria. The NPI texted six of the people on the list, selected randomly, to recruit to a second focus group interview, but was unsuccessful in recruiting further participation.

measurement. Phase 2 was a qualitative data collection with the participants and NPI meeting via video conference as instruments of data collection. Questions about CSNL responsibilities and expectations were sent by text message and email prior to conducting the focus group. The group discussed RQ #3 *How is the CSNL voice actualized in terms of relevance, practicality, and meaningfulness in the CSNL competencies identified in Phase 1*. Each of the four CSNL competencies identified in Phase 1 were discussed individually, probing for necessary KSA's definitions and applicability (see Table 10).

data collection. The Phase 2 focus group interview was conducted on July 8, 2019, between 9 am and 11 am, using a web-based interactive technology (See Appendix H for the interview schedule). Due to technical difficulties, the interview was not recorded, which may have influenced the iterative process of data review. The NPI moderated the session and took extensive notes during the focus group interview and immediately after its conclusion. The focus group interview was conducted based on the provided schedule. The Phase 2 focus group interview schedule included an introductory

phase, in which participants familiarized themselves with each other and the focus group interview technology and discussed the CSNL role definition. Next, the NPI reviewed the overall participation expectations. Third, the group reviewed the results of the Phase 1 survey process, addressing RQ #3, discussed in the analysis section.

Analysis.

Analysis was an iterative process conducted using the scrupulous notes collected during and after the focus group interview, the code book, and the research journal, which included the NPI's thoughts, feelings, beliefs, and intuitions regarding the focus group's responses. Each of the Phase 1 CSNL competencies [referred to as working competencies heretofore] were reviewed for potential KSA contribution and accuracy of verbiage (i.e. did the competency as written describe its application). From Phase 1, the competency reported as most commonly used was Table 7 competency item #1 The group determined that mutual respect, trust, and civility were interdependent attitude requirements necessary to accomplish this leadership competency. One participant stated [*paraphrased*], 'respect and civility did not require trust during interactions, but trust was necessary to form relationships.' The group did not indicate that additional knowledge or skills were necessary for this competency, but oral communication techniques and relationship-building skills were discussed.

Communication was a skill the group did not specifically include as a KSA, but as each competency was discussed, communication was described as implicitly necessary to the CSNL successfully performing the competency, particularly when accessing and/or utilizing other members of the healthcare team. Relationship-building also was not specifically identified as a necessary skill, but the theme was identified by the NPI, and

supported as accurate by Phase 2 participants, as essential to successful interpersonal interactions. The group agreed the competency and its KSAs were written accurately. See Table 12 for the Phase 2 accepted working competencies, with associated KSAs, identified as competency #1, and so forth.

The second most commonly used working competency was competency item #2. The group indicated the included constructs (i.e. empowered decision-making, professional accountability, and autonomy) were independent KSAs, with one leading to the next. When questioned by the NPI, they indicated they meant that autonomy was necessary to reach professional accountability, which was in turn necessary to gain empowered decision-making ability. In other words, autonomy leads to professional accountability, which leads to empowered decision-making, which, as explained by the group, equals the practice environment.

The group indicated that autonomy was based on each patient care plan situation and could be fluid in practice. Essentially, as one participant stated [*paraphrased*], 'You can't have autonomy unless you understand your role in the patient care plan'. One participant indicated that the patient's plan of care determines the nurse's level of autonomy based on physician orders and patient expectations. Furthermore, the group agreed that a working understanding of the organization's policies and the Nurse Practice Act (NPA) integrated with personal experience, knowledge, and each individual patient situation was necessary to bring autonomy-in-action.

As part of working competency #2, 'professional accountability' was defined as "the person you are when no-one is watching". One of the participants recounted that nurses "do a lot when nobody is watching them. Accountability is doing what should be

done without being told to do it." The group discussed the difference between 'responsibility' and 'accountability'. According to the members of the focus group, 'responsibility' was doing what was expected because the rules say to do it, but 'accountability' was doing what should be done because it was the right thing to do. Finally, according to the group, empowered decision-making was the result of combining autonomy and professional accountability. Ultimately, the group revised working Competency #2 to "Created a practice environment of empowered decision-making". Again, see Table 12 for further explanation of the accompanying KSAs.

Working Competency #3 was competency item #3 in Table 7. The necessary knowledge for Competency #3 was understanding of the organization's policies, training and competency in the use of specific pieces of equipment, as well as the availability of needed supplies. The group reiterated the need to know who to call when for help. Interestingly, the necessary attitudes were 'courage' and 'healthy fear'. The participants indicated that a healthy fear motivated them to act in compliance with the Nurse Practice Act and organizational practice expectations to protect themselves and their license(s), but *courage* was necessary to act in the face of conflict and opposing forces. To act in the patient's best interest required extra courage, particularly when the perceived opposition was in a position of authority. The group indicated that organizations that use the *Just Culture Algorithm* were more likely to "have your back when something [*adverse*] happens", as one participant stated. The *Just Culture Algorithm* was designed to ensure that when care varies from the expected, an objective evaluation of the action was conducted. See Figure 5 for a graphic of the *Just Culture Algorithm*.

Finally, the group reviewed working Competency #4 from Table 7 competency item #4. They agreed that 'prioritizing quality activities' was the competency. Knowledge requirements for this competency were regulatory requirements, support/ancillary staff availability, and expected patient outcomes. Regulatory requirements for the group meant the CSNL needs to know about Core Measures' expectations and best practices as applied to and by U.S. Department of Health and Human Services (HHS) Core Measures for acute care facilities. Knowledge of support and ancillary staff availability meant the CSNL must have a working relationship with the personnel who supported the RN's patient care activities. The CSNL needed to know who was available to assist and support the patient – essentially the CSNL needed to know *who* to call *when* for *what*, which could also be called 'clinical excellence'.

Competency #4 necessary skills were appropriate clinical excellence, delegation, appropriate ancillary/supportive staff utilization, and collaboration, while cooperation was a required attitude. Appropriate delegation for an RN was defined by each state's Nurse Practice Act but allowed for extensive latitude for the CSNL's application. The focus group stated that to effectively delegate, "*you have to 'know the person' to whom you are delegating*" as one of the participants stated. When questioned about what '*know the person*' means, the participant said the CSNL must understand and know what were the supportive and ancillary person(s) allowed to do by training, policy, and regulation and how well can he/she do it. Finally, and more importantly according to the participants, what and when does the CSNL need the delegated intervention(s).

Relationship building and relationship maintenance were skills necessary to support this competency but were not specifically included as a KSA for the CSNL

competencies. The group indicated these skills were a basis for nursing in general. Again, excellence in communication was an unvoiced skill for the CSNL. As the group talked, it was obvious that effective communication skills were necessary to relationship building, relationship maintenance, and interactions between members of the team.

Procedures to Enhance Control and Rigor

Due to technical difficulties, the interview was not recorded, limiting the researcher's ability to review for accuracy using an iterative process; however, the participants were provided the results for validation of the accuracy of their contribution(s) before the data was forwarded to Phase 3. A Code Book was developed for consistency of future *CSNL Study*© interviews. The researcher maintained a journal to describe activities, theme development, and thought processes regarding comprehension and grasp of the participants' contribution.

The NPI acted as a facilitator during the discussion, offering probing questions for clarification purposes, digging deep into the participants' rich knowledge base to extract the maximum data possible during the interview. Copious notes were written during and immediately after the interview. The NPI reviewed the notes repeatedly to better understand the messages the data contained. The resulting list of competencies and KSAs were provided to the Phase 2 participants giving them an opportunity to correct or revise the information, if necessary. The participants agreed the resulting information was accurate and reflected what they had said during the focus group interview.

Results

Phase 2's research question was '*How was the CSNL's voice actualized in terms of relevance, practicality, and meaningfulness in the CSNL competencies identified in*

Phase 1?'. The results, described in Table 12, answered RQ #3 with the identification of the Phase 2 working CSNL competencies with associated KSAs as developed through the CSNL's voice. It was important to note that the definitions discussed above, associated with each competency's KSAs, emerged during the Phase 2 focus group discussion and were not assigned *A priori*. The results of Phase 2, in some ways, mirrored the state of nursing science regarding CSNL competencies. While no universally accepted list of CSNL competencies/KSAs exists, Franks-Meeks (2017) developed a list of assigned CSNL competencies/KSAs from a literature review, as described in Chapter 2.

Phase 3 Delphi Confirmation

Methods

A Delphi technique is effective research method to compile and concentrate expert opinion using an iterative feedback process (Skulmoski, Hartman, & Krahn, 2007). It is especially effective in interpreting and decrypting incomplete or poorly understood information. The Delphi technique was selected as the final phase of the pilot to ensure the data were accurate, appropriate, meaningful, and met the expectations of the CSNL SME reviewers from their perspective, effectively capturing the CSNL voice. It provided credibility, validity, and reliability to the results.

sample. Phase 2 participants provided the names of six subject matter experts (SMEs) who might be willing to participate in Phase 3. The NPI contacted the potential SMEs via email, text messages, and face-to-face, and three agreed to participate in the 3-step Delphi. The SMEs recruited to Phase 3 were from the same acute care hospital as the Phase 2 participants (see Table 13). The CSNL SMEs each had more than five years'

experience, included both male and female, and varied in age from young adult to late middle adult. See Table 14 for a full description of the CSNL SME demographics.

data collection. The Phase 3 SMEs were provided the working set of Phase 2 competencies and associated KSAs via email. The definitions of the four working competencies, as determined by the Phase 2 discussion, were included to ensure data accuracy between phases. They were asked to review the competencies for accuracy and appropriateness. Next, they were asked to assess the definitions from Phase 2 for application of the competencies' meaningfulness. Finally, they were asked to determine whether the identified competencies and KSAs should be included in the final set of CSNL competencies and KSAs. Phase 3 was planned to include a three-round Delphi technique. The first round was delivered via email to the SMEs the last week of July 2019; however, since all agreed in the first round that the identified competencies/KSAs were appropriate for CSNLs, the NPI omitted round 2 and moved on to the planned round 3. Round 2 was intended to reconcile discrepancies between the CSNL SME recommendations for the CSNL competencies and KSAs.

The third and final round involved assigning the CSNL competencies confirmed in Round 1 to constructs within the Authentic Leadership Theory (see Appendix I). This work occurred the second week of August 2019. The CSNL SMEs returned the working competencies to the NPI with their recommendations for ALT assignment. All CSNL SMEs agreed on the constructs that were aligned with each KSA across four competencies.

Procedures to Enhance Control and Rigor.

The NPI provided the results of Phase 2 to the CSNL SMEs with the associated definitions as identified from Phase 2 participants. Phase 3 participants, the CSNL SMEs, were asked to review the definitions for accuracy and agreement with their own expectations.

Results

The Phase 3 SMEs agreed with the Phase 2 results of identified CSNL competencies and associated KSAs. They indicated that the definitions were accurate, appropriate, and meaningful to the CSNL role and needed no further clarification. According to Phase 3 CSNL SMEs, communication was a necessary skill and that respect, trust, and civility were necessary for working competency #1. Second, they supported working competency #2, including the following knowledge requirements: 1) understanding and comprehension of CSNLs' organization's policies and state's nurse practice act; 2) personal and professional experience's lessons integrated into their practice; and 3) actualization of the healthcare team's patient care plan. They indicated that working competency #2 further supported the CSNL's autonomy in the context of individual patient plans of care based on the integration of all the healthcare team members' recommendations of which the patient and support system were essential partners. Finally, the second competency included professional accountability and a willingness to work hard in the best interests of the patient. See Table 16 for the Phase 3 finalized working competencies.

Next, working competency #3 had several necessary KSAs, some of which were surprising to the NPI. Competency #3's attitudes included courage and healthy fear. All

the pilot's participants agreed that the CSNL must have courage to stand in the face of opposition and conflict at the bedside, but must also have a healthy fear of consequences, both expected and untoward. According to the participants, the 'healthy fear' brings to bear a heightened sense of awareness of forces outside the CSNL's control, which may assist the CSNL to recognize, and perhaps act on, subtle cues that would assist in excellent care delivery. Competency #3's identified skill was the activation of the 'Just Culture' algorithm. As discussed above, the 'Just Culture' algorithm uses a no-blame attitude to evaluate the questioned action.

Finally, the fourth, and last, competency included a working grasp of unlicensed assistive personnel, ancillary, and supportive staff's capabilities, both by regulatory and training requirement expectations. It was in working competency #4 appropriate delegation was introduced and, by extension, relationship development and maintenance. It was important to note that both Phase 2 and Phase 3 participants mentioned that recognizing proficiency and excellence in their peers and coworkers was necessary to appropriate delegation. Communication, collaboration, and cooperation were also included in competency #4.

To close Phase 3, the Phase 3 SMEs assigned the finalized CSNL competencies to the Authentic Leadership Theory constructs. See Table 3 for ALT constructs, the conceptual definitions, *A priori* assignment of NE competencies, and assignment of the final working competencies to the ALT constructs. First, working competency #1 was assigned to the ALT 'heart' construct. Second, competency #2 was assigned to the 'values' construct, while competency #3 was included in two ALT constructs: purpose and relationships. The ALT construct, 'purpose', was defined as the CSNL's

compelling advocacy for the patient's best interest, while 'relationships' was the CSNL's influence on members of the healthcare team. Finally, competency #4, was assigned to the self-discipline construct.

Phase 3's RQ #4 and RQ #5 were answered during a two-round Delphi process. Round one answered RQ #4 when the CSNL SMEs reviewed and finalized the working competencies as accurate, appropriate, and meaningful to the CSNL role. Research question #5 was answered when the CSNL SMEs assigned each competency to its matching ALT construct. See Table 3 for the final working CSNL competencies, their conceptual definition(s), and the assigned ALT constructs.

Discussion

With improved participation rates, the information collected could be practice altering for nursing, particularly for leaders at the bedside. They practice leadership in a manner that nursing does not fully understand, cannot effectively measure, with no method of standardized reproduction. The nurse scientist agreed with the IOM regarding nursing leadership but could find no evidence of valid and reliable understanding of the CSNL role in patient care delivery. Furthermore, the leadership expectations, which had been assigned to the CSNL, needed to be evaluated from the point of view of the community to which they were applied. Currently, CSNL are evaluated using nurse executive and/or nurse manager leadership expectations, this pilot illustrated that the expectations are not interchangeable with CSNL expectations. Leadership at the bedside was a poorly understood phenomenon, and it deserved a closer look by nursing science.

The NE list of competencies seemed, at first glance, to be at too high a level for the CSNL's application and the participants may have recognized their role's

contribution(s), in part. Verbiage, or the language of the competencies appears to have played a part in their selection. Participants indicated that preliminary CSNL competency #3 and #4 were used approximately monthly. However, patient safety is practiced *daily.* as is, for example, regulatory requirements for nurse-sensitive patient outcomes. The language of the competencies must be evaluated for CSNL recognition and application.

The survey did not include questions designed to evaluate the participants' level of nursing expertise, other than the 18 months of experience. In the next iteration of the survey, the nurse scientist will include questions about their level of expertise both time in the nursing profession and their self-designated Benner's novice to expert levels. The participants' level of experience, novice to expert, should be included in the analysis of the frequency of item use. There may be an interesting interaction between the level of expertise and the frequency the item(s) were used.

Furthermore, the influence of Kantor's Theory of Management combined with Benner's Novice to Expert Theory on the development and exhibition of leadership competencies must be explored. Kantor's theory indicated that organization culture can encourage or inhibit displayed behaviors. The conflux of the influences of these two theories may be very important in understanding the development and display of CSNL competencies.

The mixed methods methodology of sequential explanatory research was effective in identifying the most commonly used leadership competencies and the qualitative method applied the quantitative data to the lived life experience of the CSNL. Finalizing the data using CSNL subject matter experts ensured the data was accurate and was from

the CSN voice. Using a multiphase design allowed for repeated data triangulation with multiple reviews of the data by different CSNL community members and ensured it was accurate, applicable, and of value to the community.

Next, the *CSNL Study*© pilot emphasized the importance of effective marketing and recruitment efforts. The successful completion of the pilot substantiated that the nurse scientist's hypotheses and research questions were valuable in supporting the study's purpose, which would, in turn, be effective in marketing and recruitment efforts. The nurse scientist further hypothesized that enlisting professional nursing organizations to assist in recruitment in a grassroots effort would greatly improve participation rates. The professional nursing organizations' participation would give the *CSNL Study*© validity, encouraging rank-and-file participation in the survey.

Scheduling the interview was challenging. Multiple interview technologies (e.g. remote electronic technologies, face-to-face interviews, email interviews, or text messaging interviews) might improve participation. The remote electronic technology worked well, but using the visual aspect increased participant anxiety stimuli (i.e. How do I look? What were they seeing behind me?). The system used allowed the participants to block their images, but the nurse scientist lost the unspoken messages and cues. The nurse scientist must ensure the audio-visual recording equipment was functioning prior to beginning the interview. Recording the interview would improve the iterative review process. Including the participants in a final review of the data would be important and improve the accuracy of the results, providing a validating triangulation of the data from multiple points of view.

Using Phase 2 participants to identify Phase 3 SMEs was effective. Participation rates were improved by using multiple methods of recruitment repeatedly (i.e. email, face-to-face, telephone conversations, and text messaging). The required 'national certification' eligibility criteria may not be necessary. While a national certification increases nurse peer regard, it limited the number of potential participants. In this case, the CSNL SMEs were members of an organization that had implemented a unit-based Clinical Ladder excellency program that served to support the pilot's eligibility of leadership and practice excellence through a peer and managerial review, which addressed the eligibility concern. Using an email delivery process worked well for information transfer and allowed the participants to complete their contributions quickly and effectively. It was important to provide to the Phase 3 SMEs the Phase 2 leadership competency and KSA definitions when they were asked to perform the evaluation(s).

Comparing the results of Phase 2, as described in Table 12 and the state of the science in Table 15 revealed the CSNL pilot both supported and opposed current nursing science regarding CSNL competencies/KSAs. In general, the state of the science in Table 15 listed expected behaviors overall, while the CSNL pilot listed many of them as KSAs under a competency umbrella. When comparing the Pilot's results to currently published competency and KSA expectations, the following commonalities and differences were noted. According to Franks-Meeks (2017), communication, clinical excellence, relationship building and/or maintenance, and quality/safety for both the patient and employee(s) were included in the literature, while the following were not included, but were, however, included by the CSNL pilot's participants: attention to

organizational policies and Nurse Practice Act requirements nor delegation to appropriate supportive and ancillary staff.

The CSNL pilot served to improve the nurse scientist's understanding of the implications of the larger study. Delineating data based on level of expertise may be important in better understanding the leader at the bedside application of leadership competencies and practices. During the NPI's interactions with the CSNL participants, it was obvious that the leader at the bedside concept was a new, unexplored, and, heretofore, unknown phenomenon. One of the Phase 3 CSNL SMEs stated, "*I had never thought about being a CSNL in those terms and needing those qualities and traits, but they are true!*" The importance of completing the nationwide *CSNL Study*© cannot be underestimated.

Strengths & Limitations

Strengths

Deep engagement of the CSNL voice improved the pilot's credibility. Furthermore, the pilot's process was effective in the multiphase design. Collecting observational data via the survey, then exploring and adding definitions and expectations for the CSNL role during the focus group's discussion ensured data accuracy, applicability and meaningfulness by adding the qualitative research rigor. Finally, the Delphi technique finalized the credibility and dependability of the results. Accessing the CSNL multiple times in multiple venues resulted in a rich data set that began to explain the leadership expectations of the CSNL role. The mixed methods design deeply integrated the voice of the participants in the results.

Limitations

The *Leader at the Bedside*© survey must be thoroughly evaluated for validity and reliability. Its length may have been a barrier to participation. Furthermore, using the original NE competencies as a base may have been a barrier to nurses who worked at the bedside, as the verbiage may need to be revised to better match CSNL competencies. Next, the pilot's participation rates were not statistically significant limiting its generalizability. Additionally, most of participants came from a single hospital. The nurse scientist hypothesized that the hospital's culture surely influenced the results, in keeping with Kantor's Management Theory (1983), which stated that individual behaviors were directly influenced by the supporting organization's cultural expectations. The pilot did not attempt to evaluate the supporting organization's culture.

Recommendations

Lessons Learned

Every phase was solidly based on the CSNL's participation and voice. The pilot identified multiple potential points of failure in each phase. Effective marketing and recruitment efforts proved to be crucial in each phase; its importance cannot be overemphasized. In Phase 1, for electronic distribution of the RN invitation email to be successful in recruitment efforts, the NPI must ensure the participating organizations have an inclusive RN employee distribution list. In Phase 2, meeting scheduling required considerable effort and management of audiovisual recording equipment was indispensable. Phase 3's Delphi technique worked well for the Pilot.

Further, the pilot provided a glimpse of the possibilities that can be realized through a nationwide *CSNL Study*©. An initial observational design was necessary since

so little information was published on the subject. Second, the qualitative methodology of Phase 2 allowed the nurse scientist to capture the lived experience, or speaking voice, of the participants, providing an opportunity for a rich data collection. Finally, using the Delphi technique to validate and finalize the data allowed for the members of the CSNL community to stamp '*approved*' on the information.

Summary

In conclusion, the CSNL pilot was successful in identifying potential process pitfalls and possible revisions and remedies. It gave a glimpse of the possible results from a nationwide *CSNL Study*©. It supported the importance of capturing the CSNL community's voice to identify, define, and, ultimately, actualize objective evaluations of the CSNL competency at the bedside.

Chapter Five: Summary and Conclusion

Leadership was an important competency for the clinical staff nurse. It can drive quality and excellence in care delivery and organizational financial viability. The *CSNL Study*©, when completed, will provide a foundation for nursing education and training to minimize the on-the-job experience required to learn the CSNL competencies and knowledge, skills, and attitudes (KSAs). Unlike many manual nursing skills, soft skills like leadership are difficult to evaluate objectively. The CSNL pilot supported the necessity of completing the *CSNL Study*© to provide an objective evaluation basis for CSNL competencies and KSAs.

The CSNL pilot was a multiphase, sequential, explanatory mixed methods research design which allowed the nurse scientist to capture the voice of the CSNL. The participants identified, defined, applied, and determined the meaningfulness of leadership competencies and KSAs as they believe the competencies apply to their nursing role at the bedside. Finally, the CSNL subject matter experts (SMEs) determined how the identified competencies both supported and were supported by the Authentic Leadership Theory. The Authentic Leadership Theory explained how nurses' formative lives were expressed in their professional interactions, defining and describing the personality traits that make clinical staff nursing leadership different from other kinds of leadership.

Research Program: Next Steps

The CSNL pilot supported the importance of completing the nationwide *CSNL Study*©, addressing the gap in nursing science regarding clinical staff nurse leadership competency and by, extension, the gap in nursing education and training. The

importance of completing the *CSNL Study*© in a large statistically effective sample cannot be overstated. A full, nationwide, statistically significant study can complete the work started by the CSNL pilot.

The CSNL pilot illustrated the importance of making the research-patient outcome link. If nurses did not recognize why the research improved the patient experience, they were unlikely to participate in data collection or integrate the findings into day-to-day practice. Research efforts may benefit from effective marketing, but less traditional recruitment and data collection methods may also contribute positively to participation rates. Collecting qualitative data can be difficult in many ways, from scheduling to capturing the information to the iterative process of understanding the data.

The CSNL pilot confirmed that more research was needed. A large sample *CSNL Study*© must be conducted to fully understand the complexities of the CSNL expectations captured through the voice of the participants. Understanding the influence of role on leadership expectations was important. The competencies identified in the pilot survey were NE competencies applied to the CSNL role. More accurate verbiage in a CSNL competency survey would improve accuracy of identification during the data collection process. A separate qualitative study may be necessary to improve verbiage in the competency items.

The length of the survey may inhibit participation. Furthermore, multiple items in the survey had no response or a response of "*I never used this competency*." Those items must be removed and the *Leader at the Bedside*© survey tool be evaluated for validity and reliability. See Appendix J for the *Leader at the Bedside*© survey tool. The four CSNL competencies identified through the CSNL pilot must be further tested and validated

before they can be integrated into nursing education and practice. The nurse scientist must ensure the CSNL competencies set was complete, including all the supporting KSAs.

The CSNL concept is new and poorly understood. There may be a need to perform further qualitative explorations of the CSNL community accessing RNs who view themselves as CSNLs, as well as those who do *not* see themselves as CSNLs to identify how they recognize the CSNL via competency. Next, the CSNL community should be asked if all RNs need to be able to exhibit leadership competency, like more manual nursing skills such as catheter insertion. As stated above, nursing leadership at the bedside improves patient outcomes and by extension organizational success. Does every RN need to be able to perform 'basic CSNL competencies' or is it a specialized skill? More research is needed.

While the Authentic Leadership Theory was fully supported by the pilot, inclusion of Benner's theory of novice to expert would be an added dimension to the data collection. An exploration of the influences of CSNL experiences on leadership competency recognition and identification would be beneficial in understanding how the CSNL KSAs are developed, applied, and passed on to the next generation. Furthermore, the inclusion of hospital culture influences, as described by Kanter's Management Theory, must eventually be examined to identify how culture influences the development or inhibition of leadership competency development and application at the bedside.

Conclusion

The recipients of healthcare delivery deserve the very best nursing care possible during each, and every healthcare interaction. Excellence in nursing care includes quality

leader at the bedside leadership competencies. Effective CSNL competency improves quality and excellence in healthcare delivery. Improved quality and excellence in healthcare delivery improves supporting organizational financial stability and patient satisfaction.

Effective CSNL competency was learned, and earned, through training, education, and experience. While no amount of training and education can replace the importance of practicing the skills (i.e. experience), a basic understanding of the CSNL competency expectations would improve integration of the competencies and KSAs into day-to-day interactions. Training and education in both the academic and clinical settings will provide a basic understanding of the CSNL competencies with opportunities to practice the skills in a simulation setting. Training and education must be grounded in valid and reliable nursing science, like the *CSNL Study*©. The CSNL pilot, and by extension, the *CSNL Study*© will provide the nursing science necessary to complete the spirit and ultimately, the study's goal: improving the patient experience through improved clinical staff nurse leadership competency.

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Sherron Franks-Meeks

General

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.editorialmanager.com%2Flwwesubmissions%2Flogin.asp%3Fa%3Dr&data=02%7C01%7Candrei.greska%40wolterskluwer.com%7C602b450ede504115d83a08d712957eff%7C8ac76c91e7f141ffa89c3553b2da2c17%7C0%7C0%7C636998305602080622&sdata=3g%2BZJZEb%2B3pme1VQNgtaGe7QaM4sdiyRHnxBS81PqHI%3D&reserved=0). Please contact the publication office if you have any questions.

Appendix C: Permission to use the ANCC's Survey Tool

Sherron Meeks

From: Meadows, Mary <mmeadows@aha.org>

Sent: Wednesday, September 27, 2017 1:07 PM

To: Sherron Meeks

Cc: Hancock, Beverly; Gergely, Susan

Subject: Re: Permission to adapt survey

Sharron
AONE is happy to approve your request. Please resend the document for our signature. Thank you!
MT Meadows

Sent from my iPhone

On Sep 27, 2017, at 11:00 AM, Sherron Meeks <sherron.meeks@midlandhealth.org> wrote:

> Ms. Hancock & Gergely;
>
> Thank you so much for your response! I did formally request permission via the link – but have not gotten any response on it.
>
> I am concerned since I need to finalize my Dissertation Proposal.
>
> Any help would be greatly appreciated.
>
> Thanks, Sherron Franks-Meeks

> From: Hancock, Beverly [mailto:bhancock@aha.org]
> Sent: Wednesday, September 27, 2017 10:44 AM
> To: Sherron Meeks <sherron.meeks@midlandhealth.org>; Gergely, Susan <sgergely@aha.org>
> Cc: Meadows, Mary <mmeadows@aha.org>
> Subject: RE: Permission to adapt survey
>
> Hello Sharon,

I had forwarded your request to MT Meadows, our Director of Professional Practice. She sent you a response on 9/14, but perhaps it did not get through to you. Here is her response:

Sharon:
Thank you for contacting AONE. Your request was referred to me as director of professional practice. I would like to clarify your permission to use request. It appears that you would like to use the AONE Nurse Manager Competencies that were derived and revised through the role delineation study. The Role Delineation Study itself is an internal document and not shared publicly.

Please clarify your specific request using the permission to use form available on our website http://www.aone.org/docs/reprint-permission.pdf

I am happy to answer additional questions you may have. Please feel free to contact me. Sincerely,
MT
Meadows
mmeadows
@aha.org

Beverly Hancock, DNP, RN-BC
Senior Director, Leadership Development
American Organization of Nurse Executives (AONE)
155 N. Wacker Dr. Suite 400
Chicago, IL 60606
312-422-2817

From: Sherron Meeks [mailto:sherron.meeks@midlandhealth.org]
Sent: Wednesday, September 27, 2017 9:40 AM
To: Gergely, Susan <sgergely@aha.org>; Hancock, Beverly <bhancock@aha.org> Subject: RE: Permission to adapt survey

Good day to you. I have not received confirmation that I can adapt the nurse executive survey to my needs. I would like to submit my Final Proposal to my Dissertation Committee on Saturday – Please, can I have permission to use the tool?

Thanks, Sherron Franks-Meeks

From: Sherron Meeks
Sent: Wednesday, September 13, 2017 1:24 PM
To: sgergely@aha.org; bhancock@aha.org
Cc: Sherron Meeks <sherron.meeks@midlandhealth.org>
Subject: Permission to adapt survey

Dear Ms. Gergely and/or Ms. Hancock;

Please, let me introduce myself. I am a PhD candidate for the University of Texas at Tyler's Nursing Program. My dissertation expects to establish a comprehensive set of clinical staff nurse leadership competencies using a mixed methods design. I would like to adapt the 2014 Nurse Executive Role Delineation Study tool to my study's quantitative data collection phase (a survey).

I will not make any changes to the 78 work activities verbiage. I will remove the current scoring strategy and replace it with one to assess clinical staff nurse leaders' alignment with the established nurse executive competencies. I will also change the demographic information collected.

I will ask the question: How often do you use these work activities?

0 = Never
1 = Annually
2 = Monthly
3 = Weekly
4 = Daily

I would, respectfully, request permission to adapt your tool to my participants' needs.

I would be willing to answer any questions you might have, regarding my study proposal.

Thank you;

Sherron Franks-Meeks, PhD(c); MPAL, RN, RN-BC, CSRN, CVRN-BC I

Appendix D: CNO Email

Dear Nurse Executive;

I am a doctoral candidate in the PhD program in the School of Nursing at the University of Texas at Tyler. I respectfully ask for your consideration of my request for RNs from your organization (called clinical staff nurse leaders [CSNL] for the study) to participate in a study entitled, *Leader at the Bedside: Establishing Clinical Staff Nurse Leadership Competencies* (the CSNL Study). The study has been approved by the University of Texas at Tyler's IRB. The purpose of the CSNL study is to establish a set of comprehensive CSNL competencies and their associated knowledge, skills, and attitudes (KSAs) from the perspective of the CSNL. The study will employ a mixed methods design beginning with a survey that will be followed by focus group(s). It is expected that the set of valid and reliable CSNL competencies from the study will allow for education, training, and objective evaluation of leadership activities performed by the clinical staff nurse.

If you agree for your nurses to be invited to participate in the CSNL Study, please forward the attached RN recruitment email to your RNs. This RN recruitment email includes an explanation of the study, information about informed consent and a URL link to the CSNL Study's *Leader at the Bedside* survey. The RNs who choose to participate and complete the survey will be offered the option to participate in the follow-up focus group(s) interview(s). As CNO of your organization, your role will include forwarding the CSNL recruitment email to invite your RNs to participate, then returning an email note to me with the total number(s) of RNs to whom you sent the recruitment email. I will follow-up with you in two weeks to assist with any concerns, and to remind you distribute the RN recruitment email, if needed.

Please feel free to contact me with any questions you may have at SFranksMeeks@patriots.uttyler.edu. I thank you, in advance, for your time and attention.

Thank you;

Sherron Franks-Meeks, PhD(c), MPAL, BSN, RN, RN-BC, CVRN BC-I, CSRN
Principal Investigator, CSNL Study
SFranksMeeks@patriots.uttyler.edu

Appendix E: RN Recruitment email

Dear Registered Nurse (RN);

Hello. I am a doctoral candidate in the PhD program in the School of Nursing at the University of Texas at Tyler. I respectfully request your participation, as a CSNL, in a study entitled, *Leader at the Bedside: Establishing Clinical Staff Nurse Leadership Competencies* (the CSNL Study). The clinical staff nurse leader (CSNL) makes optimal patient outcomes possible and improves organizational financial successes. The CSNL may also be known as a bedside nurse, staff nurse, or point of care nurse, and is *not a member of management*. The CSNL's job description does not include language about managing people, supplies, or other resources. The CSNL may perform the tasks of Charge Nurse, but continues to perform at the bedside, engaged in direct patient care activities for the majority of his/her work day. The CSNL is acknowledged by his/her peers as a leader, seen with respect, admiration, creating a desire to emulate and model the CSNL's behavior(s). Further, the CSNL is acknowledged as a leader by the organization's management as a leader, seen as respectfully soliciting assistance in leading, guiding, or soliciting other nurses' participation in the unit/department's quality and/or practice initiatives.

The purpose of the CSNL study is to establish a set of comprehensive CSNL competencies and their associated knowledge, skills, and attitudes (KSAs) from the CSNL perspective. It is expected that the set of valid and reliable CSNL competencies from the study will allow for education, training, and objective evaluation of leadership activities of the clinical staff nurse. The study has been approved by the University of Texas at Tyler's IRB (IRB Protocol #Sum2018.172). Please contact Dr. Gloria Duke, Chair of the UT Tyler IRB, if you have any questions about your rights as a study participant.) We know of no risk to you other than those encountered in normal, everyday life. Personal benefits to you may not be realized, but the benefits to society include a better understanding of the leadership expectations for the clinical staff nurse that may result in better RN leadership education, training, and evaluation.

If you choose to participate in the CSNL study, you will be asked to complete an online survey that is expected to take about 20-30 minutes of your time. The online survey contains questions about how often you engage certain activities/behaviors. Once submitted, your information cannot be retrieved, or removed, individually, since no individually-identifiable markers will be associated with the data.

When you have completed the online survey, you will be provided an opportunity to volunteer to participate in discussions with your nurse peers. The discussion will explore and explain the results of the nation-wide survey. If you choose to participate in

the discussion, you will share your contact information in a separate survey by clicking on a URL at the end of the study survey. This keeps your responses to the online study survey and your contact information separate. When you complete the contact information for focus groups, you will be contacted by the research nurse to explain how and when the focus groups will be conducted, your role in the focus group, and to answer your questions. The focus groups will be conducted with video conference software. Finally, by participating in the survey, you will be given the option to enter a raffle for a $100 gift card.

Please feel free to contact me with any questions about the study at SFranksMeeks@patriots.uttyler.edu. Thank you for your time and consideration. If you choose to participate, please click (or cut and paste) the following link to complete the online study survey.

https://www.surveymonkey.com/r/3DXHKZP

Thank you;

Sherron Franks-Meeks, PhD(c), MPAL, BSN, RN, RN-BC, CVRN BC-I, CSRN
Principal Investigator, CSNL Study
SFranksMeeks@patriots.uttyler.edu

Appendix F: Email to Potential Phase 2 Participants

CSNL Study Focus Group Participation

Sherron Franks-Meeks
Sun 5/26/2019 10:47 AM

To: claire.martin789@yahoo.com <claire.martin789@yahoo.com>; heidi.johnson@midlandhealth.org <heidi.johnson@midlandhealth.org>; baycain@yahoo.com <baycain@yahoo.com>; austin.hall@yahoo.com <austin.hall@yahoo.com>; misty.long@aol.com <misty.long@aol.com>
Cc: Sherron Franks-Meeks <sfranksmeeks@patriots.uttyler.edu>

1 attachments (42 KB)
irb-informed-consent-abbreviated.CSNL Study.dr.duke.doc;

Good day to you!

I am so excited that you are interested in participating in this very important original nursing research.

Before we can get started, a few housekeeping items...

Please respond to each of the following questions with a yes/no - and return to me with the signed consent attached. You may use an electronic signature....

Eligibility criteria (can you participate by the study's requirements):

1. You must be an RN.
2. You must spend more than 50% of your worktime engaged in direct patient care activities.
3. You must have **more than 18 months** since you first graduated from nursing school.
4. You must be acknowledged by peers as a leader (you must be at least a Level 2 RN).
5. Do you have a national nursing certification?
6. What is your level of education (*remove all nonapplicable levels*)? ADN, BSN, MSN, DNP, PhD

Exclusion Criteria (if you meet any of these, you can't participate)

1. Current workload includes management role.
2. Do your peers view you as 'management'?
3. Have you participated in formal leadership training/management role in the past 12 months?

The meeting will be via electronic format (Zoom Session) and will be recorded for transcription. The recording will be viewed only by me (the researcher), my Chair (Dr. Ellen Fineout-Overholt), and the paid transcriptionist. It will be maintained on a single, secure jump-drive until it is completely destroyed at the end of the data collection period for the project.

I will send, to those of you who meet all criteria, a PDF/copyrighted file of the Competencies we will discuss.

You will need to ponder the following questions and be prepared to discuss:

1. How do you use the competency/KSA (knowledge, skill, attitude)?
2. When do you use the competency/KSA?
3. Why do you use the competency/KSA?
4. What is the significance of this competency/KSA?
5. Is this a competency or a KSA?
6. Is there any competency missing from the list that you believe should be included?
7. Who do you know of whom you would consider an **EXPERT Clinical Staff Nurse Leader** who meets the above criteria?

You will not use your names on the Zoom session, but instead the last four digits of your phone number will be your identification - to protect your identity.

The elephant in the room - many of you will recognize each other during this pilot project recording. Please remember this is a research project! Please respect and protect each other's opinions as you would someone you didn't know. Please do not discuss the proceedings outside of the recording.

I will create a Doodle Poll to determine the best time(s) for us to meet (electronically) and will send you the invitation when you have completed (*and meet all the criteria*) the above questions and returned the consent.

Again, I cannot every thank you enough for your participation in this research!
Sherron

Appendix G: Interview Goals & Expectations

1. Pre-meeting distribution of Phase 1 results (in PDF format).

2. Introductory phase
   a. Define the CSNL role for participants
   b. Participant expectations

3. Using the Working Set of CSNL Competency KSAs
   a. How, when, why do they use the KSAs?
   b. Practical, Relevant, and Meaningful?

4. Gather competencies not in Working Set of CSNL Competency KSAs

5. Gather recommendations for potential Phase 3 CSNL SMEs

6. Pre-meeting distribution of Phase 1 results (in PDF format).

7. Introductory phase
   a. Define the CSNL role for participants
   b. Participant expectations

8. Using the Working Set of CSNL Competency KSAs
   a. How, when, why do they use the KSAs?
   b. Practical, Relevant, and Meaningful?

9. Gather competencies not in Working Set of CSNL Competency KSAs

10. Gather recommendations for potential Phase 3 CSNL SMEs

Appendix H: Interview Schedule

1. Pre-meeting activities
    a. Consent for participation
    b. Determine eligibility for participation
    c. Doodle Poll for meeting data/time
    d. Distribution of Phase 1 results (in PDF format).
    e. Confidentiality Statement distribution

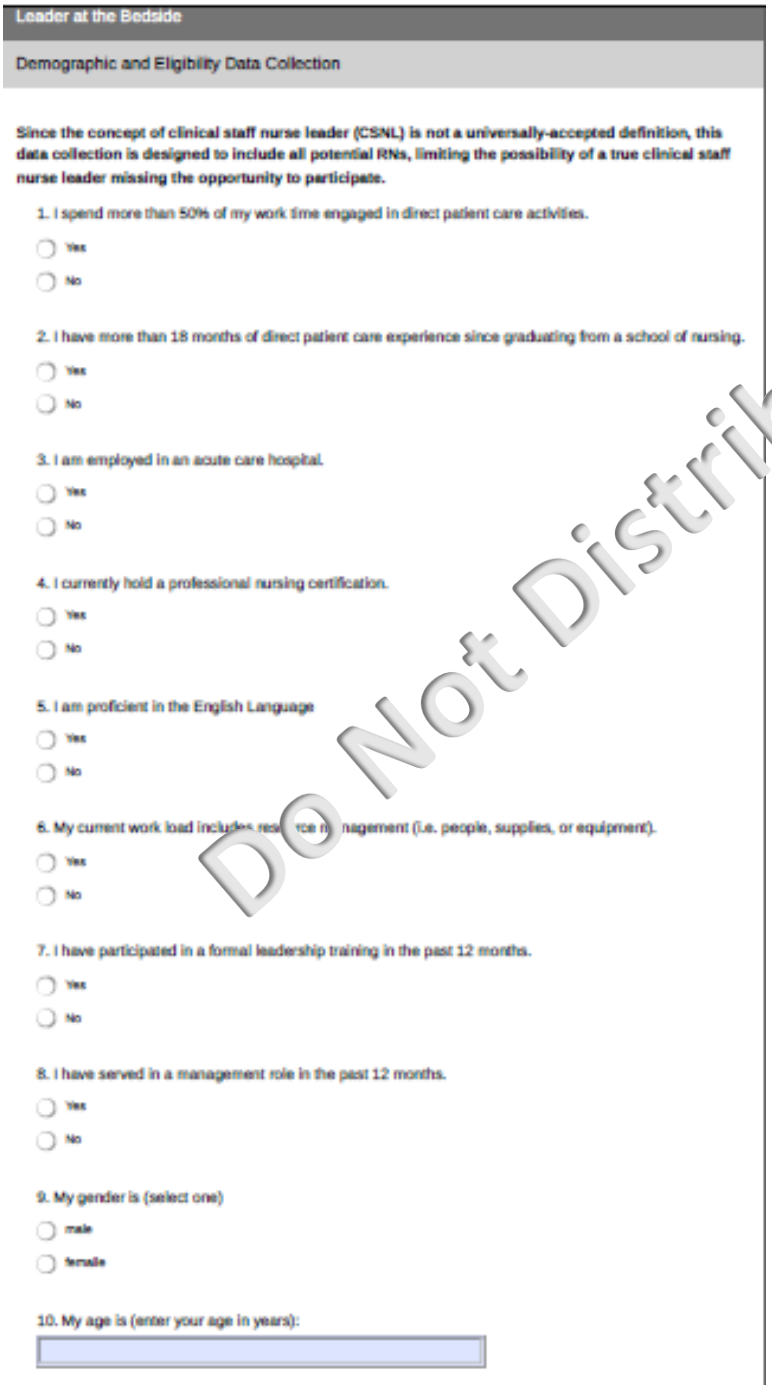
2. Meeting
    a. Introductory phase
        i. Define the CSNL role for participants.
        ii. Define participant/mediator role expectations.
    b. Using the Working Set of CSNL Competencies, determine the following:
        i. How, when, why do they use the Competencies?
        ii. What knowledge, skills, and attitudes are necessary for successful mastery of the Competencies?
        iii. How are the Competencies practical, relevant, and meaningful to them?
    c. Finalize Working Set of CSNL Competencies with associated KSAs.
    d. Gather recommendations for potential Phase 3 CSNL SMEs.

3. Meeting Conclusion
    a. Reiterate confidentiality expectations.
    b. Review finalized Working Set of CSNL Competencies/KSAs.
    c. Thank you

Appendix I: ALT Constructs with CSNL Competencies

ALT Construct	CSNL Competencies
Heart	#1: Fostered a professional work environment of mutual respect, trust, and civility.
Purpose	#3: Promoted workplace practices that protect employee and patient rights and safety.
Values	#2: Created a practice environment of empowered decision-making.
Relationships	#3: Promoted workplace practices that protect employee and patient rights and safety.
Self-Discipline	#4: Prioritized quality activities.

Appendix J: *Leader at the Bedside*© Tool



Leader at the Bedside

Demographic and Eligibility Data Collection

Since the concept of clinical staff nurse leader (CSNL) is not a universally-accepted definition, this data collection is designed to include all potential RNs, limiting the possibility of a true clinical staff nurse leader missing the opportunity to participate.

1. I spend more than 50% of my work time engaged in direct patient care activities.
   - Yes
   - No

2. I have more than 18 months of direct patient care experience since graduating from a school of nursing.
   - Yes
   - No

3. I am employed in an acute care hospital.
   - Yes
   - No

4. I currently hold a professional nursing certification.
   - Yes
   - No

5. I am proficient in the English Language
   - Yes
   - No

6. My current work load includes resource management (i.e. people, supplies, or equipment).
   - Yes
   - No

7. I have participated in a formal leadership training in the past 12 months.
   - Yes
   - No

8. I have served in a management role in the past 12 months.
   - Yes
   - No

9. My gender is (select one)
   - male
   - female

10. My age is (enter your age in years):

11. My highest level of completed nursing education is:

- ◯ Diploma nursing degree
- ◯ Associate's Degree in Nursing (ADN)
- ◯ Bachelor's Degree of Science in Nursing (BSN)
- ◯ Master's Degree of Science in Nursing (MSN)
- ◯ Doctoral Degree in Nurse (DNP/PhD)

12. My employer, an acute care hospital organization, has (select one of the following):

- ◯ Daily census greater than 400 patients
- ◯ Daily census between 100 and 399 patients
- ◯ Daily census less than 100 patients
- ◯ Is a Critical Access Hospital

13. I live in the following geographical region (select the region that includes your state):

- ◯ The Midwest (IA, NE, KS, OH, MO, MN, SD, ND, MI, IL, IN, WI)
- ◯ The Northwest (NY, CT, MA, NH, ME, PA, NH, VT, RI)
- ◯ The South (TN, MS, TX, FL, LA, AL, GA, AR, OK, VA, MD, SC, DC, NC, WV, DE, KY)
- ◯ The West (WA, AZ, CA, OR, CO, AK, ID, NM, [illegible] MT)
- ◯ Other (AE, AP, APO)

14. The community surrounding my organization is (select one):

- ◯ Metropolitan
- ◯ Suburban
- ◯ Rural
- ◯ Frontier

15. My primary nursing unit is staffed for how many beds?

16. Are there any leadership activities/behaviors/competencies that you believe have been left off this list? If so, please enter them here. You can add as many here as you desire.

17. Are there any activitiesw/behaviors/competencies that you perform annually, or less often? If so, please enter them here.

Leader at the Bedside

Leadership Activities/Behaviors/Competencies

15. In the drop-down selection box indicate how often in the past six months you used the following activity/behavior/competency.

	I never used this activity/behavior/competency.	I used this activity/behavior/competency seldom (less than once per month).	I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).	I used this activity/behavior/competency often (more often than weekly, but not daily).	I used this activity/behavior/com frequently (almost day).
Fostered a professional work environment of mutual respect, trust, and civility	○	○	○	○	○
Created a practice environment of empowered decision-making, professional accountability, and autonomy	○	○	○	○	○
Facilitated active involvement of nurses in decision making related to professional standards of practice	○	○	○	○	○
Approve plans, policies and procedures for the appropriate utilization of nursing personnel at all practice levels in accordance with the provisions of the state's nurse practice act, professional practice standards, and regulatory and accreditation agencies	○	○	○	○	○
Developed policies and procedures that ensure regulatory compliance with professional standards and organizational integrity	○	○	○	○	○
Represented nursing as an advisor to an organization's decision-making body for planning and operations	○	○	○	○	○
Evaluated trends impacting nursing practice and the healthcare environment	○	○	○	○	○
Collaborated in the design, development, and improvement of information systems to ensure appropriate, effective and efficient patient and family centered clinical practice.	○	○	○	○	○
Collaborated with administrative and clinical peers in determining the acquisition, allocation, and use of fiscal and human resources to achieve best outcomes.	○	○	○	○	○
Allocated resources to provide care using a multidisciplinary approach	○	○	○	○	○
Identified organizational opportunities and priorities to facilitate a safe care delivery system for the populations served	○	○	○	○	○
Designed processes to establish and maintain standards consistent with the identified outcomes	○	○	○	○	○
Selected appropriate databases to measure and track desired outcomes.	○	○	○	○	○

Implemented models such as just culture to promote a culture of high reliability and safety	○	○	○	○	○
Developed the nursing strategic plan consistent with the organizational strategic plan	○	○	○	○	○
Established a framework for professional practice built on mission, vision, philosophy, core values, evidence, and standards of practice	○	○	○	○	○
Promoted a framework for professional practice built on mission, vision, philosophy, core values, evidence, and standards of practice	○	○	○	○	○
Integrated the ANA Bill of Rights for Registered Nurses and Code of Ethics with Interpretive statements into daily practice	○	○	○	○	○
Promoted workplace practices that protect employee and patient rights and safety	○	○	○	○	○
Planned for succession by mentoring nurse leaders and direct care nurses	○	○	○	○	○
Created a climate to promote professional development of staff	○	○	○	○	○
Created a climate to promote employee satisfaction and engagement.	○	○	○	○	○
Provided opportunities for staff education, based on learning needs assessment, informal feedback from staff, and program evaluation data	○	○	○	○	○
Established new roles and responsibilities based on the changing needs in patient population	○	○	○	○	○
Established new roles and responsibilities based on the changing needs in the healthcare environment	○	○	○	○	○
Participated in the evaluation and regulation of individuals as appropriate through credentialing, privileging, or certification proce	○	○	○	○	○
Collaborated within the organization and community to promote comprehensive patient focused healthcare delivery to the population served	○	○	○	○	○
Collaborated on formal and informal performance appraisal processes for nursing practice	○	○	○	○	○
Collaborated in establishing approaches to manage interdisciplinary conflict, such as chain of command and effective communication.	○	○	○	○	○
Established mechanisms to assess community healthcare needs specific to populations served (patients/clients/residents/community)	○	○	○	○	○

Analyzed the effectiveness and efficiency of clinical and administrative processes	○	○	○	○	○
Developed strategies to recruit, recognize, and retain a competent, engaged, and satisfied workforce	○	○	○	○	○
Developed business plans, including new programs and services	○	○	○	○	○
Implemented business plans, including new programs and services	○	○	○	○	○
Evaluated business plans, including new programs and services	○	○	○	○	○
Collaborated in developing workplace programs to promote and protect employee and patient rights and safety	○	○	○	○	○
Fostered a vision for professional nursing practice that promotes patient and family centered care	○	○	○	○	○
Cultivated an environment to promote leadership across all levels of nursing	○	○	○	○	○
Elicited support for nursing strategic plans and other organizational initiatives	○	○	○	○	○
Fostered an environment of transparency, appreciative inquiry, innovation and risk-taking	○	○	○	○	○
Removed barriers to effectively implement strategic plan to achieve vision	○	○	○	○	○
Incorporated strategies for sustained change	○	○	○	○	○
Evaluated own leadership effectiveness related to the alignment and the attainment of the strategic plan and the vision for professional nursing	○	○	○	○	○
Created an environment where [illegible] engages in reflective nursing practi	○	○	○	○	○
Fostered an environment that supports life-long learning	○	○	○	○	○
Incorporated relevant research and evidence-based principles into leadership practice	○	○	○	○	○
Encouraged innovative activities and actions for improving quality and safety	○	○	○	○	○
Used a variety of sources of power to change systems, structures, and policies to achieve alignment with vision	○	○	○	○	○
Led change-management processes	○	○	○	○	○
Leveraged the value of nursing to influence other stakeholders	○	○	○	○	○
Ensured cultural competency that recognizes and includes diverse population and individual differences	○	○	○	○	○

Created an environment that is supportive of the development and implementation of the professional practice model which fosters excellence in care delivery	○	○	○	○	○
Influenced healthcare policy development through local, state, or national political advocacy	○	○	○	○	○
Built relationships with key stakeholders	○	○	○	○	○
Represented the organization and the profession from a public relations perspective to the media and the broader community	○	○	○	○	○
Fostered an environment of transformational learning that promotes critical thinking and clinical judgment	○	○	○		○
Established a framework for professional nursing practice that is built on innovation, evidence-based practice, and new knowledge that ensures safe, efficient, quality patient care	○	○		○	○
Promoted professional nursing practice that is built on innovation, evidence-based practice, and new knowledge that ensures safe, quality patient care	○	○	○	○	○
Advocated for resources to support nurse investigation, development, implementation, and systematic evaluation of standards of practice	○	○	○	○	○
Aligned nursing research and evidence-based practice with nursing and organizational strategic plans	○	○	○	○	○
Disseminated research and evidence-based findings, guidelines and practices	○	○	○	○	○
Created an environment that is supportive of nurse investigation, development, implementation, and systematic evaluation of standards of practice and standards of care	○	○	○	○	○
Developed innovative plans related to care delivery systems	○	○	○	○	○
Integrated evidence-based practice into clinical and operational processes	○	○	○	○	○
Established procedures to ensure the review of proposed research studies, including protection of the rights of human subjects	○	○	○	○	○
Facilitated the development and continuous improvement of organizational systems, processes, and practices	○	○	○	○	○
Supported outcome measurement and evidence-based practice through the use of nursing and healthcare related national benchmarks (e.g. National Database of Nursing Quality Indicators, Leapfrog, CDC)	○	○	○	○	○

Facilitated the appropriate use of innovative systems, applications and new technologies throughout the continuum of care	○	○	○	○	○
Facilitated interdisciplinary collaboration in data analysis and decision-making processes	○	○	○	○	○
Collaborated in the identification of organizational opportunities and priorities to ensure a safe care delivery system for the populations served	○	○	○	○	○
Integrated clinical, human resource, and financial data to support decision-making	○	○	○	○	○
Facilitated interdisciplinary participation to include the voice of the customers in the identification of desired outcomes	○	○	○	○	○
Facilitated the monitoring and evaluation of nursing care in accordance with established professional, regulatory, and organizational standards of practice	○	○	○	○	○
Established baselines for clinical and non-clinical processes and outcome measures	○	○	○	○	○
Used internal and external benchmarking data to evaluate performance and support best practices and decision-making	○	○	○	○	○
Directed the identification of key indicators, including measures of quality, safety, and other outcomes of nursing practice	○	○	○	○	○
Evaluated process and outcome trends over time compared to baseline and national benchmar	○	○	○	○	○
Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes	○	○	○	○	○
Used internal and external benchmarking data to evaluate performance and support best practices and decision-making	○	○	○	○	○
Directed the identification of key indicators, including measures of quality, safety, and other outcomes of nursing practice	○	○	○	○	○
Evaluated process and outcome trends over time compared to baseline and national benchmarks	○	○	○	○	○
Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes	○	○	○	○	○

Table 1: Comparisons in Published Leadership Competencies Expectations

Competency	**NE[1]**	**NM[2]**	**CSN**
Communication & Relationship Building			
Effective communication	X		X
Relationship management	X	X	X
Influencing behavior	X		X
Diversity	X	X	
Community involvement	X		
Medical/Staff relationships	X		
Academic relationships	X		
Knowledge of the Healthcare Environment			
Clinical practice knowledge	X	X	X
Delivery models & work design	X		
Healthcare economics & policy	X		
Governance	X		
EBP/Outcome measurement	X		X
Patient safety	X		X
Performance Improvement (PI)/metrics	X	X	X
Risk management	X		
Leadership			
Foundational thinking skills	X	X	X
Human Resource		X	X
Personal journey disciplines	X	X	X
Systems thinking	X		X
Succession planning	X		
Change management	X		X
Professionalism			
Personal & professional accountability	X	X	
Career planning	X	X	
Ethics	X		
Advocacy	X		
Business Skills			
Financial management	X	X	
Human resource management	X	X	
Strategic management	X	X	
Information management & technology	X	X	

(Source: Franks-Meeks, 2017)

Table 2: Comparing CSNL Competencies: With and Without the CSNL Voice

Competency	Without	With
Communication & Relationship Building		
Effective communication	X	X
Relationship management	X	
Influencing behavior	X	X
Diversity		
Community involvement		
Medical/Staff relationships		
Academic relationships		
Knowledge of the Healthcare Environment		
Clinical practice knowledge	X	X
Delivery models & work design		
Healthcare economics & policy		
Governance		
EBP/Outcome measurement	X	X
Patient safety	X	
Performance Improvement (PI)/metrics	X	
Risk management		
Leadership		
Foundational thinking skills	X	
Human Resource	X	X
Personal journey disciplines	X	X
Systems thinking	X	
Succession planning		
Change management	X	X
Professionalism		
Personal & professional accountability		
Career planning		
Ethics		
Advocacy		
Business Skills		
Financial management		
Human resource management		
Strategic management		
Information management & technology		

(Source: Franks-Meeks, 2017)

Table 3: Table of Constructs, Conceptual Definitions, and Final Working Competencies

Construct	Conceptual Definitions	CSNL Competencies (Operational Definition guided by *Leader at the Bedside* survey tool) *(A priori)*	CSNL Competencies (Final Operational Definition by CSN SMEs)
Heart	**Compassion**: The observable implementation of 'heart', seen as the CSNL's ability to feel empathy for, and support the emotional welfare of, patients.	4, 5, 51, 52, 57, 58, 63, 64, 65, 78	#1: Fostered a professional work environment of mutual respect, trust, and civility.
Purpose	**Passion:** The observable implementation of 'purpose', seen as the CSNL's compelling advocacy for patients' best interests.	19, 24, 30, 33, 34, 35, 41, 42, 45, 46, 55, 56, 59, 60, 61, 62, 71,	#3: Promoted workplace practices that protect employee and patient rights and safety.
Values	**Behaviors:** The observable implementation of 'values', seen as the CSNL's observable activities on behalf of the patients.	11, 12, 13, 16, 21, 27, 36, 37, 38, 66, 67, 68,	#2: Created a practice environment of empowered decision-making.
Relationships	**Connectedness:** The observable implementation of 'relationships', seen as the CSNL's influence on healthcare team members.	1, 2, 3, 6, 7, 8, 9, 10, 20, 22, 23, 25, 26, 29, 32, 48, 49, 50, 53, 54, 69, 70, 73, 74, 75, 76	#3: Promoted workplace practices that protect employee and patient rights and safety.
Self-Discipline	**Consistency:** The observable implementation of 'self-discipline', seen as the CSNL's reliability and trustworthiness to act honestly and openly during his/her professional interactions.	14, 15, 17, 18, 28, 31, 39, 40, 43, 44, 47, 77	#4: Prioritized quality activities.

Table 4: Research Questions Divided into Phases

Phase 1	
	RQ #1: Of the existing established nurse executive (NE) leadership competencies, which associated KSAs do CSN leaders identify as essential to the CSNL role?
	RQ #2: What other leadership KSAs do CSN leaders identify as essential to their role competencies?
Phase 2	
	RQ #3: How is the CSN leader voice actualized in terms of relevance, practicality, and meaningfulness in the CSNL competencies identified in Phase 1?
Phase 3	
	RQ #4: How complete (i.e. having all the necessary or appropriate parts), accurate (i.e. correct in all details), appropriate (i.e. suitable or proper in the circumstances), and meaningful (i.e. having a serious, important, or useful quality or purpose; communicating something that is not directly expressed; Merriam-Webster online dictionary, 2010) are the final CSNL competencies (i.e., those identified in Phase 1 and verified in Phase 2) as evaluated by CSNL subject matter experts (SME)?
	RQ #5: How do CSNL SME associate the final CSNL competencies with the Authentic Leadership Theory domains?

Table 5: Inclusion/Exclusion Criteria for Phase 1

Inclusion Criteria	Exclusion Criteria
1. Must be an RN.	1. Not an RN.
2. Spends more than 50% of worktime engaged in direct patient care activities.	2. Spends less than 50% of worktime engaged in direct patient care activities.
3. More than 18 months of direct patient care experience since nursing school graduation.	3. Current workload that includes resource management (e.g. performs payroll expectations, completes corrective action/disciplinary actions, approval/finalization of staffing scheduling, and/or develops/defends budgetary needs).
4. Views themselves as a leader (as measured by a national professional nursing certification (e.g. CCRN, CEN, CORN, etc.)	4. Participation in a formal leadership training or management role in the past 12 months.
5. Must be employed directly by the sponsoring organization (not per diem, or short-term traveler) to allow for integration of organizational culture influences on the CSNL behaviors.	

Table 6: Regional Assignment for U.S. States

Region	US States' Assignment
Midwest	IA, NE, KS, OH, MO, MN, SD, ND, MI, IL, IN, WI
Northwest	NY, CT, MA, NH, ME, PA, NH, VT, RI
South	TN, MS, TX, FL, LA, AL, GA, AR, OK, VA, MD, NC, SC
West	WA, AZ, CA, OR, CO, AK, ID, NM, UT, HI, NV, WY
Other	Air Force hospitals, Army hospitals, Navy hospitals

Table 7: Phase 1 Statistical Outcomes

		Survey Item	**# of Cases**	**Freq**	**%**	**Mean**	**St. Dev.**
		Demographics					
		Gender (Female)	10	10	100		
		Age	10	9		35.78 years	11.54
Item #	Likert Score	Competencies					
1		****Fostered a professional work environment of mutual respect, trust, and civility**	10			4.00	0.00
	4	*I used this activity/behavior/competency frequently (almost every day)*		10	100		
		Total		10	100		
2		****Created a practice environment of empowered decision-making, professional accountability, and autonomy**	10			3.00	1.33
	0	*I never used this activity/behavior/competency.*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		5	50		
		Total		10	100		
3		****Facilitated active involvement of nurses in decision making related to professional standards of practice**	9			2.67	1.32
	0	*I never used this activity/behavior/competency.*		1	10.0		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30.0		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20.0		
	4	*I used this activity/behavior/competency frequently (almost every day).*		3	30.0		
		Total		9	90.0		
		-Missing		1	10.0		
		Total		10	100.0		
4		****Promoted workplace practices that protect employee and patient rights and safety**	10			2.70	1.767
	0	*I never used this activity/behavior/competency.*		2	20.0		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10.0		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		6	60		
		Total		10	100		
5		***Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes**	10			2.40	1.78
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		5	50		
		Total		10	100		
6		**Facilitated interdisciplinary participation to include the voice of the customers in the identification of desired outcomes**	0				
		Missing		10	100		
7		**Collaborated with administrative and clinical peers in determining the acquisition, allocation, and use of fiscal and human resources to achieve best outcomes.**					
		Missing	0	10	100		
8		**Established procedures to ensure the review of proposed research studies, including protection of the rights of human subjects**	10			0.00	0.00
	0	*I never used this activity/behavior/competency.*		10	100		
9		**Used internal and external benchmarking data to evaluate performance and support best practices and decision-making**	10			0.10	0.32
	0	*I never used this activity/behavior/competency.*		9	90		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
		Total		10	100		
10		**Developed business plans, including new programs and services**	10			0.10	0.32
	0	*I never used this activity/behavior/competency.*		9	90		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
		Total		10	100		
11		**Influenced healthcare policy development through local, state, or national political advocacy**	10			0.10	0.32
	0	*I never used this activity/behavior/competency.*		9	90		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
		Total		10	100		
12		**Analyzed the effectiveness and efficiency of clinical and administrative processes**	10			0.20	0.42
	0	*I never used this activity/behavior/competency.*		8	80		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
		Total		10	100		
13		**Developed strategies to recruit, recognize, and retain a competent, engaged, and satisfied workforce**	10			0.20	0.63
	0	*I never used this activity/behavior/competency.*		9	90		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
14		**Evaluated business plans, including new programs and services**	10			0.20	0.42
	0	*I never used this activity/behavior/competency.*		8	80		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
		Total		10	100		
15		**Lead change-management processes**	10			0.20	0.42
	0	*I never used this activity/behavior/competency.*		8	80		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
		Total		10	100		
16		**Established a framework for professional nursing practice that is built on innovation, evidence-based practice, and new knowledge that ensures safe, efficient, quality patient care**	10			0.20	0.63
	0	*I never used this activity/behavior/competency.*		9	90		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
17		**Evaluated process and outcome trends over time compared to baseline and national benchmarks**	10			0.20	0.63
	0	*I never used this activity/behavior/competency.*		9	90		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
18		**Developed the nursing strategic plan consistent with the organizational strategic plan**	10			0.30	0.48
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
		Total		10	100		
19		**Established mechanisms to assess community healthcare needs specific to populations served (patients/clients/residents/community)**	10			0.30	0.68
	0	*I never used this activity/behavior/competency.*		8	80		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
20		**Developed policies and procedures that ensure regulatory compliance with professional standards and organizational integrity**	10			0.31	3.16
	0	*I never used this activity/behavior/competency.*		9	90		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
		Total		10	100		
21		**Represented nursing as an advisor to an organization's decision-making body for planning and operations**	10			0.95	0.74
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
		Total		10	100		
22		**Evaluated trends impacting nursing practice and the healthcare environment**	9			0.89	0.60
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		6	60		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		9	90		
		Missing		1	10		
		Total		10	100		
23		**Collaborated in the design, development, and improvement of information systems to ensure appropriate, effective and efficient patient and family centered clinical practice.**	10			0.70	0.95
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		4	40		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
24		**Allocated resources to provide care using a multidisciplinary approach**	10			1.20	1.62
	0	*I never used this activity/behavior/competency.*		5	50		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
25		**Identified organizational opportunities and priorities to facilitate a safe care delivery system for the populations served**	10			1.10	1.37
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		4	40		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
26		**Designed processes to establish and maintain standards consistent with the identified outcomes**	10			0.70	0.82
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
		Total		10	100		
27		**Selected appropriate databases to measure and track desired outcomes.**	10			0.70	1.16
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
28		**Implemented models such as just culture to promote a culture of high reliability and safety**	10			0.70	1.25
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
29		**Established a framework for professional practice built on mission, vision, philosophy, core values, evidence, and standards of practice**	10			0.50	0.97
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
30		**Promoted a framework for professional practice built on mission, vision, philosophy, core values, evidence, and standards of practice**	10			1.70	1.57
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
31		**Integrated the ANA Bill of Rights for Registered Nurses and Code of Ethics with Interpretive statements into daily practice**	10			2.00	1.70
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		3	30		
		Total		10	100		
32		**Planned for succession by mentoring nurse leaders and direct care nurses**	10			1.90	1.45
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
33		**Created a climate to promote professional development of staff**	10			2.10	1.52
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		4	40		
	4	*I used this activity/behavior/competency frequently (almost every day).*		3	30		
		Total		10	100		
34		**Created a climate to promote employee satisfaction and engagement.**	10			2.30	1.64
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
	4	*I used this activity/behavior/competency frequently (almost every day).*		4	40		
		Total		10	100		
35		**Provided opportunities for staff education, based on learning needs assessment, informal feedback from staff, and program evaluation data.**	10			0.90	1.45
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
36		**Established new roles and responsibilities based on the changing needs in patient population**	10			1.10	1.52
	0	*I never used this activity/behavior/competency.*		6	60		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
37		**Established new roles and responsibilities based on the changing needs in the healthcare environment**	10			1.10	1.52
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
38		**Participated in the evaluation and regulation of individuals as appropriate through credentialing, privileging, or certification process**	10			0.90	1.45
	0	*I never used this activity/behavior/competency.*		9	90		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
39		**Collaborated within the organization and community to promote comprehensive patient focused healthcare delivery to the population served**	10			1.10	1.29
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
		Total		10	100		
40		**Collaborated on formal and informal performance appraisal processes for nursing practice**	10			0.60	0.97
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
41		**Collaborated in establishing approaches to manage interdisciplinary conflict, such as chain of command and effective communication.**	10			0.50	0.85
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
		Total		10	100		
42		**Implemented business plans, including new programs and services**	10			0.50	1.08
	0	*I never used this activity/behavior/competency.*		8	80		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
43		**Collaborated in developing workplace programs to promote and protect employee and patient rights and safety**	10			0.50	0.70
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
44		**Fostered a vision for professional nursing practice that promotes patient and family centered care**	10			1.50	1.58
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
45		**Cultivated an environment to promote leadership across all levels of nursing**	10			1.80	1.48
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
46		**Elicited support for nursing strategic plans and other organizational initiatives**	9			0.89	0.93
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
		Total		9	90		
		Missing		1	10		
		Total		10	100		
47		**Fostered an environment of transparency, appreciative inquiry, innovation and risk-taking**	10			1.90	1.29
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		4	40		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
48		**Removed barriers to effectively implement strategic plan to achieve vision**	10			0.80	1.23
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		4	40		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
49		**Incorporated strategies for sustained change**	10			1.00	1.05
	0	*I never used this activity/behavior/competency.*		5	50		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		5	50		
		Total		10	100		
50		**Evaluated own leadership effectiveness related to the alignment and the attainment of the strategic plan and the vision for professional nursing**	10			0.80	0.63
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		6	60		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
		Total		10	100		
51		**Created an environment where staff engages in reflective nursing practice**	10			1.50	1.27
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		5	50		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
52		**Fostered an environment that supports life-long learning**	10			1.80	1.39
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		4	40		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
53		**Incorporated relevant research and evidence-based principles into leadership practice**	10			1.10	1.45
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
54		**Encouraged innovative activities and actions for improving quality and safety**	10			1.80	1.55
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
55		**Used a variety of sources of power to change systems, structures, and policies to achieve alignment with vision**	10			0.50	0.97
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
56		**Leveraged the value of nursing to influence other stakeholders**	10			0.60	1.08
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
57		**Ensured cultural competency that recognizes and includes diverse population and individual differences**	10			1.60	1.58
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		3	30		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
58		**Created an environment that is supportive of the development and implementation of the professional practice model which fosters excellence in care delivery**	10			1.80	1.55
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		3	30		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
59		**Built relationships with key stakeholders**	10			0.90	1.19
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
		Total		10	100		
60		**Represented the organization and the profession from a public relations perspective to the media and the broader community**	10			0.10	0.32
	0	*I never used this activity/behavior/competency.*		9	90		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
		Total		10	100		
61		**Fostered an environment of transformational learning that promotes critical thinking and clinical judgment**	10			1.60	1.58
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
62		**Promoted professional nursing practice that is built on innovation, evidence-based practice, and new knowledge that ensures safe, quality patient care**	10			1.80	1.48
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
63		**Advocated for resources to support nurse investigation, development, implementation, and systematic evaluation of standards of practice**	10			1.30	1.16
	0	*I never used this activity/behavior/competency.*		2	20		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		5	50		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
64		**Aligned nursing research and evidence-based practice with nursing and organizational strategic plans**	10			0.70	0.95
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		4	40		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
65		**Disseminated research and evidence-based findings, guidelines and practices**	10			0.70	0.95
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		4	40		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
66		**Created an environment that is supportive of nurse investigation, development, implementation, and systematic evaluation of standards of practice and standards of care**	10			1.30	1.57
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
67		***Integrated evidence-based practice into clinical and operational processes***	10			1.90	1.59
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		2	20		
		Total		10	100		
68		***Facilitated the development and continuous improvement of organizational systems, processes, and practices***	10			0.90	1.29
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
69		***Supported outcome measurement and evidence-based practice through the use of nursing and healthcare related national benchmarks (e.g. National Database of Nursing Quality Indicators, Leapfrog, CDC)***	10			0.90	0.74
	0	*I never used this activity/behavior/competency.*		3	30		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		5	50		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		2	20		
		Total		10	100		
70		***Facilitated the appropriate use of innovative systems, applications and new technologies throughout the continuum of care***	10			0.90	1.29
	0	*I never used this activity/behavior/competency.*		5	50		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
71		***Facilitated interdisciplinary collaboration in data analysis and decision-making processes***	10			0.80	1.32
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
72		***Collaborated in the identification of organizational opportunities and priorities to ensure a safe care delivery system for the populations served***	10			1.20	1.39
	0	*I never used this activity/behavior/competency.*		4	40		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
73		***Integrated clinical, human resource, and financial data to support decision-making***	10			0.60	1.08
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
74		***Facilitated the monitoring and evaluation of nursing care in accordance with established professional, regulatory, and organizational standards of practice***	10			1.00	1.49
	0	*I never used this activity/behavior/competency.*		6	60		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		1	10		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		10	100		
75		***Established baselines for clinical and non-clinical processes and outcome measures***	10			0.50	1.08
	0	*I never used this activity/behavior/competency.*		8	80		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
76		***Directed the identification of key indicators, including measures of quality, safety, and other outcomes of nursing practice***	9			1.00	1.32
	0	*I never used this activity/behavior/competency.*		4	40		

		Survey Item	# of Cases	Freq	%	Mean	St. Dev.
	1	*I used this activity/behavior/competency seldom (less than once per month).*		3	30		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	4	*I used this activity/behavior/competency frequently (almost every day).*		1	10		
		Total		9	90		
		Missing		1	10		
		Total		10	100		
77		***Evaluated process and outcome trends over time compared to baseline and national benchmarks***	10			0.50	0.97
	0	*I never used this activity/behavior/competency.*		7	70		
	1	*I used this activity/behavior/competency seldom (less than once per month).*		2	20		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		1	10		
		Total		10	100		
78		***Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes***	10			2.00	1.83
	0	*I never used this activity/behavior/competency.*		4	40		
	2	*I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).*		1	10		
	3	*I used this activity/behavior/competency often (more often than weekly, but not daily).*		2	20		
	4	*I used this activity/behavior/competency frequently (almost every day).*		3	30		
		Total		10	100		

Table 8: Phase 1 Competencies Pearson's Correlations

	Fostered a professional work environment of mutual respect, trust, and civility	Created a practice environment of empowered decision-making, professional accountability, and autonomy	Promoted workplace practices that protect employee and patient rights and safety	Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes	Facilitated active involvement of nurses in decision making related to professional standards of practice
Fostered a professional work environment of mutual respect, trust, and civility	.[a]				
Created a practice environment of empowered decision-making, professional accountability, and autonomy	.[a]	1			
Promoted workplace practices that protect employee and patient rights and safety	.[a]	0.330	1		
Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes	.[a]	0.091	0.034	1	
Facilitated active involvement of nurses in decision making related to professional standards of practice	.[a]	.869**	0.657	0.300	1

a. Cannot be computed because at least one of the variables is constant.

Table 9: Tests of Normality

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Fostered a professional work environment of mutual respect, trust, and civility		9			9	
Created a practice environment of empowered decision-making, professional accountability, and autonomy	0.316	9	0.010	0.763	9	0.008
Facilitated active involvement of nurses in decision making related to professional standards of practice	0.196	9	.200*	0.872	9	0.130
Promoted workplace practices that protect employee and patient rights and safety	0.403	9	0.000	0.693	9	0.001
Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes	0.345	9	0.003	0.769	9	0.009

*. This is a lower bound of the true significance.
a. Lilliefors Significance Correction

Table 10: Phase 2 Competencies with KSAs

Competency	Knowledge	Skill	Attitude
#1: Fostered a professional work environment of mutual respect, trust, and civility.	No knowledge?	- Communication	- Respect - Trust - Civility
#2: Created a practice environment of empowered decision-making.	- Organizational policies - Nurse Practice Act - Personal experience - Professional experience - Patient care plan	- Autonomy defined by each situation	- Professional accountability - Hard-working attitude (willingness to continue to work for the patient's best interest)
#3: Promoted workplace practices that protect employee and patient rights and safety.	- Organization policies - Equipment training - Supply availability - Staff availability	- 'Just Culture' algorithm application	- Courage - Healthy Fear of consequences (expected and untoward)
#4: Prioritized quality activities.	- Regulatory requirements - Supportive staff availability - Ancillary staff availability - Expected patient outcomes	- Clinical excellence - Appropriate delegation - Appropriate ancillary staff utilization (who and when) - Collaboration - Communication	- Cooperation

Table 11: Inclusion/Exclusion Criteria for Phase 2

Inclusion Criteria	Exclusion Criteria
1. Must be an RN.	1. Not an RN.
2. Spends more than 50% of worktime engaged in direct patient care activities.	2. Spends less than 50% of worktime engaged in direct patient care activities.
3. More than 18 months of direct patient care experience since nursing school graduation.	3. Current workload that includes resource management (e.g. performs payroll expectations, completes corrective action/disciplinary actions, approval/finalization of staffing scheduling, and/or develops/defends budgetary needs).
4. Views themselves as a leader (as measured by a national professional nursing certification (e.g. CCRN, CEN, CORN, etc.)	4. Is acknowledged by peers as a member of 'management'.
5. Must be employed directly by the sponsoring organization (not per diem, or short-term traveler) to allow for integration of organizational culture influences on the CSNL behaviors.	5. Views themselves as a member of 'management'.
6. Acknowledged by peers as a leader.	6. Participation in a formal leadership training or management role in the past 12 months.
7. If the sponsoring organization has implemented a Career Ladder, has attained 'competent' status, minimally.	

Table 12: Working Competencies

Fostered a professional work environment of mutual respect, trust, and civility		
	Frequency	Percent
I used this activity/behavior/competency frequently (almost every day).	10	100.0
Created a practice environment of empowered decision-making, professional accountability, and autonomy		
	Frequency	Percent
I never used this activity/behavior/competency.	1	10.0
I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).	2	20.0
I used this activity/behavior/competency often (more often than weekly, but not daily).	2	20.0
I used this activity/behavior/competency frequently (almost every day).	5	50.0
Total	10	100.0
Promoted workplace practices that protect employee and patient rights and safety		
	Frequency	Percent
I never used this activity/behavior/competency.	2	20.0
I used this activity/behavior/competency seldom (less than once per month).	1	10.0
I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).	1	10.0
I used this activity/behavior/competency frequently (almost every day).	6	60.0
Total	10	100.0
Prioritized quality activities based on regulatory requirements, human resource needs patient outcomes		
	Frequency	Percent
I never used this activity/behavior/competency.	2	20.0
I used this activity/behavior/competency seldom (less than once per month).	2	20.0
I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).	1	10.0
I used this activity/behavior/competency frequently (almost every day).	5	50.0
Total	10	100.0
Facilitated active involvement of nurses in decision making related to professional standards of practice		
	Frequency	Percent
I never used this activity/behavior/competency.	1	10.0
I used this activity/behavior/competency sometimes (more than once per month, but less than weekly).	3	30.0
I used this activity/behavior/competency often (more often than weekly, but not daily).	2	20.0
I used this activity/behavior/competency frequently (almost every day).	3	30.0
Total	9	90.0
Missing	1	10.0
Total	10	100.0

Table 13: Inclusion/Exclusion Criteria for Phase 3

Inclusion Criteria	Exclusion Criteria
1. Must be an RN. 2. Spends more than 50% of worktime engaged in direct patient care activities. 3. More than 18 months of direct patient care experience since nursing school graduation. 4. Acknowledged by peers as a leader. 5. Views themselves as a leader (as measured by a national professional nursing certification (e.g. CCRN, CEN, CORN, CMSRN, etc.) 6. Must be employed directly by the sponsoring organization (not per diem, or short-term traveler) to allow for integration of organizational culture influences on the CSNL behaviors. 7. Acknowledged by the organization's formal leadership (i.e. management) as a leader at the bedside. 8. If the sponsoring organization has implemented a Career Ladder, has attained 'expert' status, minimally.	1. Not an RN. 2. Spends less than 50% of worktime engaged in direct patient care activities. 3. Current workload that includes resource management (e.g. performs payroll expectations, completes corrective action/disciplinary actions, approval/finalization of staffing scheduling, and/or develops/defends budgetary needs). 4. Is acknowledged by peers as a member of 'management'. 5. Views themselves as a member of 'management'. Participation in a formal leadership training or management role in the past 12 months.

Table 14: Phase 3 Participant Demographics

Characteristic	(n)
Gender	n = 2 Male n = 1 female
Continuous years of nursing experience	n = 2 > 10 years n = 1 > 5 years
Level of nursing education	n = 2 BSN n = 1 ADN
Practice expertise	n = 1 Emergency Department n = 2 Critical Care Unit
Practice shift	n = 2 night shift n = 1 day shift
Nursing training origination	n = 1 Canadian training n = 2 US training

Table 15: State of the Science

Publication	Competency/KSA
Kouzes & Posner (2012)	• Modelling the way • Challenging status quo • Inspiring others • Enabling others • Encouraging others
Cook & Leathard (2004)	• Clinical Expertise
Patrick, Laschinger, Wong, & Finegan (2011)	• Seeking change • Interpersonal competence • Role modeling • Information sharing • Celebrating accomplishments
Ezziane (2012)	• Clinical excellence • Human skills • Leadership conceptual skills • Individual attributes
Chavez & Yoder (2015)	• Clinical ability • Effective communication • Relational coordination
McNamara, et al. (2014)	• Self-awareness • Advocacy • Empowerment • Decision-making • Communication • Teamwork • Clinical excellence • Quality & Safety
Ezziane (2012)	• Emotional intelligence (i.e. self-awareness, social skills, self-regulation, & social awareness)
Franks-Meeks (2017)	• Effective communication • Relationship management • Influencing behavior • Clinical practice knowledge • Evidence-based practice/Outcomes • Patient safety • Performance improvement metrics • Foundational thinking skills • Human resources • Systems thinking • Personal journey disciplines • Change management

Table 16: Phase 3 Finalized Working CSNL Competencies

CSNL Competencies
#1: Fostered a professional work environment of mutual respect, trust, and civility.
#3: Promoted workplace practices that protect employee and patient rights and safety.
#2: Created a practice environment of empowered decision-making.
#3: Promoted workplace practices that protect employee and patient rights and safety.
#4: Prioritized quality activities.

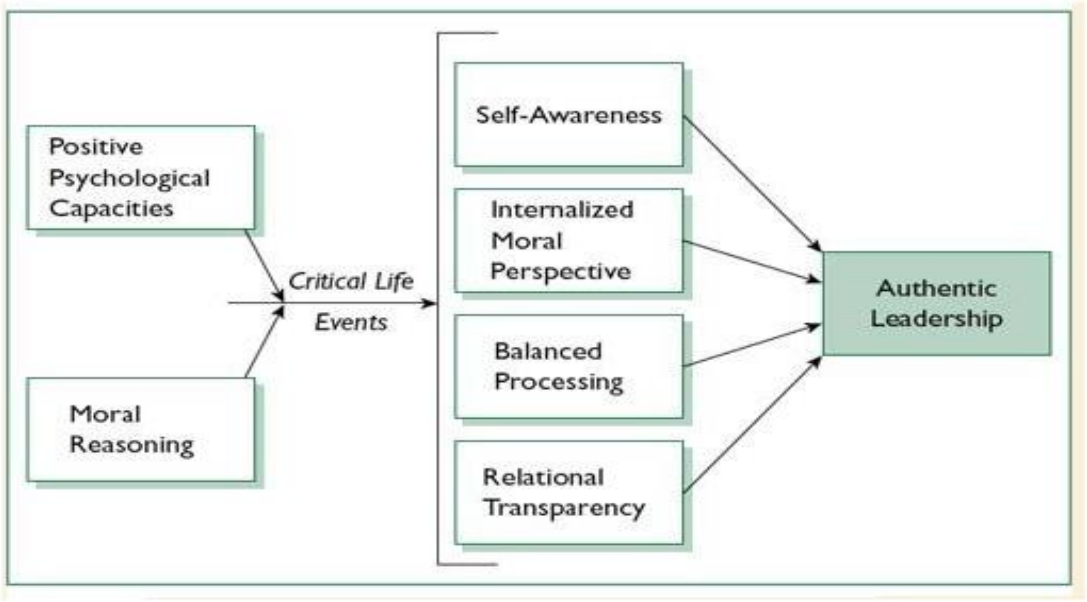


Figure 1: Authentic Leadership development process

(Source: Northouse, 2016, p. 202)

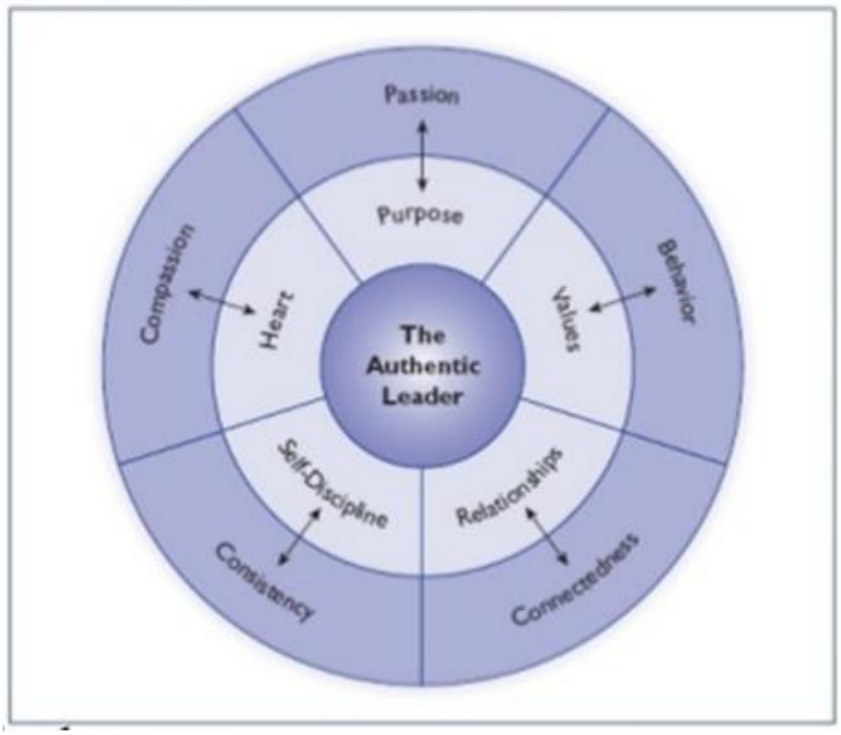
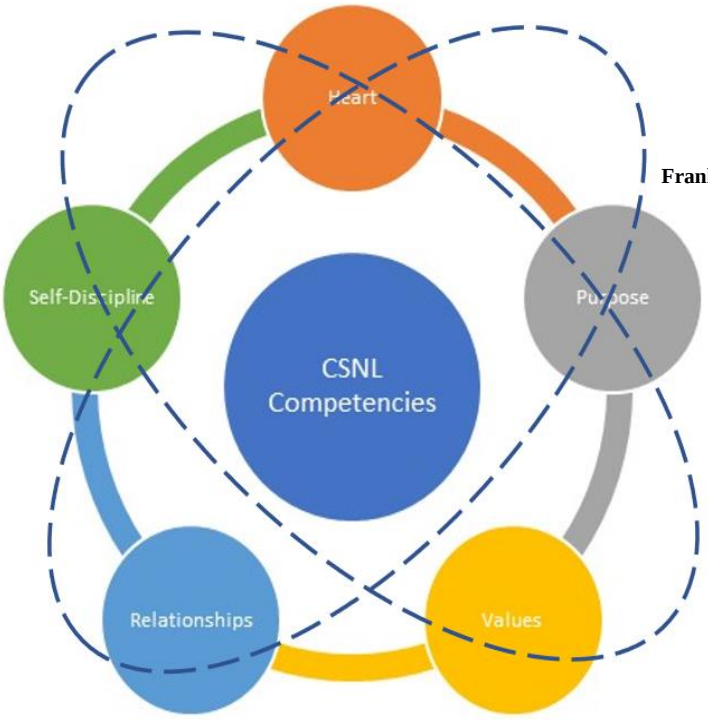


Figure 2: Authentic Leadership Theory

Source: Northouse, 2016, p. 198

- **<u>Heart = Compassion</u>**: The observable implementation seen as the CSNL's ability to feel empathy for, and support the emotional welfare of, patients.
- **<u>Purpose = Passion</u>**: The observable implementation seen as the CSNL's compelling advocacy for patients' best interests.
- **<u>Values = Behaviors</u>**: The observable implementation seen as the CSNL's activities on behalf of the patients.
- **<u>Relationship = Connectedness</u>**: The observable influence of the CSNL on healthcare team members.
- **<u>Self-discipline = Consistency</u>**: The observable implementation of the CSNL's reliability & trustworthiness to act honestly and openly during his/her professional interactions.



Franks-Meeks, 2019©

Figure 3: Authentic Leadership Theory constructs applied to CSNL competencies

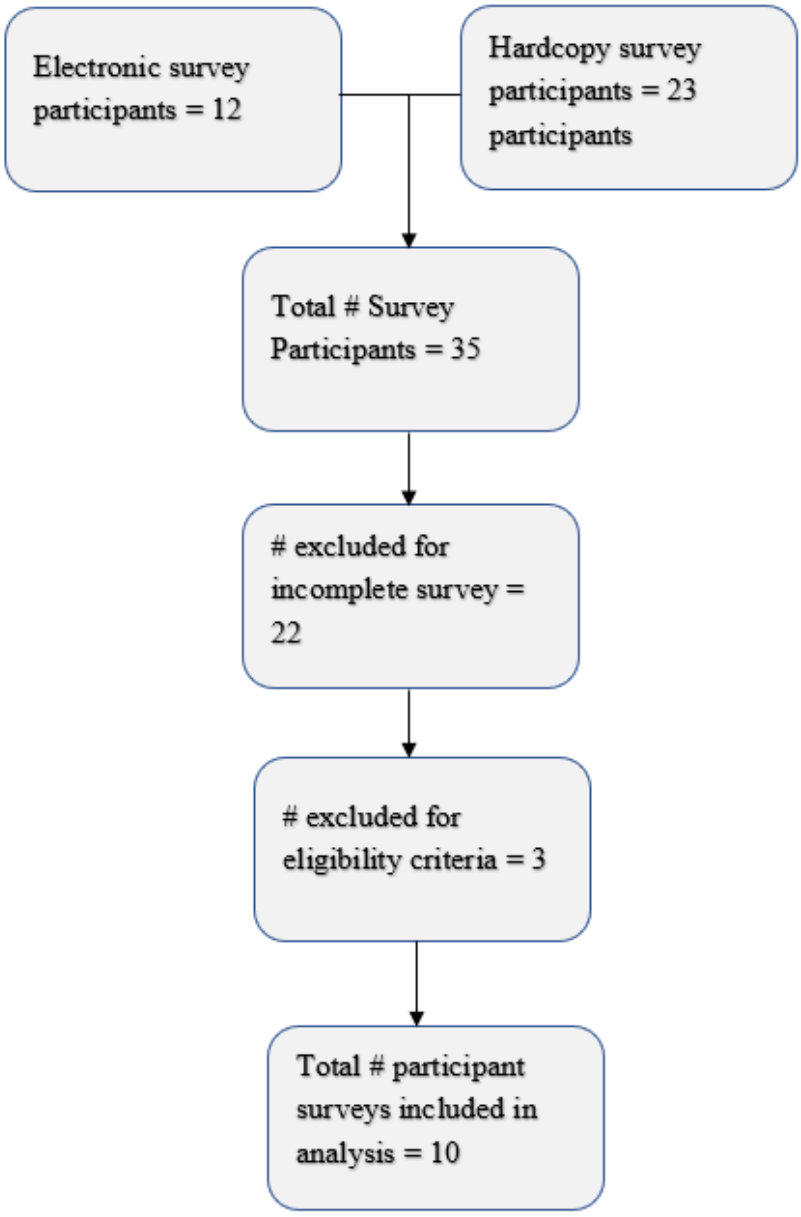


Figure 4: Study Survey Participant Data Collection

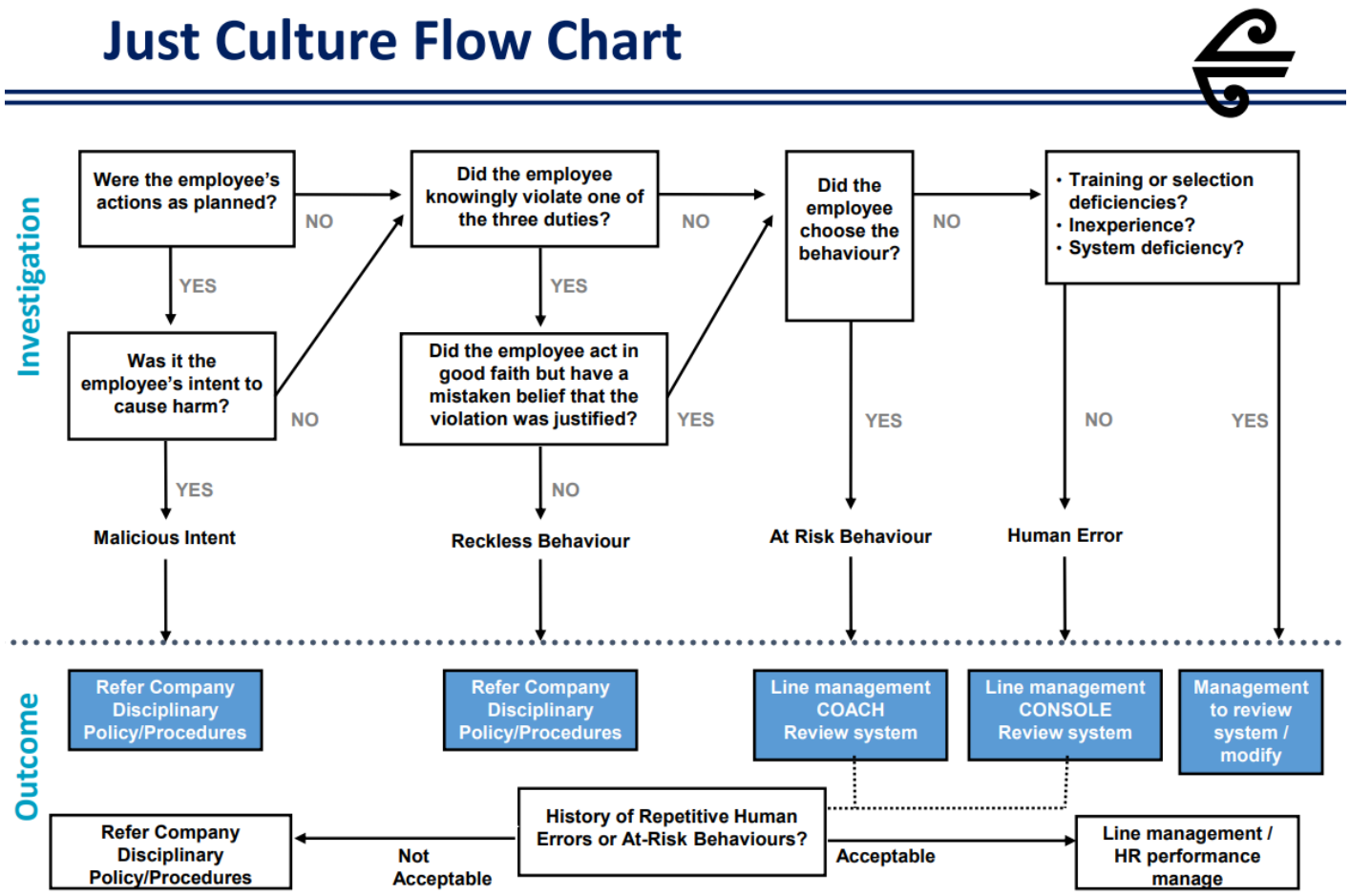


Figure 5: The Just Culture Algorithm (Henderson, 2016)

BIOGRAPHICAL SKETCH

NAME: Franks-Meeks, Sherron Denise

eRA COMMONS USER NAME (credential, e.g., agency login): NA

POSITION TITLE: Associate Professor of Nursing, University of Texas, Permian Basin, Odessa, TX

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
McLennen Community College, Waco, TX	ADN	05/1983	Nursing
University of Texas, Arlington, Arlington, TX	BSN	12/2012	Nursing
University of Texas, Permian Basin, Odessa, TX	BA	05/2005	Leadership Studies
University of Texas, Permian Basin, Odessa, TX	MPAL	05/2007	Public Admin Leadership
University of Texas, Tyler, Tyler, TX	PhD	12/2019	Nursing

A. Personal Statement

I have extensive experience, training, and education in leadership theory and its application. I believe that leadership, particularly clinical staff nurse leadership is poorly understood. I hope to explore the clinical staff nurse leader (CSNL) phenomenon to ultimately define CSNL competency requirements. Leadership at the bedside is one of the most important aspects of nursing practice, but the gap in nursing's understanding of this role is extensive. My future research program includes exploring the CSNL expectations, behaviors, and knowledge through the voice of the CSNL community to improve objective evaluations of CSNL competency and develop training and education programs for both practicing nurses and academic nursing programs.

B. Positions and Honors

Positions and Employment

2018 to present Associate Professor of Nursing, College of Nursing, University of Texas, Permian Basin, Odessa, TX
2017 to 2018 Adjunct Nursing Instructor, College of Nursing, University of Texas, Permian Basin, Odessa, TX
2013 to 2018 Nursing Education Coordinator, Midland Memorial Hospital, Midland, TX
2011 to 2018 Stroke Coordinator, Midland Memorial Hospital, Midland, TX
2011 to 2018 IRB Manager, Midland Memorial Hospital, Midland, TX
2013 to 2010 Director of Nursing, Brazosport Regional Medical System, Lake, Jackson, TX
2008 to 2009 Quality Management Manager, Midland Memorial Hospital, Midland, TX
2005 to 2008 Nursing Quality & Research RN, Midland Memorial Hospital, Midland, TX
2000 to 2005 Hospital Supervisor, Midland Memorial Hospital, Midland, TX
2000 to 2001 Director of Nursing/ED, Winkler County Memorial Hospital, Kermit, TX
1999 to 2000 Charge Nurse – Critical Care Unit, Midland Memorial Hospital, Midland, TX
1990 to 1999 Staff Nurse, Midland Memorial Hospital, Midland, TX
1998 to 1990 Charge Nurse – ICCU , Providence Hospital, Waco, TX

Other Experience and Professional Memberships

2019 to present Member, Joining the Social Media World Task Force, Texas Nurses' Association (TNA)
2018 to 2019 Member, Financial Committee, TNA
2015 to present RN Member, Texas' Council on Heart and Stroke, Texas Department of State Health and Services (DSHS)
2011 to 2017 Coordinator, Stroke Community Outreach/Education, Midland Memorial Hospital, Midland, TX
2013 to 2015 Chair, Texas Partnership for the Reduction of CVD and Stroke
2011 to present Member, Texas Partnership for the Reduction of CVD and Stroke
2016 to present Member, Texas Organization for Nurse Executives (TONE)
2016 to present Member, American Organization for Nurse Leaders (AONL)
2013 to present Member, American Association for Critical Care Nurses (AACN)
2013 to present Member, Texas Nurses' Association (TNA)
2013 to present Member, American Nurses' Association (ANA)

C. Contributions to Science

PRINTED PUBLICATIONS (Refereed)

Franks-Meeks, S. (accepted for publication). Nursing research participation: We can do better. *Nursing 2019*.

Sanchez, L., Keesee, L., & **Franks-Meeks, S**. (*rejected*). Translating simulation best practices into functional data for clinical educators. *Clinical Simulation in Nursing*.

Franks-Meeks, S. (2017). Clinical staff nurse leadership: Identifying gaps in competency development. *Nursing Forum, 53*(3). doi: 10.1111/nuf.12217

Franks-Meeks, S. (2008) Nurses and computer competency. *Journal of Nurses Staff Development.* Sept-Oct; 24: 248-51

PUBLICATIONS (OTHER)

Franks-Meeks, S. (2017). *Clinical staff nurse leadership competencies: Unexplored opportunities*. 2nd World Congress on Nursing & Nurse Education. FL: Miami.

Boswell, C., Powers, R., & **Franks-Meeks, S**. (2017). *Changing a culture to advance thinking.* 44th Annual National Conference of the Professional Nurse Educators Group: Forging Revitalization, Eliminating Gaps Between Nursing Science and Patient Care. PA: Pittsburg.

Ramdeo, C., Boswell, C., Powers, R., & **Franks-Meeks, S**. (2016). *Creation of an Academy of Inquisitive Thinking*®. ANCC Pathway to Excellence Conference. PA: Philadelphia.

Franks-Meeks, S. (2015) Poster presentation: *Engaging staff nurses in personal professional development by gap analysis.* Association for Nursing Professional Development annual conference. NV: Las Vegas.

Franks-Meeks, S. (2012, October) Reducing 30-day All-cause Stroke Readmissions Using Evidence-Based Practice (Poster Presentation). *Nurses Leading Change and Transfoming Care.* NM: Las Cruces.

RESEARCH PROJECTS COMPLETED

2019 Leader at the Bedside: Establishing Clinical Staff Nurse Leadership Competencies (The CSNL Study)

2015 Effects of meaningful recognition on Registered Nurses' compassion satisfaction and compassion fatigue

2014 Small Troubles, Adaptive Response (STAR-2): Frontline Nurse Engagement in Quality Improvement

2006 Nurses and Computer Competency Survey

OTHER RESEARCH ACTIVITIES

2015 January: Nurse Educator's Conference in the Rockies Abstract Reviewer for conference

2016 January: Nurse Educator's Conference in the Rockies Abstract Reviewer for conference

D. Additional Information: Research Support and/or Scholastic Performance

LICENSURE

08/30/1983-Current	Texas State Board of Nurse Examiners #508098

CERTIFICATIONS

Certified Nurse Professional Development Specialist Exp. 06/2019

Certified Stroke Registered Nurse

Exp. 09/2020

Certified Cardio-Vascular Registered Nurse Exp. 03/2019