EXPANDING TRANSFORMATIONAL LEADERSHIP THEORY IN NURSING:
EXAMINING THE SOCIAL PROCESSES USED BY TRANSFORMATIONAL LEADERS

by

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A thesis submitted to the
Faculty of the Graduate School of the
University of Colorado in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

College of Nursing
2015
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Date 5/13/2015
Executive level leaders in a hospital or health system focus strategic initiatives on patient health and well-being. Chief nursing officers (CNO’s) in a hospital or health care organization play a critical role in ensuring safe work environments. In 2004, The Institute of Medicine addressed a need for the application of transformational leadership into nursing work environments to promote patient safety (Institute of Medicine, 2004). While the core of transformational leadership is universal, what exactly transformational leaders do in terms of strategies and actions remains unclear. Transformational leadership theorists refer to managers as transactional leaders whose power is positional in contrast to transformational leaders who innovate and inspire, and whose power comes from others (Bass, 2008). Health services and business literature make clear distinctions between leaders and managers; however, a review of the nursing literature revealed a growing lack of distinction between nursing management and leadership competencies.

This descriptive qualitative study used the grounded theory constant comparative method to investigate the social processes, specifically the strategies and actions employed by CNOs in a hospital setting. Data were collected during three phases during a 6-month period. The range of data sources included the Multifactor Leadership Questionnaire (MLQ) 5X-Short and formal- and semi-structured interviews. The first phase consisted of the MLQ differentiation of CNOs who displayed high levels of
transformational leadership according to the questionnaire data. The second phase involved one-on-one interviews with CNOs who scored high on transformational leadership. These CNOs described their style as having elements of both servant leader and situational leader and employed specific strategies and actions to ensure a safe and effective work environment. The third phase consisted of a test for fitness of the emerging theory, following up with the interviewees regarding the emergent, expanded theory. The emergent strategies and actions describe an expanded transformational theory based on a CNO’s philosophical perspective. The researcher also constructed a conceptual framework regarding how transformational nurse leaders function, specifically referring to the social process of CNOs. For current and future nurse leaders, the specific strategies and actions of transformational leadership regarding CNOs enable more effective development of nurse leaders and improve the safety and effectiveness of work environments.

The form and content of this abstract are approved. I recommend its publication.

Approved: Joyce Verran
This work is dedicated to my mother, Suzanne O’Neill Baggot. Her inspiration has nurtured all that is good in my life. This work is no exception.
ACKNOWLEDGEMENTS

No research endeavor happens in isolation. It is for this reason that I offer my deepest gratitude to those who made this possible. I am certain that one of Dr. Joyce Verran’s (Advisor) gifts to the world has been her contributions to her students. Dr. Verran has pushed me, challenged me, encouraged me, and most importantly, made me a better thinker and researcher. What every academician could learn from Dr. Verran is how she is able to bring her expertise to her students while remaining humble. More than five years under Dr. Verran’s guidance, she demonstrated no ego needs. Without a doubt, Dr. Verran made me a better researcher. More significant, Dr. Verran has made me a better leader.

This study would not have been possible without Dr. Joyce Verran, Dr. Socorro Escandon, Dr. Sharon Pappas, and Dr. Colleen Goode who, during the slow period of recruitment, stayed by my side and ensured that I was able to recruit a very robust sample of nurse executives. Dr. Escandon’s knowledge and expertise in qualitative inquiry allayed my fears related to a grounded theory endeavor, which enabled a much greater contribution to nursing science than if I had played it “safe” with quantitative methods. Dr. Escandon’s generosity of time and talent has touched me. She was the perfect person for my committee, and I thank Dr. Verran for making the connection for me. Dr. Escandon is masterful in the grounded theory method. This work would also not have been possible without the Chief Nursing Officers who volunteered to participate in this research and contributed to the expansion of theory, which I am profoundly grateful for. I would also like to thank Dr. Amy Barton, Dr. Jackie Jones, and Dr. Linda Flynn for their guidance and support throughout this process.
To my father, Dr. M.G. Baggot, whose love of medicine inspired me from a very young age. My brother Dr. Patrick Baggot taught me what it means to be a disciplined student. My classmates in the doctoral program provided me with support, comfort, wit, compassion, and grace. The relationships I forged with my classmates may very well be the greatest gift for me on this journey. To my three older sisters, Kathleen, Rosie, and Eileen who have believed in me and cheered me on my entire life, their confidence and support have pushed me to take personal and professional risks that I would not have taken otherwise. Finally, my husband Dr. Theodore Lin who has had the most important job on this journey. More important than reviewing drafts and serving as my editor at times, he was a present and compassionate father to our young children, Harry and Emily, which afforded me the time that I needed to accomplish this work.
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CHAPTER I

INTRODUCTION

Several challenges underscore the importance of leadership to the U.S. health care system, including: (a) the negative effect of health care representing 19% of the U.S. economy, (b) the inherent pressures of a large aging population, (c) a growing workforce that values healthy work environments and work-life balance, (d) upcoming retirements of current leaders, and (e) projected workforce shortages (Aiken et al., 2012; Kaiser Family Foundation, 2012). In nursing, early conceptualizations of leadership initially focused on management of patient care, which gave nursing a solid foundation in the concept of management. More recent efforts include the sentinel work by the Institute of Medicine (IOM), who identified nursing leadership as critical to assuring the safety of hospitalized patients (Kohn, Corrigan, & Donaldson, 2000). The IOM (2004) identified leadership as one of four sources of threat to patient safety and called for widespread adoption of transformational leadership in nursing to advance a culture of safety and improve patient outcomes. Numerous researchers support the IOM findings that nursing leadership is related to improved patient safety and improved nursing work environments (Aiken et al., 2012; Currie & Watterson, 2010; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Kazanjian, Green, Wong, & Reid, 2005; Tourangeau, Giovannetti, Tu, & Wood, 2002).

The IOM (2004) called on health care leaders to ensure that the care provided in American hospitals and health systems is safe, effective, efficient, timely, patient-centered, and equitable. The National Center for Healthcare Leadership maintained that not only do health care leaders need to possess technical knowledge, but these leaders
must also demonstrate competence in change management, transformation, and innovation (Davidson, Griffith, Sinioris, & Carreon 2005). In October 2010, the IOM report *The Future of Nursing: Leading Change, Advancing Health* identified the cultivation and promotion of leaders within nursing as one of four key recommendations to ensure the delivery of safe, patient-centered care in a rapidly changing health care environment. Researchers have found that leadership involvement in clinical improvements has a positive effect on cost outcomes (Walton et al., 2000) and improved job satisfaction (Robbins & Davidhizar, 2007).

Researchers have studied transformational leadership more than any other leadership theory in nursing and health services literature. Researchers studying transformational leadership have predominately focused on the effects leaders who possess transformational leadership characteristics have upon those who follow the leaders, without consideration of the specific strategies and actions the transformational leaders use to achieve the goals that meet the criteria of a transformational leader. Despite growing research regarding the outcomes associated with leadership strategies and actions (Aiken et al., 2012; Currie & Watterson, 2010; Judge & Piccolo, 2004; Martinez et al., 2011; Podsakoff, MacKenzie, & Bommer, 1996; Rosen et al., 2010; Singer, Falwell, Gaba, & Baker, 2008; Squires, Tourangeau, Spence Laschinger, & Doran, 2010), the nature of the interactions of nurse transformational leaders who produce improved outcomes is still unclear. This is partially because prior to the first IOM report, efforts to improve patient safety were largely aimed at preventing human error rather than system error (Kohn et al., 2000; Woodhouse, Burney, & Costa, 2004). Since 2000, multiple calls have been made to expand the application of transformational
leadership on the nursing profession; however, acquiring knowledge of precisely how transformational leadership is operationalized is a necessary step to enhance uptake of transformational leadership (IOM, 2004; Reay et al., 2009).

**Background**

A major focus in nursing and health services research, since the sentinel work of the IOM in 2000, is enabling healthy and safe environments for both nurses and patients. The central function of leadership is to create a common purpose (Burns, 1978). Burns (1978) described *leadership* as an interdependent relationship between leader and follower influenced by the values and needs of both leader and follower. While the original concept is attributed to Burns, based on the work of Max Weber, a substantial body of literature accrued on transformational leadership theory. Similarly, Bass (2008) based his transformational leadership theory on Burns’ conceptualization, but made many modifications as the theory evolved.

While the health services and business literature appear to make clear distinctions between leaders and managers, a review of the nursing literature found a growing lack of distinction between nursing management and leadership competencies (Jennings, Scalzi, Rodgers, & Keane, 2007). Bennis (2009) asserted that managers, meaning those functioning in a supervisory role, administer and leaders innovate. In contrast, transformational leadership theorists refer to managers as transactional leaders whereby their power is positional, in contrast to transformational leaders who innovate and inspire and whose power comes from others (Marshall, 2011). Full range leadership theory, which evolved from transformational leadership theory, suggests that leadership and management exist on a continuum that could explain the “graying” of concepts in the
Bass and Avolio (2000) conducted research to investigate Burns’ (1978) theories of transformational and transactional leadership and identified that leaders use a combination of leadership actions, depending on the nature of the work, the work environment, and the specific needs of the individuals completing the work.

Full range leadership theory (see Table 1.1) describes specific dimensions within the realm of transformational, transactional, and passive leadership that leaders use to motivate others. Similar to Benner’s (1982) novice to expert theory in clinical nursing, managers and leaders evolve as those individuals develop the core competencies of management and leadership. Management has a series of objectives met differently by managers based upon whether the manager is a transformational leader or a transactional leader. Management is often transactional, task related, and local, whereas leadership subsumes management and adds the competencies of influence, vision, and change management at an organizational level.

Transformational leadership theorists identified foundational characteristics of transformational leaders: (a) charisma or idealized influence, which involves a leader energizing followers through a clear sense of purpose; (b) inspiration and vision whereby a leader is goal-oriented and grounded in ethical values; (c) intellectual stimulation whereby a leader uses inquiry to improve problem solving; and (d) individualized consideration, which means the leader pays attention to a follower’s individual needs in an effort to foster development (Bass & Riggio, 2006). Through such characteristics, transformational leaders establish a culture of shared vision around a set of collective beliefs and values. McCormack et al. (2002) suggested transformational leaders alter the prevailing culture, creating a context for the integration of evidence. Through a meta-
analysis, Judge and Piccolo (2004) provided support for the validity of transformational leadership and its generalizability across settings.

Table 1.1 *Full Range Leadership Theory*

<table>
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<tr>
<th>Leadership Dimensions</th>
<th>Definition</th>
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<tr>
<td><strong>TRANSFORMATIONAL LEADER</strong></td>
<td>Change their associates’ awareness of what is important, and move them to see themselves and the opportunities and challenges of their environment in a new way. Transformational leaders are proactive: they seek to optimize individual, group and organizational development and innovation, not just achieve performance “at expectations.” They convince their associates to strive for higher levels of potential as well as higher levels of moral and ethical standards.</td>
</tr>
<tr>
<td>Idealized influence</td>
<td>Admired, respected, and trusted. Followers identify with and want to emulate their leaders. Leader earns credit with followers by considering followers' needs over his or her own needs. The leader shares risks with followers and is consistent in conduct with underlying ethics, principles, and values.</td>
</tr>
<tr>
<td>Inspirational motivation</td>
<td>Leaders behave in ways that motivate those around them by providing meaning and challenge to their followers' work. Individual and team spirit is aroused. Enthusiasm and optimism are displayed. The leader encourages followers to envision attractive future states, which they can ultimately envision for themselves.</td>
</tr>
<tr>
<td>Intellectual stimulation</td>
<td>Leaders stimulate their followers' effort to be innovative and creative by questioning assumptions, reframing problems, and approaching old situations in new ways. There is no ridicule or public criticism of individual members' mistakes. New ideas and creative solutions to problems are solicited from followers, who are included in the process of addressing problems and finding solutions.</td>
</tr>
<tr>
<td>Individualized consideration</td>
<td>Leaders pay attention to each individual's need for achievement and growth by acting as a coach or mentor. Followers are developed to successively higher levels of potential. New learning opportunities are created along with a supportive climate in which to grow. Individual differences in terms of needs and desires are recognized.</td>
</tr>
<tr>
<td><strong>TRANSACTIONAL LEADER</strong></td>
<td>Displays actions associated with constructive and corrective transactions. Contingent reward and management-by-exception are two core behaviors associated with 'management' functions in organizations.</td>
</tr>
<tr>
<td>Contingent reward</td>
<td>Transactional contingent reward leaders clarify expectations and offers recognition when goals are achieved.</td>
</tr>
<tr>
<td>Management-by-exception</td>
<td>Specifies the standards for compliance, as well as what constitutes ineffective performance, and may punish followers for being out of compliance with those standards. Closely monitoring for deviances, mistakes, and errors and then taking corrective action as quickly as possible when they occur.</td>
</tr>
<tr>
<td><strong>PASSIVE/AVOIDANT BEHAVIOR</strong></td>
<td>Passive leaders avoid specifying agreements, clarifying expectations, and providing goals and standards to be achieved.</td>
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**Summary of the Problem**

The IOM’s call for the application of transformational leadership to create nursing work environments that promote patient safety has resulted in a marked increase in articles related to the concept. What remains unclear in the literature is a precise understanding of the strategies and actions transformational leaders use to operationalize the goals that demonstrate the characteristics of transformational leadership. Though management and leadership failures receive far less attention than clinical failures, management failures can also result in harm to patients and health care organizations (Reason, 1990; Rundall et al., 2007). In order for broad uptake of transformational leadership to occur, sufficient understanding of the specific strategies and actions of transformational leadership needs established. A more in-depth understanding will further efforts to foster a culture of safety and improved nursing work environments.

Despite modest and growing agreement in the literature that a better understanding of transformational leadership promotes a culture of safety and transforms nursing work environments, studies using qualitative approaches have been limited, with grounded theory approaches being particularly scarce. The researcher aims to address the gaps in existing knowledge related to specific strategies and actions of nurse transformational leaders by incorporating grounded theory methods. The researcher hopes that this approach enables and informs the development and uptake of transformational leadership and will ultimately expand and extend the already existing transformational leadership theory and its effects.
Strategy

Leadership strategy, a critical component to an organization’s success, is a complex cognitive process undertaken by transformational leadership that includes a critical evaluation of the current state of a situation or environment against a desired future state. This cognitive process then drives a set of specific actions intended to close an identified gap or achieve a desired future (Passmore, 2013). Once a leadership strategy is implemented, clinical and organizational outcomes inform the effectiveness of a particular leadership strategy. Effective leader strategies in nursing result in improved work environments for nurses, improved patient safety, and improved health outcomes.

Actions

In the context of leadership, action can be described in terms of three major domains: completing tasks, managing individuals, and managing teams. The researcher believes that transformational leaders, in executing his or her role, take specific actions based on his or her own leadership philosophy as shown in Figure 1.1.

*Figure 1.1. Expanding transformational leadership theory: Understanding the social processes of transformational leaders in nursing.*
**Approach**

A descriptive qualitative design with a grounded theory approach was necessary to achieve the research aims of this study. The original conception of grounded theory (GT), commonly referred to as *classic grounded theory*, originated with sociologists Glaser and Strauss in 1967 in their book *The Discovery of Grounded Theory*. At first, Glaser and Strauss were interested in observing how dying occurred across hospital settings and, through their research, developed methods for analyzing observations, much of which became the basis for classic GT. Classic GT offers systematic methods for conducting qualitative research.

Essential elements of classic GT include simultaneous involvement in data collection and analysis, the construction of analytic codes, constant comparison and memo writing, sampling for the purpose of theory construction, literature review, and advancing middle-range theory (Charmaz, 2006). By the 1990s, researchers knew GT for its rigor and usefulness, and current quantitative researchers often use GT during research projects. A more contemporary approach to GT advanced by researchers includes a move away from classic GT, which is rooted in positivism.

Charmaz (2006), searching for more flexible approaches to GT, have rejected the notion of scientist as separate which classic GT assumes. While Charmaz juxtaposed more modern approaches such as constructivist GT and traditional objectivist approaches, many classic grounded theorists disagree with this characterization, offering instead that classic grounded theory effectively incorporates elements of both approaches without being either (Martin & Gynnild, 2012).
Traditionally, GT researchers conducted data collection using approaches such as non-structured open-ended interviewing. Beginning with a single, broad open-ended question enables subjects to determine what is relevant for him or her, thereby collecting rich data that gets beneath the surface of social processes. In more modern approaches to GT, the researcher sees the world as the participants see it, entering the participants’ situations and settings. Charmaz (2006) stated that GT methods offer the advantage of quickly gaining a sharp focus on a set of general concepts with the first question often “what is happening here?” For this reason, GT is well suited for research questions pertaining to actions or processes, or social situations (Charmaz, 2006).

**Purpose and Rationale**

The overarching objective of this study was to expand the theory of transformational leadership that explains the nature of the social processes of transformational leadership nurse leaders. More specifically, this research contributes to the theoretical underpinnings of transformational leadership and explains the strategies and actions of transformational leadership that contribute to the transformation of nursing work environments and foster a culture of safety.

Traditional leadership theories centered on leadership traits and actions (Gerstner & Day, 1997; Van Breukelen, Schyns, & Le Blanc, 2006). Understanding the nature of the social processes, including the specific strategies and actions of transformational leadership nurse leaders, is a valuable extension of existing transformational leadership theory. This orientation may provide a clearer understanding of precisely how to develop and advance broad uptake of transformational leadership, and by extension, this would improve nursing work environments and advance patient safety. The theoretical
extensions provided by this research are useful for the following reasons. First, the outcomes produced by leadership strategies and actions are well documented as having positive effects on job satisfaction, safety culture, trust, organizational commitment, intentions to leave, organizational identification, and organizational citizenship tactics (Bass & Riggio, 2006; Judge & Piccolo, 2004; Lowe et al., 1996; MacKenzie, Moorman, & Fetter, 1990). Researchers have demonstrated that the effects of transformational leadership strategies and actions include increased self-actualization, self-esteem, and self-efficacy (Bass & Riggio, 2006; Dvir, Eden, Avolio, & Shamir, 2002; Shamir, Zakay, & Popper, 1998).

Extending knowledge of what transformational leadership strategies and actions may produce favorable outcomes beneficial to health care organizations so that leaders may consciously promote such performance. In summary, the existing research indicates multiple benefits of extending knowledge regarding how transformational leadership is operationalized among nurse leaders. This research has significant implications for extending the performance of nurse leaders, and by extension, promoting a culture of safety and transforming nursing work environments. This study contributes to advancing nursing science by addressing a critical barrier to progress in transformational leadership uptake using a qualitative GT approach to address the research problem.

**Research Aims**

The researcher developed two aims designed to fulfill the overarching purpose of the study. Aim 1 was to examine the social processes transformational leaders use to influence individuals within an organization and effect positive outcomes. This includes (a) understanding the specific strategies transformational leaders use during his or her
social process, and (b) understanding how a transformational leader’s strategies are related to specific actions and how strategies and actions change depending on the specific individual the transformational leader engages with.

In order to understand the social processes used by transformational leaders to influence others, the researcher addressed the following questions:

1. What is the transformational leadership philosophy that sets the stage for how the transformational leader enters the social process?
2. What are the strategies and actions that transformational leaders use to influence outcomes?

Aim 2 was to validate the fitness of emerging theory related to the social processes used by transformational leaders.

**Significance**

Worsened by the economic crisis and collapse of the financial system in the United States, health care has reached a critical tipping point. Americans spend 38 cents out of every dollar on health care (CMS, 2014). While the health reform legislation of 2010 offered an opportunity to transform care delivery in the United States, many intervening variables pointed to a challenging time ahead for health care leaders. Eroding reimbursement, lack of access to capital, an aging population, growth in obesity and chronic diseases, staggering projections for 2020 for nursing and physician shortages because of the 30 million newly ensured entering the health care system, and a rise in consumerism place increased pressure on an already fractured system (Malone et al., 2008; Weinstock, 2010). In 2000, the IOM estimated that as many as 98,000 patients die each year in hospitals from preventable medical errors (Kohn et al., 2000). In a more
recent study published in 2013, James suggested Americans have made little progress since 2000. James estimated that more than 400,000 patients die each year at the hands of the U.S. health care system. Researchers documented that more Americans die in hospitals from preventable medical errors than motor vehicle accidents, breast cancer, or AIDS (Kohn et al., 2000).

Understanding the nature of nurse transformational leadership actions and interactions is important as it has an effect on nurses’ abilities to provide safe, high quality patient care. This study contributes to the transformation of health care by expanding knowledge and contributing to the theory of transformational leadership that informs and furthers the understanding of the relationship between transformational leadership and positive outcomes. Using GT to build a theory that explains strategies utilized by transformational leaders that lead to positive outcomes was significant in that it informed precisely how the U.S. health care system educate and develop future nurse leaders. Through this study, the researcher intended to inform researchers, policy makers, leaders, and managers regarding the topic of transformational leadership and nurse leaders. To achieve the level of radical change required in the 21st century, organizations must develop leaders who generate trust and empower individuals. The researcher hoped that the study informs health care executives at the forefront of change and who are committed to leadership development programs in the areas of: (a) transformational leadership, patient safety, and quality outcomes; (b) organizational and cultural change; and (c) advancing nurses understanding and uptake of transformational leadership.
Summary

This chapter provided an introduction to the research study. The purpose of the study was stated along with research questions. A brief overview of the literature offered evidence for the significance of the study. In summary, many benefits exist to extending knowledge regarding transformational leadership in nursing. While much work must occur to fully understand the relationships between specific actions of nurse transformational leadership, context, and outcomes in health care work environments, in order to do so, a better understanding of the phenomena of interest is necessary. While instruments exist that address the characteristics of transformational leaders, little information exists regarding the specific strategies and actions taken by transformational leaders to improved outcomes.

Achieving the aims of this study added to research in the field by addressing the lack of understanding regarding what transformational leaders offer that contributes to positive outcomes. The researcher hoped that the results of this study would contribute to the emergence of a GT and explain how elements of transformational leadership lead to unique actions that result in specific outcomes, thereby enabling broad uptake of transformational leadership. In the following chapter, a comprehensive review of related literature presents a basis for the purpose of the study and the rationale for exploration of the social processes of transformational nurse leaders.
CHAPTER II

REVIEW OF LITERATURE

The researcher conducted the literature review for the purpose of formulating the researcher questions, as well as clarifying the existing knowledge on transformational leadership and nurses. Glaser (1978) suggested that with the inductive approach of GT, the researcher must possess as few preconceived ideas about the phenomenon as possible. Strauss and Corbin (1990) maintained that in some cases, researchers have knowledge about a phenomenon but seek a new understanding and familiarization with his or her prior knowledge in order to guide the research. However, Strauss and Corbin cautioned against getting too imbued with the literature because of the risk of introducing bias to the interpretation of the data. Two sentinel publications by the IOM (2000, 2004) surfaced the problem of errors and adverse events for patients accessing health care in the United States and recommended significant modifications in nursing work environments to improve patient safety. The latter report (IOM, 2004) specifically focused on the importance of transformational leadership, illuminating the importance of nursing leadership to ensuring a culture of safety and improving patient outcomes.

Search Methods

The researcher conducted an integrated review of the literature on the topic of transformational leadership, limited to sources written in English and accessible through electronic databases. The search involved the following databases: Business Source Premier, CINAHL, Ovid Medline and Medline-in-process, and Web of Science. These databases offered the entire range of work in the area of transformational leadership, including opinion papers, empirical studies, and review articles across all management
settings, regardless of industry. The search terms included: \textit{transformational leadership, management, leadership, and nursing outcomes}, individually and in combination with \textit{outcomes}. The initial search narrowed to English-only research journals yielded 709 topic-based articles. Literature primarily focused on articles published between the years of 2001 and 2011, which yielded 422 publications, and those published in the last five years yielded 322 publications. After removing duplicates, the search narrowed to only articles dealing with management and leadership, yielding 183 citations. Further narrowing of articles to only those relevant to health care yielded 81 articles, as summarized in Appendix G. The researcher then organized the articles by level of evidence utilizing The AACN Evidence Leveling System (Armola et al., 2009). The evaluation is structured to include a review of the concepts of transformational leadership and management and nursing outcomes, followed by a summary of research regarding transformational leadership related to nursing outcomes.

**Management and Leadership**

While health services and business literature appear to make clear distinctions between leaders and managers, a review of the nursing literature found a growing lack of distinction between nursing management and leadership competencies (Jennings et al., 2007). Bennis (2009) asserted that managers administer, while leaders innovate. Transformational leadership theorists refer to managers as transactional leaders whose power is positional in contrast to transformational leaders who innovate and inspire and whose power comes from others (Marshall, 2011). Full range leadership theory, which evolved from transformational leadership theory, suggests that leadership and management exist on a continuum that could explain the “graying” of concepts in the
nursing literature (Bass, 2008). For the purpose of this study, the researcher used Bass’s theory. Similar to Benner’s (1982) novice to expert theory in clinical nursing, managers and leaders evolve as he or she develops the core competencies of management and leadership. Management is often transactional, task related, and local, whereas leadership subsumes management and adds the competencies of influence, vision, and change management at an organizational level.

**Management**

Traditional management theories focused on the organization rather than individuals and included concepts such as hierarchy, chain-of-command, division of labor, and rules and regulations (Marshall, 2011). Traditional management theory, which set the stage for management via objectives and is still seen in some hospital cultures, is criticized for being too rigid, authoritarian, and mechanistic (Marshall, 2011). In the health services literature, as recent as 2009, researchers described managers in terms of three main functions: core business transaction management, operations management, and strategic management (Kovner, Fine, & D’Aquila, 2009). Later in the 20th century, behaviorist theories emerged which focused away from the organization, instead looking at individuals’ styles or traits. Situation theory, which evolved as a reaction to individually focused trait theory, has situational factors as the premise for management (Marshall, 2011).

While reviewing the literature prior to the first IOM report, efforts to improve patient safety were largely aimed at preventing human error rather than system error (Woodhouse et al., 2004). In contrast, Walshe and Shortell (2004) were interested in understanding how hospitals dealt with major failures. Using a case study approach, the
researchers looked at major hospital failures in six countries (Walshe & Shortell, 2004). Walshe and Shortell defined *major failure* as a “breakdown in services or provision that resulted in substantial harm to many patients” (p. 104). The researchers found that major failures in hospitals related to four factors, one being management (Walshe & Shortell, 2004). Lack of fundamental management systems, demonstration of little cooperation among managers and clinicians, and absence of effective clinical leadership related to major failures in hospitals (Walshe & Shortell, 2004).

In Morrell’s (2008) qualitative narrative inquiry, the researcher critically examined differing ideological fibers in the nascent literature regarding the phenomenon of management: pragmatism, progress, systematization, technique, and accumulation. Using narrative theory, the researcher analyzed ideological fibers inside the narrative of management. Morrell asserted that the claims underpinning management may be interpreted as a common narrative about the relationship of management study to management practice. Scrutinizing the approach to management, Morrell identified how contemporary efforts to translate the principles of evidence-based medicine to management overlooked ethics and judgment. In addition, Stewart (2002) offered a detailed exposition of management, describing management as a necessary “attitude of mind” that considers not only the evidence but also the nature of evidence.

Genrich, Banks, Bufton, Savage, and Owens (2001) determined if managers could learn shared decision-making using the Vroom-Yetton-Jago leadership model. A convenience sample of 27 health care managers who attended a 90-minute class was eligible for inclusion in the pretest and posttest on similar cases studies for this quasi-experimental study (Genrich, Banks, Bufton, Savage, & Owens, 2001). A paired t-test
revealed statistically significant findings, indicating that delegating and sharing decision making can be learned.

A number of researchers investigated nurse manager attributes and those managers influence on the practice environment (Lemire, 2001; Zori et al., 2010). Zori et al. (2010) were interested in knowing if a nurse manager’s critical thinking skills influenced registered nurses’ (RN) perceptions of the practice environment. The researchers utilized the California Critical Thinking Disposition Inventory (CCTDI) to assess nurse managers’ critical thinking and the Practice Environment Scale (PPS) to measure the nursing work environment (Zori et al., 2010). The researchers established significant (p<.001) variances among nurse managers’ CCTDI scores for open-mindedness, analyticity, and critical thinking confidence, and significant differences (p<.01) when compared with RN mean subscale and overall PPS scores (Zorie, Nose, & Musil, 2010).

These researchers suggested that the ability of nurse managers to exercise critical thinking may enable those managers to foster positive work environments conducive to staff satisfaction and retention for RNs. The ability to enable positive work environments is important because the practice environment in which nurses work affects staff nurses’ job satisfaction and nurse retention (Mark, Salyer, & Wan, 2003; Scott, Gleason, Sochalski, & Aiken, 1999). Additionally staff satisfaction is highly correlated with patient satisfaction (Harter, Schmidt, & Hayes, 2002).

Since 2004, the number of studies regarding health services and nursing research has increased related to the effectiveness of management practice in health care, and researchers have put forth several models of management. Factors related to
management include the ability to balance the tension between efficiency and safety, trust, change management, shared decision-making, and knowledge management. In nursing, one of the best examples of evidence-based management is the Magnet hospital initiative, which requires hospitals to take an empirical approach to ensure safe work environments.

**Leadership**

Nursing leadership in hospitals and health care organizations plays a critical role in ensuring safe work environments (IOM, 2004). The central function of leadership is to enable a common purpose (Burns, 1978). The Joint Commission on Accreditation of Hospital Organizations (2009) contended that transformational leadership will be the dominant leadership approach in the U.S. in the coming years. The National Center for Healthcare Leadership (as cited in Davidson et al., 2005) articulated that not only do health care leaders need to possess technical knowledge, but these leaders also must demonstrate competence in change management, transformation, and innovation.

The IOM (2004) confirmed leadership is an antecedent to workplace safety. Leadership involvement in clinical improvements has a statistically significant effect on cost outcomes (Walston, Burns, & Kimberly, 2000) and improved job satisfaction (Robbins & Davidhizar, 2007). Alexander, Herald, Jiang, and Fraser (2007) conducted semistructured interviews with a convenience sample of hospital and system leaders focusing on present and future challenges regarding quality, costs, and efficiency in addition to potential solutions. An emerging theme was the importance of researchers taking a proactive role in getting his or her research into the hands of potential users and using those users to shape future research.
In four different studies, researchers suggested that leadership may be related to outcomes by fostering and enabling effective teamwork (Anderson et al., 2003; Doran et al., 2004; McNeese-Smith, 1999; Pollack & Koch, 2003). Houser (2003) explained that empowering leadership may be associated with improved patient outcomes by promoting nursing expertise through increased staff stability and reduced turnover. Similarly, nurses' job satisfaction correlated with patient satisfaction and positive leadership (McNeese-Smith, 1999). This supports previous research findings that effective leadership is related to patient outcomes because of nurses' increased job satisfaction. In addition, a number of researchers posited that clear communication of expectations from leaders facilitates improved clinical outcomes (Anderson et al., 2003; Boyle, 2004; Doran et al., 2004; McNeese-Smith, 1999).

**Transformational leadership.** During the last 10 years, an increase in attention to the construct of transformational leadership occurred, because of both the IOM’s call for transformational leadership uptake and the views of outspoken proponents of transformational leadership (IOM, 2004; Reay et al., 2009). While the IOM called for the adoption of transformational leadership practices by hospital and health care managers and leaders, some divergent voices cautioned against this approach (Arndt & Bigelow, 2007). First, Booth, Kenrick, and Woods (1997) criticized empiricism as a reductionist approach that is inappropriate for the study of the complex nature of the nursing phenomena. Critical theorists object to the movement, criticizing it for assuming that management and evidence are neutral (Learmonth & Harding, 2006). From the critical theory perspective, leadership is not necessarily a good thing as the nature of leadership and management assumes an unequal distribution of power, which could be negative for
employees. Other researchers contend that management is not a science and may not be amenable to scientific study (Cascio, 2007).

McCormack et al. (2002) suggested that transformational leaders alter the prevailing culture, thereby creating a context for the integration of evidence. A meta-analysis conducted by Judge and Piccolo (2004) provided support for the validity of the generalizability of transformational leadership across various settings. Earlier, Lowe, Kroeck, and Sivasubramaniam (1996) evaluated 39 studies using the Multifactor Leadership Questionnaire (MLQ-5X Short), a widely used measure of transformational leadership (Judge & Piccolo, 2004). McFadden, Henagan, and Gowen (2009), drawing on high reliability organization theory and multifactor leadership theory, hypothesized that senior leaders possessing transformational leadership characteristics have a positive effect on safety culture.

Using the MLQ-5X Short (See Appendix E), the authors obtained survey data from 200 hospitals. The MLQ-5X Short is a full range leadership theory instrument aimed at describing and measuring the use of transformational leadership elements by a leader. The 45-item MLQ-5X Short is comprised of 12 scales: (a) idealized influence (attributes), (b) idealized influence (behaviors), (c) inspirational motivation, (d) intellectual stimulation, (e) individual consideration, (f) contingent reward, (g) management-by exception (active), (h) management by exception (passive), (i) laissez-faire leadership, (j) extra effort, (k) effectiveness, and (l) satisfaction (Bass & Avolio, 1995). Using a structural equation model, the authors found a direct link between promoting a culture of safety and transformational leadership. This study provides
empirical evidence that promoting patient safety begins with top leaders who demonstrate the attributes of transformational leadership (McFadden, Henagan, & Gowen, 2009).

Transformational leadership enacted by nurse managers is related to higher nurse satisfaction, retention, and patient satisfaction (Robbins & Davidhizar, 2007). Laschinger, Shamian, and Thomson (2001) studied Magnet hospitals and found that autonomy and control of the practice environment are positively associated with trust in management—one of the five practices of management as articulated by the IOM (2004) and a hallmark of transformational leaders. Scott, Gleason, Sochalski, and Aiken (1999) conducted a review of studies on Magnet hospitals, and found that control of nursing practice and autonomy were Magnet characteristics. A recent qualitative study aimed at identifying facilitators and barriers for health care organizations to sustain Magnet recognition identified macro- and micro-level system facilitators and barriers to sustainability. Parsons and Cornet (2011) found executive leadership and management were a dominant theme, with subthemes of leadership philosophy regarding the organization and its people valuing education and CNO leadership. This study informs both existing Magnet organizations and aspiring Magnet organizations regarding factors related to sustainability.

**Authentic versus transformational leadership.** The concept of authentic leadership has developed throughout the nursing and health services literature. Some researchers believe the differentiating feature of transformational leadership is that authentic leaders influence others based on the leaders’ strong sense of who he or she is and where he or she stands on issues, values, and beliefs; whereas transformational leaders influence others through a powerful and positive vision. These characteristics are
not mutually exclusive. Some authentic leaders demonstrate transformational characteristics, and some transformational leaders demonstrate characteristics of authentic leaders. Transformational leaders may have the same deep sense of self as authentic leaders in addition to demonstrating a strong vision. Authentic leadership theorists believe that authentic leaders may also have vision, but it is not a necessary condition for authentic leadership (Northouse, 2004).

Kouzes and Posner's (1995) leadership practices model also focuses on the development and sharing of vision and an emphasis on leader integrity and openness, similar to transformational leadership. Although Kouzes and Posner based the theoretical model on research findings from interviews with leaders and followers, the model is not fully developed in terms of describing how the responses of followers to leadership are linked with outcomes.

**Authentic and charismatic leadership.** Avolio and Gardner (2005) clarified that charismatic leaders may also demonstrate transformational qualities and use rhetoric to energize and persuade followers, whereas authentic leaders energize by creating meaning and influencing social reality for themselves and others. Conger and Kanungo's (1998) articulation of charismatic leadership omits the attention to leader and follower self-awareness or regulation, the role of psychological capital, and the relationship of leadership to sustainable outcomes.

**Authentic and emotional intelligence leadership.** Emotional intelligence (EI) theory, which some health care organizations such as the American Organization of Nurse Executives (AONE) and some large academic medical centers have adopted as part of the leadership development curriculum, includes the elements of self-awareness,
emotional management, self-motivation, empathy, and relationship management (Goleman, 1995). Studies linking emotional intelligence and leadership are limited; however, some evidence suggests an overlap between transformational leadership and emotionally intelligence (Boyatzis & McKee, 2005). A weakness of EI theory is that EI does not address the link between organizational outcomes and emotional intelligence, nor does it address the relationship between leader and follower.

**Leader-follower exchange.** Gerstner and Day (1997) identified that leader-member (follower) exchange and transformational leadership had multiple conceptual relationships. In the original works on vertical leader-follower theory, a precursor to existing leader-member exchange theory, transformational leadership actions were considered a key element in the development of follower-leader relationships (Dansereau, Graen, & Haga, 1975). In a more recent study, Wang et al. (2005) determined that transformational leadership behaviors were fully mediated by leader-member exchange. High-quality exchanges are classified as transformational, while low-quality exchanges are transactional (Bass, 2008; Gerstner & Day, 1997; Van Breukelen et al., 2006; Yukl, 2012).

**Instrumentation**

While some researchers have conducted qualitative studies of transformational leadership in the last 10 years, the major methodological approach among researchers has been quantitative, using a variety of instruments. The most common instrument used to measure transformational leadership is the validated MLQ-5X (Bass, 2008). The MLQ-5X assesses perceptions of leadership behaviors from laissez-faire to idealized leadership or transformational leadership, focusing on individual behaviors observed by associates.
at any organizational level. A four-point Likert scale rates the frequency of observed behaviors, with zero being not at all, and four being frequent transformational leadership, if not always. The 45-item questionnaire includes questions such as “the person I am rating seeks different perspectives when solving problems,” and “the person I am rating spends time teaching and coaching” (Bass & Avolio, 2004). Reliability and validity estimates for this instrument are included in Table 3.1 in Chapter III.

The Nursing Work Index (NWI) developed by Kramer and later revised and renamed the NWI-R (Aiken & Patrician, 2000) and again further refined and developed as the NWI-PES (Lake, 2002) is a survey-based measure of the nursing practice environment completed by staff nurses (Aiken et al., 2012). Researchers have used the NWI-PES extensively with more than 75 published papers found in the literature. The evidence from the literature supports the psychometric rigor of the instrument and suggests that nurses’ practice environments link to nursing care and patient outcomes (Aiken et al., 2012).

Researchers have utilized another widely tested instrument, The California Critical Thinking Disposition Inventory (CCTDI) to assess nurse manager critical thinking. Other scales developed to assess nurse managers include the Supportive Supervisory Scale, which measures the degree of supportive behavior a nurse manager has for staff, Kouszes and Pozner’s leadership survey, and the Mueller-McCloskey Job Satisfaction Scale (McGilton, 2010). Vroom and Yetton’s normative model addresses decision making as a social process and addresses how managers act in his or her normative model. Vroom and Yetton (1973) identified five categories of decision-
making styles ranging from autocratic to consultative and group style, and offered rules for protecting decision quality and rules for gaining acceptance of the decisions made.

Kouzes and Posner (1995) originally developed the leadership practice inventory (LPI) for educational use, but a number of industries have utilized the LPI to measure leadership practice (Tourangeau et al., 2002). The LPI is a 30-item instrument, widely used in nursing (Houser, 2003; McNeese & Smith, 1999). The LPI includes both self-assessment (completed by the leader) and the LPI Observer (completed by those who observe the leader’s practice). The LPI includes five leadership dimensions defined by Kouzes and Posner as (a) model the way, (b) inspire a shared vision, (c) challenge the process, (d) enable others to act, and (e) encourage the heart. A limitation of the LPI is that limited research exists regarding LPI psychometric properties when used to measure leadership practices of nurses (Tourangeau et al., 2002).

Boyle (2004) used Aiken, Sochalski, and Lake's (1994) conceptual model of organizational factors in an effort to understand the effect on patient safety outcomes including mortality and adverse events. In this study, Boyle (2004) measured leadership as nurse manager organizational support, a subscale of a four-factor version of the Nursing Work Index-Revised (Aiken & Patrician, 2000). Pollack and Koch (2003) used Shortell et al.’s (2007) organizational assessment instrument, where leadership was one of several dimensions. In this instrument, charisma and the ability to set clear expectations were the defining characteristics of leadership. In the above studies, the mechanism regarding how leadership related to patient outcomes was found to be indirect, contextual, and facilitative.
A number of researchers hypothesized that positive leadership behaviors (transformational, empowering, supportive, etc.) may explain improved clinical outcomes in terms of the leader’s ability to build effective teams (Anderson et al., 2003; Doran et al., 2004; McNeese-Smith, 1999; Pollack & Koch, 2003). Furthermore, Houser (2003) found that empowering leadership enables stable work environments and reduces nurse turnover, which has a positive effect on safety culture and reduces RN turnover. Nurses' job satisfaction correlates with both patient satisfaction and positive leadership (McNeese-Smith, 1999). Thus, effective leadership relates to patient outcomes through nurses' increased job satisfaction. Furthermore, a number of researchers put forth that when followers have a clear understanding of expectations for practice, patient care processes are facilitated, which, in turn, leads to better outcomes (Anderson et al., 2003; Boyle, 2004; Doran et al., 2004; McNeese-Smith, 1999). While a number of instruments exist related to identifying characteristics of managers and leaders, qualitative methods are needed in order to more fully describe and understand what it is that nurse transformational leaders do that leads to improved outcomes.

**Summary**

While the literature in the area of transformational leadership in nursing and health services is growing, many gaps remain, in part because of historical challenges procuring funding for management research. In addition, because leadership is difficult to study, much of the existing research includes lower-level descriptive studies that do not describe the exact strategies and behaviors of transformational nurse leaders. Further, quantitative approaches to transformational leadership do not adequately address the “what” of transformational leadership and do not consider the contexts in which
transformational leadership operates. This bias makes it difficult to weigh the relative value of transformational leadership interventions against each other. Finally, the workforce of nurse managers and leaders reveals many entry points and varied levels of formal education regarding transformational leadership approaches to leadership and management.

Directions for further research include the development of consistent language as well as indexing related to transformational leadership and leveraging qualitative approaches to understand the nature, strategies, and actions of transformational leadership. Additionally, higher-level studies that demonstrate the relationship between transformational leadership and improved organizational outcomes show that improved work environments and improved quality are needed. Synthesizing transformational leadership research, expanding transformational leadership research networks, and educating current and future nurse managers on transformational leadership approaches are also necessary to advance nursing science (Banaszak-Holl, Zheng, & Griffith, 2009).

In order to advance the nursing profession in the area of leadership and patient outcomes, increased focus on interventions and studies must address the influence of transformational leadership on the work environment and on patients across various clinical settings. Several study designs in this review were multisite, which needs to continue. The application of multivariate statistical procedures (e.g., HLM and SEM) should also continue as well as the use of more rigorous sampling methods. Finally, mixed and multiple methods that include qualitative approaches to the examination of transformational leadership are needed to develop richer contextual descriptions of transformational leadership in health care contexts.
CHAPTER III

METHODS

Overview

This chapter provides an overview of the methodological approach to the study, which includes the purpose and aims, the research design, the sample, instrumentation, data collection and analysis, ethical considerations, and a summary of the approach. A qualitative approach was necessary to achieve the research aims of this study. Grounded theory approaches were a good fit for this study’s purpose and aims as GT is a versatile method useful for generating explanatory substantive theory of human behavior in social contexts (Munhall, 2007). Researcher use grounded theory methods for the purpose of expanding theory, which is grounded in the data, rather than testing existing theories (Glaser, 1978, 1992; Strauss & Corbin, 1990). The importance of GT in the present study was that it incorporates the complexities related to the social processes of CNOs rather than dismissing those complexities.

Purpose

The overarching objective of this study was to expand the theory of transformational leadership that explains the nature of the social processes of transformational CNOs. More specifically, this research addressed existing gaps in transformational leadership theory by exposing some of the strategies and actions of transformational leadership that contribute to the transformation of nursing work environments and foster a culture of safety.
Research Aims

The researcher developed two aims designed to fulfill the overarching purpose of the study. Aim 1 was to examine the social processes transformational leaders use to influence individuals within an organization and effect positive outcomes. This includes (a) understanding the specific strategies transformational leaders use during his or her social process, and (b) understanding how a transformational leader’s strategies are related to specific actions and how strategies and actions change depending on the specific individual the transformational leader engages with.

In order to understand the social processes used by transformational leaders to influence others, the researcher addressed the following questions:

1. What is the transformational leadership philosophy that sets the stage for how the transformational leader enters the social process?
2. What are the strategies and actions that transformational leaders use to influence outcomes?

Aim 2 was to validate the fitness of emerging theory related to the social processes used by transformational leaders.

Qualitative Approach

Qualitative research provides a mechanism for dealing with individual experiences through inductive theory building as opposed to deductive methods (Merriam, 1998). Merriam and Creswell (2012) distinguished qualitative research as having the following attributes: (a) is based on individuals interacting with his or her social worlds, (b) uses the researcher as the primary instrument for data collection and analysis, (c) typically involves field work, and (d) is primarily inductive in that
qualitative research involves constructing research abstractions, concepts, and hypotheses.

Among the various qualitative traditions, GT is a method well suited to enhance the knowledge and understanding of the nature of leader actions and interactions. Grounded theory also includes the two foundational elements of constant comparison and theoretical sensitivity (Munhall, 2007). Grounded theory uses qualitative research methods with the aim of generating a new theory, or expanding upon theory as opposed to testing existing theories (Glaser, 1978, 1992; Strauss & Corbin, 1990). The importance of the grounded theory approach to the present study was that it aided in uncovering the social process of transformational leadership which gives rise to strategies that could be designed to address existing barriers to broad research uptake.

Figure 3.1 illustrates the evolution of GT and its key concepts since its inception. Grounded theory incorporates the complexities of the phenomena under investigation without discarding, ignoring, or assuming away relevant variables. Therefore, the richness of the data ensures that the resulting theory provides a deep understanding of the phenomenon under investigation. Grounded theory is well suited for researchers interested in explaining a process, social event, or action (Creswell, 2012). Hatch (2002) described grounded theory as developing procedures to collect and analyze data using rigorous and systematic methods that require repeated confirmation of emerging patterns.
Figure 3.1. Genealogy of grounded theory. Adapted from Morse, J. M., Stern, P. M., Corbin, J., Bowers, B., Charmaz, K., Clarke, A. E. (2009).

Moustakas (1994) described it as an unraveling of the “elements of experience” (p. 4) and a study of the elements’ interrelationships, out of which a theory emerges that helps a researcher better understand the phenomena under study.

The researcher chose qualitative approaches for this study because qualitative research involves methods that ultimately enable the expansion of existing theory, which present a significant contribution to nursing science (Creswell, 2012). This study consisted of three phases including an initial assessment of transformational leadership characteristics, one-on-one interviews, and testing for fitness of expanded theory (see Figure 3.2).
During Phase I of the study, the researcher utilized the MLQ-5X Short leadership survey to identify CNO transformational leaders. Chief nursing officers who possess transformational leadership characteristics of idealized influence, inspirational motivation, intellectual stimulation, and individual consideration on initial screening with MLQ-5X Short were invited to participate in Phase II. All Phase I participants in Phase I were eligible for Phase II. Phase II consisted of one-on-one interviews focused on the exploration and documentation of specific strategies and actions utilized by the study participants. During Phase III, the researcher employed member checking and tested for fitness of the emerging theory.

This approach assisted the researcher to validate expanded theory related to strategies, actions, and concepts identified in initial data collection (Martin & Gynnild, 2012; Munhall, 2007). Participants from the initial screening (Phase I) were contacted and asked to participate in validating and confirming findings (from Phase II). This study
received Institutional Review Board (IRB) approval by the Colorado Multiple Institutional Review Board. All participants were apprised of the study aims and gave consent to participate following IRB guidelines.

**Instrumentation**

In addressing the research questions, transformational leadership had to be identified in Phase I. The researcher used the MLQ-5X Short instrument (Appendix E) to screen and identify the transformational leadership level of respondents.

The Multifactor Leadership Questionnaire is one of the most widely used instruments to measure transactional and transformational leadership. The MLQ has undergone considerable revisions since Bass (1985) published the original MLQ. The updated seven factor MLQ-5X Short by Bass and Avolio (1993) consists of twenty-one items. The MLQ-5X Short assesses transformational, transactional, and laissez-faire performance on seven leadership dimensions. The dimensions of the MLQ-5X Short are influence, inspirational motivation, intellectual stimulation, individualized consideration, contingent reward, management-by-exception, and laissez-faire leadership.

Transformational leadership dimensions include idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. The transactional behavior dimensions include contingent reward, active management-by-exception, and passive management-by-exception, as described earlier in Table 1.1 (Bass & Riggio, 2006).

The four transformational leadership dimensions of idealized influence, inspirational motivation, intellectual stimulation and individualized consideration are highly inter-correlated (Bass & Riggio, 2006; Bycio, Hackett, & Allen, 1995; Carless,
1998; Lowe et al., 1996) and often considered a single measure of transformational leadership (Carless, 1998; Whittington, Goodwin, & Murray, 2004). The researcher did not conduct psychometric testing in this study; however, researchers have published tests of reliability and validity, as shown in Table 3.1. Appendix E contains the MLQ-5X Short instrument.

Table 3.1 Bass and Avolio’s Published Reliability and Validity on MLQ-5X

<table>
<thead>
<tr>
<th>Construct</th>
<th>Primary Author(s)</th>
<th>Reliability</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership behaviors – transformational, MLQ-5X</td>
<td>Bass and Avolio (1997)</td>
<td>.80 on all dimensions</td>
<td>Follower Rate-/Rerate: .66–.77</td>
</tr>
<tr>
<td>Leadership behaviors – transactional, MLQ-5X</td>
<td>Avolio and Bass (2004); Bass and Avolio (1997); Lowe</td>
<td>.74–.94 on all dimensions</td>
<td>Follower Rate-/Rerate: .52–.82</td>
</tr>
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</table>

**Sampling**

Merriam (1998) described two types of sampling procedures in qualitative research: probability and nonprobability. Probability (or random) sampling allows one to generalize results to the population from which the sample was taken. If generalization is not the goal, non-probabilistic sampling is more typical. Non-probabilistic sampling, a form of purposive sampling, allows a researcher to discover something specific in the sample population. Purposive sampling is used when “researchers intentionally select individuals and sites to learn or understand the central phenomenon” (Creswell, 2012, p. 204).

Sampling methods for GT are theoretical in nature. The researcher uses his or her judgment in determining the best source of observational, interview, or document data (Munhall, 2007).
Selection of CNOs

In addition to reviewing literature to identify experts in the field, the researcher polled academic and practice colleagues for names of CNOs in the area of transformational leadership and nursing. In addition, the researcher solicited professional organizations for a list of nurse executives who demonstrate transformational leadership. For the purposes of this research study, an expert was defined as a practicing nurse executive with a high degree of knowledge of transformational leadership. Inclusion criteria for participation included:

1. A minimum of 5 years of clinical or administrative leadership;
2. Currently practicing as a CNO in a hospital setting;
3. Willingness to serve;
4. Ability to dedicate the time necessary to participate in a minimum of one electronic survey, in addition to completion of a minimum of 1 one-on-one interview and a maximum of 2 one-on-one interviews;
5. Access to and proficiency in the use of email and web navigation;
6. English speaking; and
7. Scored a minimum of a 9 or greater overall on the transformational leadership sub-scales of the MLQ-5X Short.

Exclusion criteria included:

1. Less than 5 years of clinical or administrative leadership;
2. Not currently practicing as a CNO in a hospital setting;
3. Unwillingness or inability to serve;
4. Inability to dedicate the time necessary to participate in a minimum of one
electronic survey, in addition to completion of a minimum of 1 one-on-one
interview and a maximum of 2 one-on-one interviews;
5. Lack of access to or proficiency in the use of email and web navigation;
6. not English speaking; and
7. Score below 9 overall on the transformational leadership sub-scales of the
MLQ-5X Short.

Recruitment

For Phase I of the study, the recruitment strategy for this study included
solicitation of recommendations from experts in the field to identify potential study
participants. The researcher contacted nurse executives in the field to introduce the
project and ask for referrals of potential participants. The nurse executives received a
contact form with the researcher’s contact information. Nurse executives were asked to
inform potential participants who wanted to know more about the study to either provide
his or her contact information on the contact form or contact the researcher directly.
Once identifying potential participants, the researcher contacted the CNOs and provided
information about the study and interview process.

All participants who agreed to receive information regarding the study were sent
the study overview and a formal request for participation via electronic-mail (Appendix
B). The researcher identified 25 participants during initial recruitment and those
individuals received a description of the research project, including benefits and risks,
and were told that he or she could withdraw from the study at any time. Upon consent,
these participants were administered the MLQ-5X Short.
Data Collection and Analysis

Although Glaser (1978) suggested that demographic data must earn its way into the study data, as demographic information may influence interpretation the results, the researcher elected to include demographic information in the data collection process. Additional categorical variables collected include gender, age, employment status, previous leadership and management experience, and educational level (Munhall, 2007).

Phase I: The MLQ-5X Short was scored according to Avolio and Bass’ (2004) guidelines (Appendix E). The researcher recruited 25 participants for Phase I of the study. All 25 participants scored at a 9.0 or greater overall on the four attributes of transformational leadership (idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration). The researcher then asked those individuals to participate in Phase II (Avolio & Bass, 2007).

Phase II: Twenty-five participants were secured for phase II. One-on-one interviews were conducted with each participant, and interviews were audiotaped. Prior to using the ATLAS.ti version 7 software program, the researcher transcribed, reviewed, and checked the tapes against the audio tapes. Consistent with qualitative methods, the researcher open-coded data and summarized field notes immediately after each interview. In an effort to understand specific strategies and actions inherent within the social processes that leaders use, semistructured interviews were organized using an open and responsive style. Rubin and Rubin (2012) described this approach as focused on (a) interpretations of participant experiences, (b) the relationship between interviewee and interviewer, (c) attention to the serious ethical obligations for a researcher when personal
information is shared, (d) suspending the investigators opinions or perspectives, and (e) the need for flexibility given theoretical sampling.

For the interviews, the researcher utilized questions such as:

- Describe and discuss your leadership philosophy.
- What strategies and actions do you use with staff to create safe and effective work environments?
- What strategies or actions have you implemented that have resulted in safe and effective work environments?
- Please share an example where leadership was lacking. How and why was it lacking?
- Please share an example where leadership was evident. How and why was it evident?

The researcher theorized and documented ideas regarding the theoretical categories (Glaser, 1978). Theoretical categories are expected to emerge from the conceptualization of substantive categories and the categories’ relationships to each other as hypotheses to be integrated into a theory (Glaser, 1978). Data collection continued until saturation was achieved. Saturation was achieved with twelve interviews (Munhall, 2007).

**Data Analysis**

Analysis in GT involves generating a theoretical account of the phenomenon. Consistent with GT approaches, the researcher conducted collection and analysis of qualitative data concurrently, with purposive subsequent theoretical sampling and data collection for the purpose of confirming concepts and allowing hypotheses (Munhall, 2007). Open coding using ATLAS.ti version 7 analytic software resulted in the
development of categories represented in abstract by the data. To determine the relationships between categories, a number of coding ‘‘families’’ (Glaser, 1978) were employed. The first coding family is the ‘‘Six Cs’’ in which the researcher considers the causes, consequences, contexts, contingencies, covariance’s, and conditions for each data category. Theoretical coding using the Six Cs allowed the researcher to ask a number of questions regarding the data and categories to help clarify relationships (Strauss and Corbin, 1990). Those questions included:

- Is it a cause or a consequence of some other category?
- What are the intervening conditions between the causes and consequences?
- Within what context does this category emerge? Context refers to the location of events or incidents pertaining to a phenomenon (Strauss & Corbin, 1990).
- Is this category a contingency (having a bearing on another category)? In other words, what is change in this category dependent upon? This refers usually to unplanned change (Strauss & Corbin, 1990; Swanson, 1986).
- Is there covariance between this category and other categories? Covariance occurs when one category changes with the changes in another category (Strauss & Corbin, 1990).

By asking these questions of the data, and seeking answers, the level of abstraction of the categories is anticipated to increase progressively. The researcher accomplished qualitative data analysis with the use of ATLAS.ti version 7, which uncovered and systematically analyzed phenomena hidden in unstructured data. The program provides tools that allow the user to locate, code, and annotate findings in primary data material, to weigh and evaluate the importance of those findings, and to
visualize the often complex relations between the findings. The researcher used
ATLAS.ti 7 for the following analytic procedures: (a) storage and categorizing of
interview transcripts, memos, and other documents; (b) creation of categories through
computer-assisted coding; (c) conducting searches relevant to analysis, in order to
generate reports; (d) moving and linking data as higher order themes emerge; and (e)
basic hierarchical models of codes.

The themes and categories generated from transcribed data formed the basis for
the final analysis in the study. The aim of coding was to arrive at systematically derived
core categories that become the focal concepts that contribute towards theoretical
development. Theory expansion occurred around a number of core categories
specifically related to what influences a CNO’s social process and therefore what
strategies and actions CNOs engage in as part of his or her social process. The researcher
coded categories with a view to rendering the categories dense with theoretical meaning.

During Phase II coding occurred in three stages where the researcher developed a
listing of codes, which later developed into themes related to the research aims. These
stages were open coding, axial coding, and selective coding. According to Charmaz
(2012), data analysis or a constant comparative method involves continuous interaction
between the researcher, data, and the developing theory. According to Strauss (1987),
“coding involves the discovery and naming of categories, it must also tell the researcher
much more than that” (p. 26).

Open coding consisted of unrestricted coding of the data. During the course of
conducting the coding analysis, the researcher followed some important procedures, as
Strauss (1987) outlined:
Look for in-vivo codes, terms used by the people who are being studied; give a provisional name to each code, in vivo or constructed; ask a whole battery of specific questions about words, phrases, sentences, actions, in the line by line analysis; and move quickly to dimensions that seem relevant to given words and phrases. (p. 30)

In an attempt to extract the meaning of data, the researcher began analysis by developing a coding system to organize data. The data was read to identify certain words, phrases, patterns of behavior, and events that repeated or stood out.

Axial coding was the second stage of the coding. Concepts uncovered in open coding were developed into categories. Categories were generated based on specific research questions. From the categories, themes emerged. The researcher also investigated the relationships among categories of data. During this stage, key activities took place, such as examination of key features, examination of the phenomena (and how it manifested itself), and an examination of the conditions that brought about the phenomena. Selective coding comprised the third and final stage of coding. The researcher searched for the main idea through the process of reflection of the data and results generated during the open coding and axial coding. Narrative passages were developed to express the findings of the analysis. The focus at this stage was on the central idea of the expanding theory.

Phase III: Once categories and themes were determined, phase III occurred in two steps.

Data Collection

Step 1. This phase was initiated with six participants from Phase I who did not participate in Phase II. These individuals were asked to validate and confirm findings
using a member-checking approach, which focused on evaluating fitness of the categories and themes.

Step 2. Six participants who participated in both Phase I and II of the study were contacted to validate expanded theory. Participants were contacted and invited to participate in a follow-up telephone call where the researcher presented and reviewed the conceptual framework.

Data Management

The researcher assigned all study participants study identification numbers for Phase I of study. For Phase II of study, data was transcribed with no identifiers. A master list of names was kept separate from the data under lock-and-key by the investigator and will be destroyed after completion of the study. The researcher collected data from the MLQ-5X Short using an electronic survey and collated into a password-protected file.

Ethical Consideration

Ensuring the anonymity of study participants in this study was of primary concern to ensure integrity of data. Given the sensitivity of some interview questions, it was possible that participants did not provide a full account of personal experiences if he or she was not assured of anonymity. Anonymity was accomplished by assigning participant identification numbers to participants in Phase I. In an effort to further safeguard anonymity, the researcher transcribed the interviews in Phase II without identifiers.

Prior to interviews, participants received a description of the research project as part of study invitation, including benefits and risks. Participants were made aware that
he or she could withdraw from the study at any time. Electronic data, including interview recordings and transcripts, were housed on the researcher’s personal computer, with backup on a personal hard drive in the researcher’s home office, available only to the researcher. The computer was kept in a locked office, and electronic files were password protected.

**Human Subjects Protection**

The research study design was first approved by COMIRB, Colorado Multiple Institutional Review Board, prior to commencement of data collection. The researcher explained the purpose of the project at the time potential participants were invited to participate. Anonymity was maintained and information released to the participants between phases did not include individual responses, nor were participants aware of the identity of other participants. The researcher also maintained the participants’ demographic information as part of data management.

**Summary**

During this descriptive qualitative study, the researcher utilized a grounded theory approach (Appendix I). This study occurred in three phases. To ensure human subjects projections, COMIRB, Colorado Multiple Institutional Review Board, first approved the study prior to data collection. During Phase I, practicing CNOs were identified as those who met initial inclusion criteria for Phase I, and completed the MLQ-5X Short online (Appendix I). Phase II participants met inclusion criteria with scores of 9 or greater on the MLQ-5X Short survey. During phase II of the study, the researcher conducted interviews to investigate the social processes of transformational leadership for CNOs. Phase III of the study occurred in two steps. In Step 1, six
participants from Phase I who did not participate in Phase II were contacted to validate emerging themes. In Step 2 of Phase III, six participants who participated in both Phase I and Phase II were contacted to validate expanded theory. This chapter provided the execution of this study for this research, and presented the research questions and approach. The researcher also discussed and presented the data collection process.
CHAPTER IV

RESULTS

This chapter presents the findings of the study. The chapter begins with a discussion of Phase I of the study, which includes a quantitative assessment of participants’ leadership style. Quantitative results include a demographic overview of the sample and mean values for health care professionals’ MLQ-5X Short Form scores. The chapter concludes with Phases II and III, which expand on transformational leadership theory by describing the social processes of CNO transformational leaders.

Phase I Results

The researcher entered data into SPSS version 22.0 for Windows. Prior to analysis, data was screened for missing responses and outliers. Respondents with significant portions of data missing were to be removed from the dataset; no respondents had missing data. The researcher screened data for univariate outliers. To examine univariate outliers, standardized values, or $z$ scores, were calculated. Outlying values were those values below -3.29 or above 3.29 (Tabachnik & Fidell, 2012). No outlying values were found in the dataset. The researcher conducted data analysis on the responses of 25 participants.

Descriptive Statistics

The majority of participants were female ($n=23, 92\%$). Respondents held either a Master’s degree ($n=21, 84\%$) or a Doctoral degree ($n=4, 16\%$). A portion of participants had more than 20 years of leadership experience ($n=10, 40\%$). Table 4.1 presents frequencies and percentages for gender, highest level of education, and years of leadership experience.
Table 4.1 Frequencies and Percentages for Gender, Highest Level of Education, and Years of Leadership Experience Phase I Participants

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
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<td>Male</td>
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<tr>
<td>Doctoral Degree</td>
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<td>16</td>
</tr>
<tr>
<td>Years of Leadership Experience</td>
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<td></td>
</tr>
<tr>
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<td>28</td>
</tr>
<tr>
<td>More than 20</td>
<td>10</td>
<td>40</td>
</tr>
</tbody>
</table>

The researcher calculated means and standard deviations for the subscales of the MLQ-5X Short. Subscale scores were computed by summing participant responses on the items related to each subscale. Response options for MLQ-5X Short items were 0 = not at all, 1 = once in a while, 2 = sometimes, 3 = fairly often, and 4 = frequently, if not always. The subscales of the MLQ-5X Short were idealized influence, inspirational motivation, intellectual stimulation, individualized consideration, contingent reward, management-by-exception, and laissez-faire leadership. Scores on a subscale are categorized as high (9–12), moderate (5–8), or low (0–4). For the laissez-faire leadership subscale, the mean score was 3.58 (SD=2.02); this suggests that leaders’ scores were low for the laissez-faire leadership style. Leaders in the sample scored moderately on the management-by-exception (M=8.08, SD=1.84) and contingent reward (M=8.00, SD=2.18) subscales. Leaders scored highly on the idealized influence (M=10.0, SD=1.04), inspirational motivation (M=10.5, SD=.918), intellectual stimulation (M=10.3,
and individualized consideration ($M=9.80, SD=1.44$) subscales. Table 4.2 includes means and standard deviations for the MLQ-5X Short subscales.

Table 4.2 *Means and Standard Deviations for the MLQ-5X Short Subscales*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Minimum</th>
<th>Maximum</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealized Influence</td>
<td>9.00</td>
<td>12.00</td>
<td>10.00</td>
<td>1.04</td>
</tr>
<tr>
<td>Inspirational Motivation</td>
<td>8.00</td>
<td>12.00</td>
<td>10.50</td>
<td>.918</td>
</tr>
<tr>
<td>Intellectual Stimulation</td>
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<td>12.00</td>
<td>10.30</td>
<td>1.02</td>
</tr>
<tr>
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<td>7.00</td>
<td>12.00</td>
<td>9.80</td>
<td>1.44</td>
</tr>
<tr>
<td>Contingent Reward</td>
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<td>11.00</td>
<td>8.00</td>
<td>2.18</td>
</tr>
<tr>
<td>Management-by-Exception</td>
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<td>11.00</td>
<td>8.08</td>
<td>1.84</td>
</tr>
<tr>
<td>Laissez-faire Leadership</td>
<td>.00</td>
<td>6.00</td>
<td>3.58</td>
<td>2.02</td>
</tr>
</tbody>
</table>

**Transformational Leadership**

A new composite score, transformational leadership, was calculated from the items comprising the idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration subscales of the MLQ 5X Short. High scores ranged from 9–12, moderate scores ranged 5–8, and low scores ranged 0–4. For transformational leadership score, observations ranged from 7.25 to 11.75, with an average observation of 9.68 ($SD = 1.28$). The mean score reflects the fact that participants scored highly on transformational leadership as their leadership style.

**Phase II Results**

Individuals in health care leadership positions, specifically CNOs who scored high (score range of “high” equals scores between 9–12; see Appendix E) on MLQ-5X Short for transformational leadership, were interviewed regarding his or her social process related to key strategies and actions taken in his or her leadership role as a CNO in a hospital setting. This discussion focused on participants’ leadership philosophy that
informed his or her strategies and actions as a transformational leader. Additionally, CNOs revealed experiences with ineffective leadership and identified areas where the CNOs were able to improve their own practice, for example acknowledging mistakes and tailoring leadership to fit the environment. Finally, CNOs revealed the specific strategies employed with the staff and other executives, such as the CNOs’ “c-suite” peers to create safe and effective work environments. For example, CNOs encouraged keeping a patient-centered focus and engaging in shared governance. Appendix J presents the progression from open codes to substantive codes, and from substantive codes to themes and thematic categories found in the data.

**Category: Philosophical Perspective**

CNOs described their philosophical perspective as the basis for the strategies and actions he or she uses in the social process. The CNOs’ philosophical perspectives are the philosophy regarding how he or she incorporates transformational leadership into the CNOs’ existence, and how the CNOs’ cognitively think about being a transformational leadership leader. Each CNO transformational leader was asked to describe his or her personal leadership philosophy. Within this conversation, these professionals also revealed several characteristics of effective leaders. The themes presented in this section were selected because the themes related to these two concepts. The following themes emerged from the collected data:

**Strategies**

1. CNOs described their leadership philosophy as the basis for the strategies and actions he or she employs.
2. CNOs identified their leadership style as servant leadership, either directly or indirectly.

3. Leaders employed situational leadership and intentionally sought environments where their skills could be leveraged for success.

These themes are presented in further detail in the sections to follow. Figure 4.1 displays the coding progression from substantive code to thematic category for philosophical perspectives.

**Description of Leadership**

![Diagram](Diagram.png)

*Figure 4.1. Coding progression from substantive code to thematic category for philosophical perspectives.*

**CNOs identified being philosophically aligned with the leadership style of servant leadership, either directly or indirectly.** The majority of participants identified their leadership style as servant leadership. These leaders spoke of leadership that aligned with seeing themselves in service to the rest of the organization; the respondents’
litmus test to ensure a job well done was how well he or she served the rest of the organization. Participant 7 provided a vivid description of this role with the following:

I believe my leadership philosophy is one of a servant leader, and what I mean by that is that I believe my job (CNO) exists to serve the people who report to me (nursing services leaders), and I expect in return that their job (nurse managers and directors) exists to report to the nurse, and I expect the nurse's job exists to support and embrace our patients.

Participant 4 revealed, “my philosophy is that my role here (as the CNO) is to ensure that the organization, and particularly the nursing service, runs well so that the needs of the people who utilize this service—our patients and our community—are met.” Within this framework, Participant 4 proceeded to share the following:

if you have to put a coined phrase to it is that 'servant leadership' is probably one of the better words to use in the sense that, you know, my role is to help everybody to do their jobs and to be the best that they can at their job and what their own personal career aspirations might be, etc., so that we can serve our community and our patients in getting the best care for what they come to us for.

As a servant leader, the leader must support the organization in a variety of ways. Participant 1 stated, “That's really where my philosophy is around nursing leadership—what can I do as a leader to support the staff, to really make sure that they have the tools that the need to do their job.”

Leaders employed situational leadership and intentionally sought environments where their skills could be leveraged for success. In meeting the needs of the organization, servant leaders must be cognizant of the unique situation where he or she leads, and amend the process of leadership to meet the organization’s needs. Participant 3 stated, “I have always gravitated to Hersey and Blanchard, the Situational Leadership here you have the curve and you adapt your leadership style based on the audience or individual that you're leading.”
In adapting to the environment, servant leaders should examine the assets and weaknesses of the organization, and collaborate with other leaders including c-suite peers to develop a plan for the direction of the organization.

Participant 2 shared, “you match your style to the needs in a situation; every organization is different and you need to come in and assess the organizational strengths and weaknesses and adapt as a leader to meet the needs of the organization.” Participant 3 contributed to this idea of alignment as an integral aspect of effective leadership, revealing, “But it just is fascinating to me because you have to be able—back to situational leadership—you have to be able to match your leadership style with your goals and with the people.” Similarly, Participant 6 detailed how effective leaders can implement the alignment process in everyday practices with the following:

What I'll do, I'll sit back and I'll look at a group of people or a group of reports or a scope of responsibility and decide what kind of style does this group need right now? And then, at the same time, make sure that whatever style of leadership you apply in the moment, because of where you assess they are, then you continue to reassess the group as they mature because whatever style you started with the group is not necessarily going to be the same style they need as they mature.

This style of management builds on the strengths of staff and also affords an opportunity for staff to grow and develop new talents because the leader is responsive to his or her ability to master additional skill sets. Participant 12 identified this process and termed it “creating a climate of empowerment.”

Participant 5 detailed an environment in which leadership styles conflicted with culture, and as a result culture was affected. Participant 5 revealed the following:

We had gone through four CEOs in five years and the last one that was brought in was the antithesis of my style, was a former CNO who thought she knew my job as well as the CEO job. She's very micromanaging and totally, in my opinion, destroyed our culture. So you know, I'm not a victim and I knew that this wasn't going to work so, you know, I asked her to help me gracefully exit the
organization… So you've gotta know when that's not gonna work.

When faced with this dissonance, Participant 5 identified a mismatch between style and environment, and sought assistance in leaving the organization. By engaging in this process, the leader maintained service to the organization as the primary objective; in serving the organization, she discerned the need to exit her position to find an environment where her style could be leveraged for success.

**Strategies**

According to participants, a patient-centered focus, servant leadership and situational leadership were strategies CNOs described when creating a safe and effective work environment. The strategies driving this discussion were selected because of the perceived contribution of the strategies to the desired work environment. The following strategies emerged from the themes found in the results: (a) keeping a patient-centered focus, (b) servant leadership, and (c) situational leadership. Figure 4.2 shows the coding progression for strategies for safe and effective work environments.

*Figure 4.2. Coding progression from substantive code to thematic category for strategies for safe and effective work environments.*
These strategies emerged from the themes found in the results of 12 extensive interviews with CNOs and were aligned with leadership philosophies. The following sections included detailed descriptions of the themes that emerged pertaining to strategies and actions for safe and effective work environments. Included are the themes that emerged from participant discussions regarding what makes an ineffective leader, which highlights the necessary characteristics of a transformational leader.

**Safe and effective work environments.** The CNOs revealed a common set of strategies related to creating safe and effective environments within the organizations. The researcher selected the themes driving this discussion because of the perceived contribution of the themes to the desired work environment. Understanding these themes within the scope of the study creates a better understanding of the situational awareness necessary within a dynamic environment.

**Actions for Safe and Effective Work Environments**

The CNOs revealed a common set of actions related to creating safe and effective environments within the organizations. The themes in this category reflect how these leaders perceived their contribution to the desired work environment. The following themes emerged from the data. Figure 4.3 presents the coding progression from substantive code to thematic category for actions for safe and effective work environments.
Patient and staff advocacy. Underscoring the idea that quality patient service is the primary goal in health care, leaders communicated that keeping a patient-centered focus is key in creating a safe and effective work environment. As a result, considering outcomes for the patient in all processes and discussions was a strategy that leaders employed. Participants 7 and 12 noted that when advocating for resources in light of budget and overall resources, the participants kept in mind what is best for patient care, as exemplified by Participant 7’s statement: “And so if there's any conflict, we don't start talking about, you know, you did or this is what I need; we always talk about it in the context of what it did to the patient.” “If I would need to talk about pharmacy not being timely, it's not about them as a department or an individual, but I frame it in what that untimely measure or issue was done to the patient.” Participant 3 highlighted a question she poses whenever an issue arises regarding resources at a c-suite level, stating,
You know, my favorite question to ask when the exec team is kind of all whipped up about something—"So what's the best thing for the patient?" And that's kind of the "OH..." You know, everybody says "Oh yeah, of course." Because patient care is the purpose of health care, focusing on how actions affect patients is a beneficial strategy to redirect staff, bring teams together, and increase effectiveness.

**Leaders must be accessible and approachable.** Leaders indicated that both approachability and availability were more important than visibility in creating safe and effective work environments. Participant 6 broadened this discussion by making an important distinction between being visible and being available, saying “But you have to figure out how to make yourself accessible not only that you're able to be reached, but that when you sit down with someone, you're present.” Participant 7 described an experience where the previous leader was visible, but not available or approachable, stating the following:

Visibility—and my predecessor even in this role was seen to be the queen, and when I asked people what that meant like, she would do rounds on the floor but she would walk through and wave her hand like a queen... So she was visible; people saw her physical presence, but she was not approachable. So I work really, really hard to speak their language; I try to keep up somewhat clinically so I understand when I'm, you know, talking to them about sepsis and early recognition, why that's important.

Many leaders indicated *rounding* was an action that the leaders implemented to increase visibility. Participant 5 stated the following:

Bringing teams together and being visible; being out there; rounding on patients, rounding on staff, rounding on the managers. I just think good communication; visibility in a way to bring people together is the philosophy that I've found successful in my career.

Participant 10 stated that leaders, “[round] on staff as much as [they] can,” and Participant 7 echoed this sentiment, saying “I round every day, every week, and on weekends.”
To make themselves available to staff, participant 12 shared that she, “has an open door policy for anyone who wants to schedule specific time” for discussion or guidance. When the researcher probed her statement, the CNO clarified that by specific time she ensures the appropriateness of the request before engaging in conversation so that she does not undermine her leadership team. Participants 7 and 12 also reflected this sentiment. Participant 7 stated the following:

I do—I mean, everybody says they have an open door policy; I do in that I try to always find out what the issue is before I talk to the person, but anyone can make an appointment with me at any time and I'll sit and talk to them about the issue.

Access and availability was important in affording staff a venue to speak directly with leaders. Participant 6 offered a powerful reasoning for this availability, revealing:

Whenever anybody needs me, I respond. I do not push them away; I figure out how to meet their needs because if they took the time to reach out to me, I value that. I'm going to figure out how to give them the support and the time they need.

By being available to staff, leaders open the pipeline for communication, which contributes to a safe and effective work environment.

**Articulates a Clear Vision**

Participant 6 shared the following:

[One] is challenge the process. The second is inspire a shared vision. The third is enable others to act. The fourth is model the way. And then the fifth is called 'recognize the heart', but it's really recognizing other people's efforts, you know what I mean?

These strategies combined provide a blueprint for servant leadership within the context of nursing leadership. Participant 6 succinctly described the actual work of being a servant leader, and stated,

I think what I try to do is reach out to every individual and figure out where they are to build a relationship to build trust and then partner with them for change if that's needed, sustainability if that's needed.
Empowering and encourages growth. In serving the needs of the organization, the transformational leader grooms future leaders through the process of tailoring the environment to accommodate current strengths and needs. Participant 8 stated, “Good leaders surround themselves with good people, and so I just think that that's really important, to build up the team around you and to believe in them.” Offering opportunities to develop is integral to creating an environment conducive to success. Participant 7 revealed how she invests in future leaders in the same manner that previous leaders groomed her, sharing the following:

I mean, they saw something in me and they invested in me, so I constantly have a student who's with me, you know, getting their masters or I have new CNOs; they may have been CNOs for a long time, but they're new to this market and I take them with me everywhere so I think people see that I give back and I invest and, you know, if they want to follow me or want to see what I'm about, too, I always make room for students or mentorships.

Transformational leaders committed to developing future talent integrate this thrust into the leaders’ leadership philosophy. According to Participant 12, her “personal mission… [and] purpose for leading is to grow and develop others.” In assisting others with professional growth, servant leaders indicated the importance of acknowledging and learning from mistakes.

Shared governance is fundamental to the decision-making process. Shared governance and a team approach are important to the practice of nursing leadership because leaders are not always experts in all areas they guide. Participant 12 revealed:

early in my leadership career, I thought it was my job, to make all the decisions. And as you learn about what decisions you're really qualified to make and what you're not, you begin to say "Wow, I need to engage other people for those decisions that I'm not the most knowledgeable, I'm not the most adept or I just need some feedback on these things." So I think learning about how to triage decision-making has been one of those things that has been really helpful to me and it takes a little courage.
This reality encourages leaders to engage in a shared governance structure for decision-making. Participant 5 stated, “We also have shared governance, so we have a pretty robust shared governance model, so people on the unit are making the decisions that impact them the most; it's not the managers being a dictator.” Empowering individuals on the front lines to join the conversation related to how the organization functions increases the effectiveness of the organization. Participant 7 provided a detailed view of this in practice with the following:

From a day-to-day perspective, I very much believe in shared governance, and that means shared decision making, so you have to have structures in place for that really to be alive in a work setting, and that means I really create and embrace and demand a professional practice model for nursing, so that includes getting nurses at the bedside to address quality issues, peer review issues, education, evidence-based practice issues.

Incorporating these diverse perspectives on patient care provides an opportunity for rich discourse related to constructing an effective work environment.

Subtheme. Shared governance is a primary tenet of Magnet designation, and one of the 14 “forces” driving Magnet philosophy. Participant 8 illuminated the importance of shared governance in the context of Magnet designation. Participant 8 shared the following:

And so you have to learn about, you know, decision-making, and so I think that the whole Magnet structure and programing really did enable some of that for me because I learned very early on that a group—a roomful of CNOs should probably not be the group who makes the decision about what kind of drapes we use in the OR.

Through this contribution, Participant 8 was able to demonstrate the link between the Magnet designation and shared governance. Shared governance is an integral component of the Magnet structure, and it is a driving component of effective decision-making.
Although Magnet status was only addressed in one participant interview, its salience to the topic of effective leadership and decision-making warranted its inclusion as a subtheme.

**Transparency.** Honesty and transparency were repeatedly highlighted as a strategy for effective leaders to create the desired relationships and environment.

Participant 8 stated, “I've learned that I need to be transparent and honest…. I think it is probably the strongest commitment we all have to make as leaders.” This commitment helps in building trust between leaders and staff. Participant 11 detailed:

The importance of transparency in leading clinical organizations” is that “when I need to advocate, [transparency enables] my effectiveness because I am coming into the conversation with individuals where I have established trust and have been transparent.

This transparency, coupled with honesty, constructs an environment where individuals are willing to entrust the leader with setting the direction and guiding decisions for the organization. Participant 12 addressed the direct link between the importance of honesty and transparency, and being effective in a leadership role, stating, “Because those are the things you need to make visible to people so they can decide 'Do they want to follow you?'” Without buy in from staff and peers, leaders lack the effectiveness necessary to guide organizations and frame discussions related to decision-making.

**Transparency: Acknowledging mistakes is a key aspect of providing effective leadership.** Nursing leaders recognized the importance of identifying their mistakes and the potential for empowering others to act similarly, while considering mistakes as opportunities for development. Participant 3 shared the following:
I had a chief nurse once that taught me a valuable lesson. You know, she would do something—I've always been of this belief that, you know, as leaders we always have to kind of put ourselves above reproach, but this woman used to say "I really screwed that up and I thought wow"—you know, that is such a good lesson for me because that personal transparency of saying "I really messed that up" gives other people space.

Transformational leaders saw a chance to empower staff, rather than castigate staff when members make mistakes. Participant 8 stated, “We all constantly strive, or should strive, to become better leaders by understanding the weaknesses that we have. I think that makes us stronger.” In identifying areas of weaknesses and endeavoring to address these areas, leaders model for staff how they can grow and develop; the underlying concept that dissonance yields growth when properly supported gives rise to the idea that effective leaders should support development. Participant 1 detailed what this looks like in practice:

I think over time I learned that it's okay not to be that hands-on and to let things happen and to support as they happen, and even if they don't end up—even if you know there's probably a better path to go, letting people try to move through the paths because they're learning at the same point—of course, putting those guardrails up so that they don't completely fall off the ship, but just providing that type of support as people learn and grow and make change because that's how you end up with more sustainable change.

Effective leaders believed that this process of allowing staff to navigate the path to improving his or her own practice through learning and experience produces enduring change that cultivates the next wave of effective nurse leaders.

**Category: Ineffective Leadership**

The researcher asked the CNOs to provide examples of ineffective leadership. Related to this discussion, these professionals also described areas for improvement of leaders. The topics presented in this section drove the discussion related to ineffective leadership. The following concepts were gleaned from the data: (a) partiality as divisive
within teams; (b) punitive leadership was not effective within nursing leadership; and (c) ineffective leaders lacked patience, struggle with compromise, and can be reactionary with decision actions. Figure 4.4 presents the coding progression from substantive code to thematic category for ineffective leadership.

**Figure 4.2.** Coding progression from substantive code to thematic category for ineffective leadership.

The researcher recognized the importance of including a discussion of ineffective leadership to further illuminate the practices of effective leaders. The following sections present these topics in detail.

**Partiality is divisive within teams.** Participant 4 described the effect of one’s inability to be impartial to the relationship between leaders and staff in a previous position. This experience, although negative, influenced Participant 4’s future practice by making her mindful of avoiding relationships with staff that may make other staff feel
alienated or show priority to an individual person or unit. Participant 4 recalled a time when she was not yet a CNO, “We always felt that this person got priority, so it made us very distrustful of this CNO.” Ultimately this affected the relationship between the CNO, the staff member, and the rest of the staff. Participant 4 shared: “Not only did we not trust her; we didn't trust that other director. So it was a big wedge inside of our team.”

The potential division amongst staff members caused Participant 4 to avoid situations with staff where the whole team is not invited to participate. Participant 4 revealed, “If one of your group (direct reports) asks you to go to dinner by themselves and as a buddy-buddy friendly type of thing, then I think I have an obligation to turn that down unless others are invited to participate.” According to Participant 4, partiality has the potential to divide teams and erode trust in leadership. Because this may ultimately affect the effectiveness of the organization, an effective leader avoids interactions that may convey favoritism.

**Punitive leadership was not effective within nursing leadership.** Situated in the belief that servant leaders supported staff through the process of learning mistakes, is the belief that effective leaders do not practice punitive leadership. Participant 4 stated, “No, a blameful, a punitive, I'm gonna punish you, it gets you nowhere.” Leaders willing to engage staff in the process of navigating dissonance avoided placing blame and instead focused on creating teachable moments. Participant 10 echoed this sentiment, stating that within practice the leaders “allow for mistakes.”
Ineffective leaders lack patience, struggle with compromise and are reactionary at times. Participants 3 and 8 identified patience and compromise as two areas he or she has developed within his or her own careers to become effective leaders. Participant 8 saw compromise as an area where nurses grow as leaders. She shared:

And early on I was oftentimes criticized as being very black and white. I will tell you that I think that black-and-white characteristic is what makes me feel like I'm not gonna negotiate on things like quality and safety are those types of things. But it wasn't always a positive thing. I was quick to react or to have an opinion or whatever, and as I moved into leadership roles I've realized it's really important not to do that.

Opportunities for learning included compromise and meeting staff. Participant 3 described how they came to realize the importance of patience as a leader, stating “It's me really realizing that things don't always happen on my terms and a little more patience sometimes is required and I've been more accepting of that than perhaps I was early on.”

Patient leaders allow staff to learn in a manner that promotes sustainable change.

When saturation occurred, Phase III analysis and conceptualization occurred in two steps. Saturation in Phase II was reached with 12 participants. The majority of Phase II participants were female (n=11, 92%). Few participants held doctoral degrees (n=2, 17%); the remaining Phase II participants held master’s degrees (n=10, 83%). Most participants had 15–20 years of leadership experience (n=9, 76%). Table 4.3 presents frequencies and percentages for gender, highest level of education, and years of leadership experience Phase I participants.
Table 4.3 *Frequencies and Percentages for Gender, Highest Level of Education, and Years of Leadership Experience Phase I Participants*

<table>
<thead>
<tr>
<th>Phase II Participants</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>08</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Years of Leadership Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–5</td>
<td>1</td>
<td>08</td>
</tr>
<tr>
<td>5–10</td>
<td>1</td>
<td>08</td>
</tr>
<tr>
<td>10–15</td>
<td>1</td>
<td>08</td>
</tr>
<tr>
<td>15–20</td>
<td>9</td>
<td>76</td>
</tr>
</tbody>
</table>

Step 1. Phase III was initiated with six participants from Phase I who did not participate in Phase II. Six CNOs, based on their availability to participate within the allotted timeframe for data collection, were asked to validate and confirm findings using a member-checking approach, which assisted the researcher in evaluating fitness of the expanded theory. The researcher contacted the CNOs for telephone interviews where the researcher presented the themes that emerged from Phase II. The CNOs interviewed shared that the themes that had emerged were consistent with their experience of CNO transformational leaders. The CNOs interviewed did voice some surprise that there was not a stronger “Magnet” theme that emerged from the Phase II interviews. While Magnet was mentioned in the context of shared governance, the CNOs interviewed did not discuss his or her philosophy, strategies or actions regarding their social processes within the Magnet program.

Step 2. Six participants from Phase I and II were contacted to validate expanded theory. Participants were contacted and invited to participate in a follow-up telephone
call where the researcher presented the model. The researcher reviewed the expanded theory and conceptual framework with the six participants. Themes from review of the conceptual framework (Figure 4.5) with Phase III step II participants were:

1. Similar to the researcher, participants were not aware of the overlap between transformational leadership and servant leadership.

2. Participants were not surprised to learn that transformational leadership described themselves as servant leaders.

3. Validation of expanded theory of transformational leadership revealing that CNO strategies and actions are influenced by a CNOs philosophical perspective occurred during follow-up phone interviews. All CNOs voiced that their experience of their own roles was consistent with the conceptual framework. All six CNOs agreed with the place of philosophical perspective, and the six CNOs contacted stated that this finding, while it should be obvious, was somewhat of a surprise. One CNO suggested that this may be because of the lack of discussion in the literature surrounding strategies and actions. A second CNO suggested that much of the nursing leadership literature is related to specific leadership styles, which may influence the way CNOs use a certain language to describe leadership experience. Three CNOs agreed with the strategy of situational leadership as put forth in the conceptual framework.

4. Strategies and actions with Phase II step two participants were validated with CNOs voicing no surprises with strategies and actions, and common agreement existed among CNOs with respect to strategies and actions.
Summary

This chapter provided a brief review of the qualitative approach used within this study. The researcher presented the results of the quantitative analyses. These results revealed that nursing executives surveyed on the leadership style scored high in transformational leadership. The chapter also presented a discussion of the themes developed from this study. Related to the topic of leadership philosophy, professionals identified their leadership style as servant leadership, either directly or indirectly. Effective leaders employed situational leadership or intentionally sought environments
where the leaders’ skills could be leveraged for success. The leaders included in this or her philosophy a belief that the leaders should encourage growth and create an environment conducive to success. Servant leaders also believed that acknowledging mistakes is a key aspect of providing effective leadership.

Regarding strategies and actions for safe and effective work environments, leaders posited that keeping a patient-centered focus is key. Participants believed leaders must be visible and available to staff. Participants revealed that honesty and transparency were present in safe, effective work environments. According to participants, a shared governance structure and teamwork in the decision-making process were present in safe and effective work environments. Regarding examples of ineffective leadership, partiality was identified as a divisive factor within teams. The participants highlighted punitive leadership as an ineffective leadership style. Some participants remarked that ineffective leaders lacked patience and compromise. Finally, leaders identified the uncertain direction of health care reform and its effect on nursing as a future issue for CNOs.
CHAPTER V
DISCUSSION

The purpose of this qualitative study utilizing grounded theory analysis methods was to expand transformational leadership theory through a descriptive qualitative study utilizing a grounded theory design. The researcher used a GT constant comparative technique for investigating the nature and social processes of transformational leadership nurse leaders. Chapter V is organized in the following manner: restatement of problem, specific aims, research methods, introduction of expanded theory, discussion of findings, limitations, and implications for nursing.

Specific Aims

The researcher established two specific aims for the study. First, the researcher aimed to examine the social processes used by transformational leaders to influence individuals within an organization who are used to effect positive outcomes. The researcher gained an understanding of (a) the specific strategies used by transformational leaders in their social processes, and (b) how a transformational leader’s strategies relate to specific actions and how strategies and actions change depending on the specific individual the transformational leader is engaging.

To understand the social processes used by transformational leadership to influence others, the researcher asked the following questions:

1. What is the transformational leadership philosophy that sets the stage for how the transformational leadership leader enters the social process?
2. What are the strategies and actions that transformational leaders use to influence outcomes?
The second aim of the study was to validate the fitness of the emerging theory related to the social processes used by transformational leaders.

More specifically, this research contributes to the theoretical underpinnings of transformational leadership and explains the strategies and actions of transformational nurse leaders who contribute to the transformation of nursing work environments and improving patient and organizational outcomes. This chapter provides a rationale and overview of the research methods used to complete this study, as well as a discussion of the findings. From the analysis of the emergent themes, the researcher concluded that the findings support an expanded theory of transformational leadership that incorporates strategies and actions, which create a viable and efficacious leadership design.

Furthermore, the researcher found a hybridization of the two theories supports a contextual leadership model, which is not to be confused with strategic leadership that focuses on situations occurring at the executive level (Carter & Greer, 2013; Vera & Crossan, 2004). Finally, in this chapter the researcher discusses the implications for practice, limitations of the study, and recommendations for future research.

**Research Problem**

In 2004, The IOM addressed a need for the application of transformational leadership into nursing work environments to promote patient safety, which resulted in an increase in research articles related to the concept of transformational leadership. What remains unclear in the literature is a precise understanding of the strategies and actions transformational leaders use to operationalize the goals that demonstrate the characteristics of transformational leadership. Though management and leadership failures receive far less attention than clinical failures, such failures can still result in
harm to patients and health care organizations (Reason, 1990; Rundall et al., 2007). For a broad uptake of transformational leadership to occur, sufficient understanding is needed regarding the specific strategies and actions of transformational leadership.

An increased understanding of transformational leadership accelerates progress and fosters a culture of safety and improved nursing environments. Despite modest and growing agreement in the literature, studies using qualitative approaches have been limited; particularly, grounded theory approaches are especially scarce. This research addresses the gaps in existing knowledge related to specific strategies and actions of nurse transformational leaders by incorporating grounded theory methods.

Summary of Rationale and Research Methods

One of the primary goals of this research study was to address seminal researchers of transformational leadership theory (Bass, 1991, 1999, 2000; Bass & Avolio, 1993), and call for more empirical research that may contribute to the field of leadership. Traditional transformational leadership research centered on leaders’ traits and actions (Gerstner & Day, 1997; Van Breukelen et al., 2006). Understanding the nature of the social processes, including the specific strategies and actions of nurses who practice transformational leadership, presents a valuable extension of existing transformational leadership theory.

The orientation of this study provides a clear and direct understanding of precisely how to develop and advance uptake of transformational leadership within a hospital, and by extension, improves nursing work environments and advances patient safety. Researchers have well documented transformational leadership strategies and actions as having positive effects on job satisfaction, safety culture, trust,
organizational commitment, intentions to leave, organizational identification, and organizational citizenship tactics (Bass & Riggio, 2006; Judge & Piccolo, 2004; Lowe et al., 1996; MacKenzie, Moorman, & Fetter, 1990). Extending knowledge of specific strategies and actions that produce favorable outcomes is beneficial to health care organizations.

This study occurred in three phases. The first phase engaged 25 participants to complete the MLQ-5X Short in order to differentiate leadership styles among the participants. The MLQ-5X Short allowed for an accurate measure of transformational leadership styles. Only the information pertaining to the separation of these individuals was used to solidify the sample and was not used any further in the study.

During Phase II of the study, the researcher conducted interviews to investigate the social processes of transformational leadership for CNOs. The researcher utilized a qualitative design with a grounded theory constant comparative technique in order to gain rich, descriptive information regarding leadership styles within a sample of CNOs. A qualitative research study allows for exploratory research, where the specific variables of the study are unknown; this researcher also involves methods that ultimately enable the emergence of a new theory, which could present a significant contribution to nursing science (Creswell, 2012). Grounded theory’s constant comparison method is well suited to enhancing the knowledge and understanding of the nature of leader actions and interactions. The researcher accomplished this through the incorporation of the foundational elements of constant comparison and theoretical sensitivity (Munhall, 2007). The importance of the constant comparison approach to the present study was that
this approach aided the researcher to uncover the social processes of transformational leadership.

**Expanded Theory of Transformational Leadership**

One of the major themes that emerged in the results was the perception of being servant leaders. In an effort to understand the theme of CNOs viewing their leadership through multiple lenses, Table 5.1 compares the two leadership theories and illuminates specific areas of overlap in functional and accompanying attributes between the two complimentary theories. When juxtaposed as in Table 5.1, transformational leadership and servant leadership have relatively analogous characteristics. The major difference between these two theories is that servant leadership focuses outward on the individual or group the leader is serving, whereas transformational leadership focuses on the leader (Bass, 1999; Carter & Greer, 2013). This may occur because both transformational and servant leadership present attempts to define and explain people-oriented leadership styles. According to both concepts, the leadership frameworks incorporate: (a) influence, (b) vision, (c) trust, (d) respect or credibility, (e) risk-sharing or delegation, (f) integrity, and (g) modeling (Bass, 2000). Transformational leadership characteristics contribute to a CNOs ability to positively engage the staff while maintaining a patient-centered focus, therefore achieving multiple benefits for the patient, hospital, and community. From the literature, a transformational leader is bound to the service of the organization, and that leader may serve the community as a secondary benefit; however, the primary focus for a servant leader is placing the needs of the community before the leader’s own needs (Bass, 2000).
Table 5.1 *Comparison of Transformational Versus Servant Leadership Attributes*

<table>
<thead>
<tr>
<th>Transformational Leadership Attributes</th>
<th>Servant Leadership Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Idealized (charismatic) Influence</strong></td>
<td>Influence</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision</td>
</tr>
<tr>
<td>Trust</td>
<td>Trust</td>
</tr>
<tr>
<td>Respect</td>
<td>Credibility and Competence</td>
</tr>
<tr>
<td>Risk-sharing</td>
<td>Delegation</td>
</tr>
<tr>
<td>Integrity</td>
<td>Honesty and Integrity</td>
</tr>
<tr>
<td>Modeling</td>
<td>Modeling and Visibility</td>
</tr>
<tr>
<td><strong>Inspirational Motivation</strong></td>
<td></td>
</tr>
<tr>
<td>Commitment to Goals</td>
<td>Stewardship</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication</td>
</tr>
<tr>
<td>Enthusiasm</td>
<td></td>
</tr>
<tr>
<td><strong>Intellectual Stimulation</strong></td>
<td></td>
</tr>
<tr>
<td>Rationality</td>
<td>Persuasion</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>Pioneering</td>
</tr>
<tr>
<td><strong>Individualized Consideration</strong></td>
<td>Appreciation of Others</td>
</tr>
<tr>
<td>Personal Attention</td>
<td>Encouragement</td>
</tr>
<tr>
<td>Mentoring</td>
<td>Teaching</td>
</tr>
<tr>
<td>Listening</td>
<td>Listening</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Empowerment</td>
</tr>
</tbody>
</table>


The hospital environment presents an excellent example of crossover of purposes within the leadership environment. The positive effects of transformational leadership strategies and actions include increased self-actualization, self-esteem, and self-efficacy (Bass & Riggio, 2006; Dvir et al., 2002; Shamir et al., 1998). Table 5.2 displays the attributes of a transformational leader, which cover a wide range of traits.
Table 5.2 *Characteristics of Transformational Leaders (Bass, 1991)*

<table>
<thead>
<tr>
<th>Charisma</th>
<th>Inspiration</th>
<th>Intellectual Stimulation</th>
<th>Individualized Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides vision and sense of mission</td>
<td>Communicates high expectations</td>
<td>Promotes intelligence</td>
<td>Gives personal attention</td>
</tr>
<tr>
<td>Instills pride</td>
<td>Uses symbols to focus efforts</td>
<td>Rationality</td>
<td>Treats each employee individually</td>
</tr>
<tr>
<td>Gains respect and trust</td>
<td>Expresses important purposes in simple ways</td>
<td>Careful problem solving</td>
<td>Coaches and advises</td>
</tr>
</tbody>
</table>

The four major categories in Table 5.2 provide the framework of leadership influence, vision, trust, and credibility (Bass, 1991), which coincide with the CNOs' description of servant leadership, described in detail in the next section. Participants in this study expressed a servant leadership style that is patient-focused; however, the participants exhibited transformational leadership characteristics through descriptions of the CNOs’ strategies and interactions with employees. A hybridization of transformational leadership theory and servant leadership best describes an expanded transformational leadership theory for CNOs. Leadership and decision-making were based upon context of the situation. Because CNOs were patient-focused, the CNOs’ strategies guided their actions, which affected patient outcomes and benefited the organization as well. Noting the differences in the theories advances the hybridization of both theories in order to compensate for the contextual nature of CNO leadership.
Definitions

Philosophical perspective

Philosophical perspective is the underlying belief system that influences the strategies that guide leadership practice.

Strategy

Leadership strategy, a critical component to an organization’s success, is a complex cognitive process undertaken by transformational leaders, which includes a critical evaluation of the current state of a situation or environment against a desired future state. This cognitive process then drives a set of specific actions intended to close an identified gap or achieve a desired future (Passmore, 2013). Once implementing a leadership strategy, clinical and organizational outcomes inform the effectiveness of a particular leadership strategy. Effective leader strategies in nursing result in improved work environments for nurses, improved patient safety, and improved health outcomes.

Actions

In the context of leadership, action can be described in terms of three major domains: completing tasks, managing individuals, and managing teams. The researcher believes that transformational leaders, in executing their role, take specific actions based on their own leadership philosophy.

Social process

Gillin and Gillin (2008) described social process as those observable ways of interacting when groups and individuals engage in the establishment of a system of relationships (Kavitha, 2009). Social process can also be described as what happens when change disrupts existing modes of life. Gilin and Gillin describe the social process
in terms of three types of interactions: General, associative and dissociative (Kavitha, 2009).

Negative factors of poor leadership described by the participants refine the categorical factors of positive leadership attributes. Regarding examples of ineffective leadership, partiality was identified as a divisive factor within teams. In addition, punitive leadership was highlighted as an ineffective leadership style. Some participants remarked that ineffective leaders lacked patience, the ability to compromise, and were reactionary at times. Finally, leaders identified the uncertain direction of health care reform and its effect on nursing as a future issue for CNOs. Because of the dynamic environment in which CNOs work, leaders are less effective when reacting to situations and disregard the employees. Leadership models that incorporate contextual and situational awareness allow a CNO to function in the best interest of the patient and the employees.

**Strategies for Safe and Effective Work Environments**

According to the participants, a patient-centered focus, servant leadership, and situational leadership were strategies CNOs described when creating a safe and effective work environment. The researcher selected the strategies driving this discussion because of the perceived contribution of the strategies to the desired work environment. The following strategies, as presented in Figure 4.5, emerged from the themes found in the results: (a) keeping a patient-centered focus, (b) servant leadership, and (c) situational leadership.

These strategies emerged from the themes found in the results of 12 extensive interviews with CNOs, aligned with leadership philosophies. The following sections
describe in detail the emerged themes pertaining to strategies and actions that CNOs engaged as part of his or her social processes. The following includes the themes that emerged from participant discussions regarding what makes an ineffective leader, which highlights the necessary characteristics of a transformational leader. The CNOs revealed a common set of strategies relating to creating safe and effective environments within the organizations. The researcher selected the themes driving this discussion because of the perceived contribution of the themes to the desired work environment. Understanding these themes within the scope of the study creates a better understanding of the situational awareness necessary within a dynamic environment.

**Keeping a Patient-Centered Focus**

One of the most common themes that emerged dealt with CNOs’ perceived core competency, which was to ensure that nurses and patients had what he or she needed regarding resources to foster safe nursing work environments and patient safety. According to Woodhouse, Burney, and Costa (2004), the efforts to improve patient safety were largely aimed at preventing human error rather than system error. One participant explained, “I frame it in what that untimely measure or issue was done to the patient.” Similar to intentional self-disclosure as a strategy to keep patients safe and promote safe work environments, CNOs shared several operational strategies and actions that the CNOs employed in their social processes.

The CNOs explained that keeping the patient in the center of any discussion, even in the budget process, diffused historical struggles regarding scarce resources. The CNOs shared that by keeping patients as central to a budget discussion enable the CNOs to
move beyond competing with other departments, instead fostering the ability to prioritize how best to use financial resources to advance patient safety and promote safe nursing environments. One participant mirrored this belief, stating, “we always talk about it in the context of what it did to the patient,” which reiterates a patient-focus environment that is necessary for the success of the organization. Fiscal issues were part of the cultural environment; however, the CNOs always kept personal beliefs aside.

Chief nursing officers are servant leaders who provide feedback to other leaders, which directly relates to patient needs and outcomes, and in turn benefits the working community, as well as the community served. Servant leadership includes: “the view that leadership exists to serve those led and to fulfill the needs of those served. In an organizational hierarchy, those served include supervisors, peers and subordinates” (Bass, 1999, p. 8). A patient-centered environment upholds the personal beliefs that CNOs are servant leaders, but the transformative leader is able to convince those within the field of influence to understand that the needs of the individual are the needs of the community. The lack of resources for patient care is arguably contextually based and not situational. As described by Zori et al. (2010), patient care may vary from day-to-day and different processes are needed from individual to individual; the context of the situation is always changing.

**Philosophical Perspective**

**Servant Leadership**

The CNOs’ self-identified leadership style was servant leadership. The participants revealed a common philosophical orientation sharing a significant core perception related to his or her leadership process, which was to provide a professional
and values-oriented service to the nurses working under the CNOs. The participants described service as the primary social process, which was service to the leadership team, directly or indirectly to nursing staff, to patients, and to the community. One participant explained that the CNO role was “to ensure that the organization, and particularly the nursing service, runs well so that the needs of the people who utilize this service—our patients and our community—are met.”

Furthermore, the participants’ perceived primary role was to serve patients by ensuring that patients were safe and free of harm. Similarly, the CNOs described their social processes with front-line nursing as a service to nurses by ensuring that nurses have the necessary resources (staff, supplies, equipment, and leadership) to safely care for patients. Another participant described this, stating the CNO “role is to help everybody to do their jobs and to be the best that they can at their job.” The participants described mentorship of managers and directors as an important social process, philosophically underpinned by service orientation. The findings revealed a perception among CNOs that all of their decisions and interactions are grounded in a service philosophy.

The CNOs reflected that their service orientation as leaders was rooted in the nursing process and who the CNOs are as nurses, preceding and informing who the CNOs were as leaders. The participants reported their experiences as nurses interacting with the environment grounded their leadership process in service. A servant leader is described as one that selects “the needs of others” (Bass, 2000, p. 33) as a priority, which enhances the organizational goals from an individual to a societal level (Carter & Greer, 2013). According to Carter and Greer (2013) and Bass (2000), dynamic and changing
environments create a distinction between servant and transformational leadership, where servant leadership is more efficacious in the stable and consistent environment. The CNOs belief in “serving their community and patients” touches upon the servant model, whereas the environment in which the CNOs work does not.

The medical field, particularly hospitals, is a dynamic environment that experiences changes in technology, staffing, procedures, and internal policies directed by legislation. Bass (1991) described the prime conditions for transformational leadership under the persistence of change and adaptation to market conditions and advancements in technology, which “in order to succeed, the firm needs to have the flexibility to forecast and meet new demands and changes as they occur—and only transformational leadership can enable the firm to do so” (p. 31). In order to rectify the disjunction between servant and transformational leadership, CNOs may need to follow a hybridized theory combining the positive elements from servant leadership and transformational leadership, which the researcher will explored further while discussing the themes.

**Situational Leadership**

Emerging from the investigation and the CNOs’ description of his or her leadership philosophy, no one single theory of leadership explains every phenomenon or social process in the CNOs’ environment. One participant described the need for situational awareness, where the “philosophy of leadership is that you match your style to the needs in a situation.” The CNOs shared that the environment informs their actions and social processes. The participants discussed their environment oftentimes as a series of unique situations with individuals and groups having different needs. Zori et al. (2010) confirmed this belief through the following:
The nurse manager is the person upon whom staff RNs depend for guidance in solving a myriad of problems that arise on a daily basis. Nurse Managers strong in analyticity may be better able to effectively and promptly help solve clinical, interpersonal, knowledge deficit, or process-related problems.

The CNOs described that within the hospital setting, he or she may enter into unique and different social processes depending on the group or individuals with whom he or she is engaging.

The CNOs shared personal examples of situations that occurred earlier in their careers, when the CNOs did not possess the ability to adapt their leadership style to the specific needs of an individual or group. One CNO described their adaptation as “Whatever style you started with the group is not necessarily going to be the same style they need as they mature.” The CNOs described their ability to adapt to unique situations as leadership strength and as contributing to their success. “What I'll do, I'll sit back and I'll look at a group of people or a group of reports or a scope of responsibility and decide what kind of style does this group need right now?” Each situation analyzed deserved a contextual analysis from the manifold of points of view that focused solely upon the care and well-being of the patient—patient-centered attention. Personal leadership values direct the actions of a leader when faced with a situation “that requires a choice between different strategic options” (Carter & Greer, 2013, p. 378). Having situational awareness and a patient-centered focus creates heightened levels of trust in nursing staff because of attention to safety through credible support and experienced guidance (Zori et al., 2010).

The CNOs discussed the importance of the environment matching the CNOs’ unique skills. One CNO offered an example of where there was not a “fit” between their ability to serve the unique needs of an organization, leading to their belief that they would not be able to be successful in serving; therefore, they would elect to remove themselves
from the environment, rather than continuing. The participants discussed the concept of fit between a CNO’s leadership and the needs of the environment as being important to the CNO’s success or effectiveness throughout the in-depth interviews. The CNOs spoke with conviction concerning the importance of leadership “fit” and his or her ability to effectively lead. The contexts in which the CNOs were leaders defined their ability to lead. The participants perceived situational awareness and focus upon patient as necessary strategic constructs for nurse leaders.

Themes Identified

Actions for Safe and Effective Work Environments

Patient and staff advocacy. Underscoring the idea that quality patient service is the primary goal in health care, leaders communicated that keeping a patient-centered focus is key in creating a safe and effective work environment. Participants 7 and 12 noted that when advocating for resources in light of budget and overall resources, the leaders kept in mind what was best for patient care. Participant 7 stated, “And so if there's any conflict, we don't start talking about, you know, you did or this is what I need; we always talk about it in the context of what it did to the patient.” “If I would need to talk about pharmacy not being timely, it's not about them as a department or an individual, but I frame it in what that untimely measure or issue was done to the patient.” Participant 3 highlighted a question she poses whenever an issue arises regarding resources at a c-suite level, stating:

You know, my favorite question to ask when the exec team is kind of all whipped up about something—“So what's the best thing for the patient” And that's kind of the “OH…” You know, everybody says “Oh yeah, of course.”
Because patient care is the purpose of health care, focusing on how actions affect patients is a beneficial strategy to redirect staff, bring teams together, and increase effectiveness.

Leaders must be accessible and approachable. The next theme that emerged related to the CNOs intentional prioritizing and scheduling time with staff being perceived as both a strategy and an action the CNOs use in their social processes. Two CNOs described earlier points in their careers where he or she prioritized other aspects of his or her work instead of being visible. The participants discussed the multiple demands in the day and all offered specific strategies such as “town hall” meetings with staff “patient safety rounds,” “staff rounding,” and holiday and week-end rounding in patient care areas. One CNO described her process of open forum sessions, where staff are able to meet with the CNO and the CNO intentionally has no agenda. One participant described how she intentionally allowed the agenda to be the staff’s agenda. She shared that this was difficult because invariably she had questions she wanted to ask staff when spending time with staff; however, when rounding with staff or doing open forums, she suspends her typical agenda, changing it to the staff’s agenda.

Importantly, the CNOs allowed for individual, one-on-one time, which enhances the CNO’s role as servant leader by caring for employee needs. One participant expressed that he or she tries to “figure out how to meet their needs because if they took the time to reach out to me.” This sentiment aligns with transformational leadership, as

The quality of relations between the leader with an individual subordinate depended on the superior supporting the self-worth of the subordinate by showing confidence in the subordinate’s integrity, ability and motivation, and attending to his or her feelings and needs. (Bass, 1999, p. 6)

One participant described the importance of being visible with ancillary departments in order to foster collaboration. Pharmacy was an example of where this
CNO rounds with staff to foster collaboration between nursing and pharmacy. The same CNO described her process in serving staff by fostering partnership on the staff’s behalf with other department, therefore creating a culture of reaching out to other departments, which is indicative of transformational leadership.

**Articulate a clear vision.** The next action articulated by CNOs was one of articulating a clear vision for nursing that is consistent with Bass and Avolio’s characterization of transformational leadership. Transformational leadership theorists have identified foundational characteristics of transformational leaders including the ability to establish a culture of shared vision around a set of collective beliefs and values. Participant 6 shared the following:

[One] is challenge the process. The second is inspire a shared vision. The third is enable others to act. The fourth is model the way. And then the fifth is called 'recognize the heart', but it's really recognizing other people's efforts, you know what I mean?

**Empower and encourage growth.** The next theme emerged from the CNOs’ perceived importance within employee professional development and the success of those the CNOs lead. The CNOs described the use of formal structures such as nursing centers of excellence, formal mentorship programs, and investing in onsite formal education programs to enable nurse managers and directors pursue advanced degrees. The participants discussed common strategies in the social process of developing future nurse leaders, such as visualizing themselves as mentors and coaches, which was reflective of the characteristics of a transformative leader described earlier.

According to Bass and Avolio (1993), transformational leadership creates a culture of personal growth through the values and behaviors the leaders exhibit “as mentors, coaches, role models, and leaders… because they feel a personal obligation to
help” (p. 118) the employees. The CNOs’ efforts to develop future leaders is part of their social processes with direct reports, which reflects the earlier self-description of servant leadership; however, the research literature describing transformational leadership theory suggests the same factors, which indicates a discrepancy between CNO perceptions of leadership and research literature. Bass (1999) stated:

Transformational leaders focus on the self-concept of the employee and the employee’s self-esteem. The leader encourages the follower to build a self-concept that identifies with the leader’s self-concept and mission. Striving for consistency, the follower is motivated to exert extra effort to match the follower’s own self-concept with the perceived expectations of the leader, thereby raising his or her own self-esteem. (p. 8)

The conflicting perceptions between CNOs and the research literature reiterates the necessity for the hybridization of the two theories through contextual leadership within a dynamic environment. The CNOs fulfill the servant leadership role through advocacy of patient’s well-being, and fulfill the transformational leadership role through the advocacy of employee development. Both theories contribute positive concepts to the hybridization of a contextual model, where situational analysis and adaptation benefits the leader, patient, and employee.

**Transparency**

*Acknowledging mistakes is a key aspect of providing effective leadership.* An important theme that emerged was the perception of a CNO acknowledging mistakes when made. Participants shared their beliefs that acknowledging personal mistakes in their social processes contributed to establishing leadership credibility.

Specifically, the CNOs reported that one of the most important strategies the CNOs use to promote patient safety is to model their ability to acknowledge mistakes, especially the CNOs’ own past or present mistakes. Repeatedly, the CNOs gave
examples of their abilities to acknowledge their own humanness, which the CNOs believed fostered and enabled a blame-free environment to promote and support patient safety. The participants discussed the body of literature surrounding strategies for driving and enabling patient safety, a blame-free method being one of those strategies. The CNOs believed their ability to model self-disclosure without blame neutralizes mistakes, thereby creating an opportunity to understand errors and mistakes and work to prevent future mistakes and support employees. One participant explained that “providing that type of support as people learn and grow and make change because that's how you end up with more sustainable change.” The CNOs perceived central to their role was the ability to introduce environmental strategies to reduce errors and mistakes, thereby promoting patient safety and supporting nursing work environments.

The autonomy described as a characteristic in transformational leadership reflects this emergent theme, because transformational leadership allows the employee to take responsibility of his or her mistakes. Furthermore, the leader is only relating to the mistake made, and the leader takes responsibility for that mistake. Conversely, this presents an instance where the leader is a servant leader, disregarding the ill effects of an employee’s actions, which may have ramifications on the leader, thus “setting an example for others to follow and place emphasis on strong interpersonal relationships” (Carter & Greer, 2013). The hybridization of transformational leadership and servant leadership theories lends a better understanding of CNO leadership needs. The CNOs understood the context of the mistakes made and were situationally aware of the ramifications, such that these instances were turned into learning opportunities, which creates a more positive environment.
The CNOs offered specific examples regarding where he or she demonstrated honesty, and transparency shared staff and budget data with staff to enable a discussion aimed at ensuring adequate staffing while also ensuring cost effectiveness. One participant expressed “The importance of transparency in leading clinical organizations” in that “when [she] does need to advocate, [transparency enables] her effectiveness because she is coming into the conversation with individuals where she has established trust and has been transparent.” The participants also gave examples of their processes when staff ask for specific information, which maybe in the past the CNOs would have been reluctant to offer full disclosure, however the CNOs use honesty and transparency as part of their social processes. Some CNOs reported that this strategy was important to establish trust, particularly when the CNO is new to an organization. “The performance effects of transformational leadership may be more apparent over longer time periods, such as a result of the effects of trust” (Carter & Greer, 2013, p. 381). According to Bass (1999), transformational leaders develop and maintain a higher level of trust through transparency of intentions and competence.

Houser (2003) explained that empowering leadership may be associated with improved patient outcomes by promoting increased nursing expertise through increased staff stability and reduced turnover. Similarly, nurses' job satisfaction has correlated with patient satisfaction and positive leadership (McNeese-Smith, 1999). This supports previous research findings that effective leadership relates to patient outcomes, in part through nurses' increased job satisfaction. In addition, a number of researchers have posited that clear communication of expectations from leaders facilitates improved clinical outcomes (Anderson et al., 2003; Boyle, 2004; Doran et al., 2004; McNeese-
Smith, 1999). Bass and Avolio (1993) suggested that transformational leaders foster positive cultures to address the dynamic and complex situations that may arise on a daily basis.

**Shared decision-making and shared governance.** An observation and a theme was the common language among CNOs with respect to the use of shared governance as part of their social processes. The CNOs reported that shared governance not only fosters patient safety by allowing staff to make decisions related to patient care, but shared governance also empowers staff to make decisions regarding how best to staff the units and make other resource decisions that keep the patient in the center of decision-making. One CNO described this phenomenon in the following way:

> From a day-to-day perspective, I very much believe in shared governance, and that means shared decision making, so you have to have structures in place for that really to be alive in a work setting, and that means I really create and embrace and demand a professional practice model for nursing.

The CNOs agreed that shared governance has been a positive phenomenon in nursing during the last several years, which fosters nurse engagement and safer work environments. Another participant described shared governance as “you learn about what decisions you’re really qualified to make and what you’re not.” The concept of shared governance was expressed another way as “People on the unit are making the decisions that impact them the most; it's not the managers being a dictator.” Shared governance allows leaders to empower employees to accept his or her roles and take on the responsibilities of the job for the benefit of the organization. In doing so, these leaders instruct employees and “foster a culture of creative change and growth rather than one which maintains the status quo. They take personal responsibility for the development of their follower” (Bass & Avolio, 1993, p. 113). Researchers have clearly defined the
theme of shared governance in the literature as falling under transformational leadership, to the exclusion of servant leadership.

**Ineffective Leadership**

**Partiality was found to be divisive within teams.** The findings of this study reveal three emerging themes related to the social processes of ineffective leaders. The CNOs either revealed examples of their own processes, or observed where CNOs lacked objective and demonstrated partiality or favoritism in their social processes. The participants reported actions where the staff perceived CNOs as having “favorites,” thus lacking transparency and promoting a sense of secrecy. One CNO shared an experience earlier in their career as a director reporting to a CNO, whose actions included a pattern of requesting input from preferred leaders and appearing to value one member of the team’s ideas and input over another’s as being divisive to the team. Therefore, the leader did not promote a healthy transformational culture.

**Punitive leadership was not effective within nursing leadership.** The next theme among study participants was a common agreement that shared governance has replaced punitive leadership, as this behavior was not effective. The CNOs reported this pattern as much less common and shared their perception that the Magnet movement has been instrumental in shifting nursing cultures in the U.S. to being less punitive and more collaborative, because of shared governance. The demonstration of punitive consequences describes a more transactional leadership environment, which was not what the CNOs had described, and not what this study has found to be true within a nursing environment.
Lack of patience, struggle with compromise, and reactionary. Mature leaders understand that patience and understanding may prevent problems and issues from getting out of control, which was a theme that emerged from several of the participants’ responses. Negotiating daily situations through compromise, these leaders were better able to utilize resources and experience personal growth. One participant expressed, “I was quick to react or to have an opinion or whatever, and as I moved into leadership roles I've realized it's really important not to do that.” Another participant described the personal nature of self-reflection and contextual analysis: “It's me really realizing that things don't always happen on my terms and a little more patience sometimes is required.” The CNOs understood their roles as leaders, which meant that the CNOs were also creating a culture free of panic and derision. Understanding the negative aspects of poor leadership contributes to the strategies and actions necessary for positive transformational leadership.

Summary of the Findings

The emergent themes revealed that CNOs surveyed on the leadership style scored high in transformational leadership. The researcher presented a discussion of the themes that developed from this qualitative study. Related to the topic of leadership philosophy, professionals identified their leadership style as servant leadership, either directly or indirectly. Effective leaders employed situational leadership or intentionally sought environments where he or she could leverage his or her skills for success. Leaders included in their philosophy a belief that he or she should encourage growth and create an environment conducive to success. Servant leaders also believed that acknowledging mistakes is a key aspect of providing effective leadership.
Regarding strategies for safe and effective work environments, participants identified patient-centered approach, with servant leadership and situational leadership as the primary strategies. Actions leaders posited as important were patient and staff advocacy, accessibility, approachability, articulating a clear vision, balancing demands, empowering, encouraging growth, shared decision-making, shared-governance structures, support, and transparency. Regarding examples of ineffective leadership, the participants identified partiality as a divisive factor within teams. Punitive leadership was highlighted as an ineffective leadership style, as well. Some participants remarked that ineffective leaders lacked patience and compromise. Finally, the participants identified the uncertain direction of health care reform and its effect on nursing as a future issue for CNOs.

**Conclusions**

The findings from this study revealed that CNOs surveyed on leadership style scored high in transformational leadership. The theory of transformational leadership was expanded to represent the emergent themes. First, CNO transformational leaders’ philosophical basis informs CNOs’ strategies and actions. In addition, a hybridization of transformational leadership and servant leadership best describes the contextual nature of CNO leadership.

This chapter presented a discussion of the themes developed from this study. Related to the topic of leadership philosophy, CNOs described a deep sense of being patient-centered, which influences the CNOs’ strategies and actions. The CNOs identified their leadership style as either servant leadership, directly or indirectly, or transformational indirectly. The CNOs employed situational leadership when necessary or intentionally sought environments where personal skills could be leveraged for
success. The CNOs included in their philosophy a belief that CNOs should encourage growth and create an environment conducive to success. Servant leaders also believed that acknowledging mistakes is a key aspect of providing effective leadership. Participants believed leaders must be visible and available to staff.

**Implications for Practice**

Extending knowledge regarding what transformational leadership strategies and actions produce favorable outcomes that benefit health care organizations was essential to identify so that leaders may consciously promote such strategies and actions. The existing research indicates multiple benefits exist to extending knowledge of how nurse leaders operationalize transformational leadership. This research has significant implications for extending the performance of nurse leaders, and by extension, promoting a culture of safety and transforming nursing work environments by clarifying precisely what it is that CNOs do in their social processes. This study contributes to advancing nursing science by addressing a critical barrier to progress in transformational leadership uptake using a qualitative GT approach to the research problem.

**Future Issues for CNOs**

Some participants highlighted challenges that nursing executive leaders will have to face in the future. This discussion focused on uncertainty related to health care reform and its influence on how health care organizations perform. The direction of health care reform may cause nursing leaders to re-envision their responsibilities. Furthermore, organizations may experience high turnover while navigating change resulting from health care reform.
**Re-envision responsibilities.** An area of future challenges for nursing leadership and CNOs comes from health care reform, which may influence the direction of health care. Health care reform may affect, if not set, the compass for future health care direction and goal identification. With these anticipated changes on the horizon, nursing leadership could benefit from an opportunity to develop a strategy to address the effects of health care reform. A primary obstacle in planning for these changes is the absence of knowledge regarding how health care reform will affect daily operations.

**CNO turnover rates.** Organizations may experience high turnover while navigating change resulting from health care reform. High turnover is an important and inextricably linked aspect of navigating change. Turnover directly affects health care leaders, who need to investigate ways to manage changes in staffing, which may be caused by marketplace pressures or legislative reform.

**Limitations**

When assessing the results of this study, several limitations emerged. First, only one care setting, the hospital, was used for this study. Next, with Phase I participation at 25 participants and Phase II participation at 12 participants, the sample size presented another limitation. The potential for response bias related to self-reporting was another limitation. In addition, the researcher did not consider the perspectives of followers regarding the transformational leader’s strategies and actions. Further, the researcher did not attempt to link specific strategies or actions to specific organizational performance, or other outcomes in hospitals. Finally, the blurring of philosophy, strategies, and actions among participants presented a limitation. Future researchers should consider these aforementioned limitations regarding CNOs and the relationship between social
processes of transformational leadership CNOs and organizational outcomes.

**Recommendations for Future Research**

The findings of this study illuminated the strategies and actions of CNO transformational leaders as part of their social processes. Future researchers should include a larger sample of CNOs from various settings. Future researchers should include the perspectives of leaders, followers and peers. This will allow a variety of perspectives and a more inclusive picture of a CNO’s leadership style, strategies, and actions used during his or her social process. In addition to the MLQ-5X Short, future researchers should examine these data in light of the contextual factors such as organizational culture to determine how contextual influences affect the social processes of CNOs. Additionally, some consideration for a different approach to measuring transformational leadership may be warranted. This study adopted the conceptualization of transformational leadership as articulated by Bass and Avolio (2004).

**Summary**

This chapter provided an overview of research methods, a summary of the research findings, and links between this study and related literature. This research adds to the extant literature by revealing the social processes of CNOs, specifically the strategies and tactics of transformational leadership. This study contributes to the empirical data regarded as necessary for the development of transformational leadership theory. Furthermore, a hybridization of transformational leadership and servant leadership led to a contributing theory of contextual leadership within a dynamic environment. Also considered in this chapter were the limitations of the study along with recommendations for future research.
REFERENCES


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APPENDIX A

DESCRIPTIVE QUALITATIVE STUDY WITH GROUNDED THEORY

APPROACHES

Implementation Process

The overarching objective of this study was to expand transformational leadership theory through a descriptive qualitative study with a grounded theory approach. For the qualitative phase of this study, the researcher utilized a grounded theory constant comparative technique to investigate the nature and social processes of transformational leadership nurse leaders. This qualitative phase of this study consisted of three phases, which included initial assessment of transformational leadership characteristics, one-on-one interviews, and testing for fitness of expanded theory.

Phase I:

Upon consent, the MLQ-5X Short leadership survey was administered to eligible participants. Chief nursing officers who possess transformational leadership characteristics of idealized influence, inspirational motivation, intellectual stimulation, and individual consideration on initial screening with MLQ-5X Short were asked to participate in Phase II.

Phase II:

Interviews were conducted to explore and document the specific strategies and actions utilized by these study participants.

Phase III:

Member-checking and testing for fitness of an emerging theory occurred in Phase III. Participants from the initial screening (Phase I) were contacted and asked to participate in validating and confirming findings (from Phase II).
APPENDIX B

INVITATION FOR STUDY PARTICIPATION

You have been selected to participate in a research study because of your recognized expertise in leadership and as demonstrated by your participation in national organizations, certification, publication in leadership or safety, or a referral by colleagues. This study approach is grounded theory, and if you join the study, you will be interviewed to help expand transformational leadership theory by advancing the understanding of strategies and actions undertaken by transformational leaders. The researcher expects the emerging theory from this study to expand transformational leadership theory and serve as a foundation for further research in leadership and organizational outcomes and will be shared with you upon completion.

The researcher anticipates that you will participate in an online leadership survey and may be asked to participate in 1 or 2 one-on-one interviews during the next several months. The leadership survey will require approximately 15 minutes of your time. The one-on-one interviews will require 60 minutes of your time. It is your choice to participate in the study.

Every effort will be made to protect your privacy and confidentiality. Study participants will be assigned study identification numbers. A master list of names will be kept separate from the data under lock and key by the investigator and destroyed after all data are collected. Data for MLQ-5X Short will be collected using an electronic survey and will be collated into a password-protected file.

You do not have to be in this study if you do not want to. If you have questions, you can call Deirdre Baggot, at 303-335-7047. You can call and ask questions at any time. You may have questions about your rights as a participant in this study. If you have questions, you can call the COMIRB (the responsible Institutional Review Board). The COMIRB number is (303) 724-1055.

Thank you in advance for your willingness to participate in this study.
APPENDIX C

SEMISTRUCTURED INTERVIEW QUESTIONS

The researcher asked introductory interview questions during a semistructured interview, which included indicative questions only. The exact wording and the wording of intervening and supplementary questions was determined by the direction of the interview and the responses of interviewees (Martin & Gynnild, 2012). Theoretical sampling dictated subsequent and ongoing questions with the aim of clarifying and saturating the nature of concepts, and the theoretical relationship between concepts. Questions relating to transformational leadership theory and leadership strategies and actions include:

• Describe and discuss your leadership philosophy.
• What strategies and actions do you use with staff to create safe and effective work environments?
• What strategies or actions have you implemented that have resulted in safe and effective work environments?
• Please share an example where leadership was lacking. How and why was it lacking?

Follow up questions and probes were based on developing theory.
APPENDIX D

AVOLIO AND BASS CONCEPTUAL MODEL OF TRANSFORMATIONAL AND TRANSACTIONAL LEADERSHIP

(Avolio & Bass, 2005)
APPENDIX E
MULTIFACTOR LEADERSHIP QUESTIONNAIRE (5X-SHORT)

SCORING: The Multifactor Leadership Questionnaire measures your leadership on seven factors related to transformational leadership. Your score for each factor is determined by summing three specified items on the questionnaire. For example, to determine your score for Factor 1, Idealized Influence, sum your responses for items #1, #8, and #15. Complete this procedure for all seven factors.

<table>
<thead>
<tr>
<th>Total</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealized Influence (items 1, 8, &amp; 15)</td>
<td>____</td>
</tr>
<tr>
<td>Inspirational Motivation (items 2, 9, &amp; 16)</td>
<td>____</td>
</tr>
<tr>
<td>Intellectual Stimulation (items 3, 10, &amp; 17)</td>
<td>____</td>
</tr>
<tr>
<td>Individualized Consideration (items 4, 11, &amp; 18)</td>
<td>____</td>
</tr>
<tr>
<td>Contingent Reward (items 5, 12, &amp; 19)</td>
<td>____</td>
</tr>
<tr>
<td>Management-by-exception (items 6, 13, &amp; 20)</td>
<td>____</td>
</tr>
<tr>
<td>Laissez-faire Leadership (items 7, 14, &amp; 21)</td>
<td>____</td>
</tr>
</tbody>
</table>

Score Range: High = 9-12; Moderate = 5-8; Low = 0-4

SCORE INTERPRETATION

Factor 1. **Idealized Influence** indicates whether you hold subordinates’ trust, maintain their faith and respect, show dedication to them, appeal to their hopes and dreams, and act as their role model.

Factor 2. **Inspirational motivation** measures the degree to which you provide a vision, use appropriate symbols and images to help others focus on their work, and try to make others feel their work is significant.

Factor 3. **Intellectual stimulation** shows the degree to which you encourage others to be creative in looking at old problems in new ways, create an environment that is tolerant of seemingly extreme positions, and nurture people to question their own values and beliefs and those of the organization.

Factor 4. **Individualized consideration** indicates the degree to which you show interest in others’ well-being, assign projects individually, and pay attention to those who seem less involved in the group.

Factor 5. **Contingent reward** shows the degree to which you tell others what to do in order to be rewarded, emphasize what you expect from them, and recognize their accomplishments.

Factor 6. **Management-by-exception** assesses whether you tell others the job requirements, are content with standard performance, and are a believer in “if it ain’t broke, don’t fix it.”

Factor 7. **Laissez-faire** measures whether you require little of others, are content to let things ride, and let others do their own thing.
# APPENDIX F

## AACN EVIDENCE LEVELING SYSTEM FOR LITERATURE SYNTHESIS

<table>
<thead>
<tr>
<th>Level</th>
<th>AACN Evidence-Leveling System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>Meta-analysis of multiple controlled studies or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment</td>
</tr>
<tr>
<td>Level B</td>
<td>Well-designed controlled studies, both randomized and nonrandomized, with results that consistently support a specific action, intervention, or treatment</td>
</tr>
<tr>
<td>Level C</td>
<td>Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
</tr>
<tr>
<td>Level D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
</tr>
<tr>
<td>Level E</td>
<td>Theory-based evidence from expert opinion or multiple case reports</td>
</tr>
<tr>
<td>Level M</td>
<td>Manufacturers’ recommendations only</td>
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</table>

APPENDIX G

LITERATURE SYNTHESIS

<table>
<thead>
<tr>
<th>Factor</th>
<th>Author</th>
<th>Design</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and staff organization and outcomes</td>
<td>Aiken et al. (2012)</td>
<td>Exploratory Cross-sectional survey of nurses and patients in 12 countries in Europe and the United States. Aiken et al. investigated the variables of patient safety, patient satisfaction, and quality in the hospital setting.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Aiken et al. (2009)</td>
<td>Exploratory, cross-sectional survey of European nurses to test how nurse outcomes (hospital staffing, work environments, burnout, dissatisfaction, intention to leave job in the next year, are related to patient outcomes (patient safety, quality of care), patient outcomes (satisfaction overall and with nursing care, willingness to recommend hospitals) at the unit level.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Laschinger et al. (2010)</td>
<td>A predictive, non-experimental design was used to test Kanter's work empowerment theory. This study examined the impact of workplace empowerment, organizational trust on staff nurses' work satisfaction, and organizational commitment.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Estabrooks et al. (2005)</td>
<td>Exploratory study on hospital nursing characteristics and 30-day mortality.</td>
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<td>Boyle (2004)</td>
<td>Exploratory, cross-sectional survey of unit-level organizational characteristics and outcomes. Units where there was greater perception of specialization had lower rates of death, pneumonia and cardiac arrest.</td>
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<tr>
<td>Harter et al. (2002)</td>
<td>Meta-analysis of business-unit-level relationship between employee satisfaction, employee engagement and business outcomes</td>
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<tr>
<td>Aiken et al. (2000)</td>
<td>Exploratory, cross-sectional survey of Magnet and non-Magnet hospitals testing NWI to measure organizational attributes empirically and understand how contextual factors influence variation in patient outcomes.</td>
<td>C</td>
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<tr>
<td>Aiken et al. (1998)</td>
<td>Exploratory, cross-sectional analyses using administrative data on risk-adjusted patient mortality and failure-to-rescue within 30 days of admission, and nurse-reported job dissatisfaction and job-related burnout.</td>
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<td>Leadership and Decision-making</td>
<td>Genrich</td>
<td>Exploratory pilot study on group involvement in decision-making</td>
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<td>Factor</td>
<td>Author</td>
<td>Design</td>
<td>Level of Evidence</td>
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<td>Issel et al. (2001)</td>
<td>Exploratory cross-sectional study on case manager involvement in decision-making</td>
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<td>Edwards (1954)</td>
<td>Decision-making theory</td>
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<td>Literature review to identify if and how nursing leadership, collaboration, and empowerment can have a demonstrable impact on patient safety.</td>
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<td>Armstrong et al. (2009)</td>
<td>Correlational, cross-sectional survey to test Kanter’s theory as it relates to workplace empowerment and Magnet hospital characteristics as predictors of patient safety.</td>
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<td>transformational leadership and gender</td>
<td>Carless (1998)</td>
<td>Descriptive correlational survey to study gender differences in transformational leadership. Study of the differences among leaders and subordinates.</td>
<td>C</td>
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<td>Leadership theory development</td>
<td>Bass &amp; Riggio (2006)</td>
<td>The history and development of Transformational Leadership Theory and how it has evolved.</td>
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<td></td>
<td>Avolio et al. (2005)</td>
<td>Opinion paper calling for theory development around more positive leadership attributes particularly concept of Authentic</td>
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</tr>
<tr>
<td>Factor</td>
<td>Author</td>
<td>Design</td>
<td>Level of Evidence</td>
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<tr>
<td>------------------------</td>
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<tr>
<td>Leadership study</td>
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<td>transactional leadership: A meta-analytic review of the MLQ-5X literature.</td>
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<td>Leader-follower dyad</td>
<td>Dvir et al. (2002)</td>
<td>Longitudinal, randomized field experiment.</td>
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<td>Genrich et al. (2001)</td>
<td>Non experimental,</td>
<td>Non experimental, correlation study of leaders to understand if leaders</td>
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<td>could be taught when to include followers in decision-making.</td>
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<td>Correlational cross-sectional survey to examine effects of charismatic</td>
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<td>Gerstner et al. (1997)</td>
<td>Meta-analytic review of leader-member exchange theory.</td>
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<tr>
<td><strong>Social processes of transformational leadership leaders</strong></td>
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<td>Correlational cross-sectional survey to examine effects of charismatic leaders on subordinate attitudes.</td>
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<td><strong>Social processes of transformational leadership leaders</strong></td>
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<td>Meta-analytic review of effectiveness correlates of transformational and transactional leadership: A meta-analytic review of the MLQ-5X literature.</td>
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<td><strong>Social processes of transformational leadership leaders</strong></td>
<td>Podsakoff et al. (1996)</td>
<td>Correlational cross-sectional survey to examine effects of transformational leader behaviors as determinants of employee satisfaction, commitment, trust, and organizational citizenship behaviors.</td>
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<tr>
<td><strong>Social processes of transformational leadership leaders</strong></td>
<td>Graen et al. (1995)</td>
<td>Domains perspective for the development of a taxonomy for relationship-based leadership.</td>
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</tr>
<tr>
<td><strong>Leaders promote follower involvement</strong></td>
<td>Armstrong (2009)</td>
<td>Correlational, cross-sectional survey to test Kanter’s theory as it relates to workplace empowerment and Magnet hospital</td>
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<td>characteristics as predictors of patient safety climate.</td>
<td>Genrich et al. (2001)</td>
<td>Non-experimental, correlation study of leaders to understand if leaders could be taught when to include followers in decision-making.</td>
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<td></td>
<td>Shamir et al. (1998)</td>
<td>Correlational cross-sectional survey to examine effects of charismatic leaders on subordinate attitudes.</td>
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<tr>
<td>Leaders promote staff control over practice</td>
<td>Laschinger et al. (2010)</td>
<td>A predictive, non-experimental design was used to test Kanter's work empowerment theory. This study examines the impact of workplace empowerment, organizational trust on staff nurses' work satisfaction, and organizational commitment.</td>
<td>C</td>
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<td></td>
<td>Kazanijan et al. (2005)</td>
<td>Systematic review to critically appraise and synthesize all relevant primary research on the effect of the nursing environment on patient mortality.</td>
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<tr>
<td>Leadership and staff support</td>
<td>Laschinger et al. (2010)</td>
<td>A predictive, non-experimental design was used to test Kanter's work empowerment theory. This study examines the impact of workplace empowerment, organizational trust on staff nurses' work satisfaction, and organizational commitment.</td>
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<td>Armstrong (2009)</td>
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<td></td>
<td>Banaszak-Holl (2009)</td>
<td>Position paper on how to bring leadership science and evidence into health care</td>
<td>E</td>
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<tr>
<td>Factor</td>
<td>Author</td>
<td>Design</td>
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<td>leadership practice.</td>
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<tr>
<td>Alexander et al. (2007)</td>
<td>Exploratory, cross-sectional surveys to explore how hospital leaders view key determinants of hospital quality and costs, as well as the fundamental ways these leaders &quot;think&quot; about solutions to quality and cost issues in their organizations.</td>
<td>C</td>
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<tr>
<td>Arndt &amp; Bigelow (2007)</td>
<td>Literature review on how leaders use evidence to inform leadership practice and decision-making.</td>
<td>C</td>
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<tr>
<td>Leadership coaching and feedback</td>
<td>Armstrong (2009)</td>
<td>Correlational, cross-sectional survey to test Kanter’s theory as it relates to workplace empowerment and Magnet hospital characteristics as predictors of patient safety climate.</td>
<td>C</td>
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<tr>
<td>Currie &amp; Watterson (2010)</td>
<td>Qualitative study of differences between organizational culture and organizational climate, as well as the relationship between safety culture and safety climate within this broader context.</td>
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<td>Currie &amp; Watterson (2007)</td>
<td>Qualitative study to study the differences between organizational culture and organizational climate, as well as the relationship between safety culture and safety climate within this broader context.</td>
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<tr>
<td>Nurse staffing and workload</td>
<td>Laschinger et al. (2010)</td>
<td>A predictive, non-experimental design was used to test Kanter's work empowerment theory. This study examines the Impact of workplace empowerment, organizational trust on staff nurses' work satisfaction and organizational commitment.</td>
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<td></td>
<td>Aiken et al. (2009)</td>
<td>Cross-sectional survey of European nurses to test how nurse outcomes (hospital staffing, work environments, burnout, dissatisfaction, intention to leave job in the next year are related to patient outcomes (patient safety, quality of care), patient outcomes (satisfaction overall and with nursing care, willingness to recommend hospitals).</td>
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<td></td>
<td>Currie &amp; Watterson (2007)</td>
<td>Qualitative study to study the differences between organizational culture and organizational climate, as well as the relationship between safety culture and safety climate within this broader context.</td>
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<tr>
<td>Communication</td>
<td>Currie &amp; Watterson (2007)</td>
<td>Qualitative study to study the differences between organizational culture and organizational climate, as well as the relationship between safety culture and safety climate within this broader context.</td>
<td>C</td>
</tr>
<tr>
<td>transformational leadership and patient safety culture</td>
<td>McFadden et al. (2009)</td>
<td>A non-experimental design was used, drawing on high reliability organization theory, multifactor leadership theory, and total quality management literature to develop and test a model for improving patient safety to test transformational leadership effect on patient safety culture.</td>
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</tr>
</tbody>
</table>
To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material:

Instrument: *Multifactor Leadership Questionnaire*

Authors: *Bruce Avolio and Bernard Bass*

Copyright: *1995 by Bruce Avolio and Bernard Bass*

for his/her thesis research.

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com
APPENDIX I

PHASE I ELECTRONIC MLQ-5X SHORT SURVEY

<table>
<thead>
<tr>
<th>Leadership Assessment</th>
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<tbody>
<tr>
<td>Multifactor Leadership Questionnaire</td>
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</table>

Instructions: This Questionnaire provides a description of your leadership style. Twenty-one descriptive statements are listed below. Judge how frequently each statement fits you. The word “other” may mean your followers, clients, or group members. Thank you for your voluntary participation in this survey.

1. Name

2. Gender
   - Male
   - Female

3. Highest Level of Education
   - High School degree
   - Associate degree
   - Bachelor’s degree
   - Master’s degree
   - Professional degree
   - Doctorate degree

4. Number of years of leadership experience
   - 0
   - 1-5
   - 5-10
   - 10-15
   - 15-20
   - 20+
## PHASE I ELECTRONIC MLQ-5X SHORT SURVEY

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Once in a while</th>
<th>Sometimes</th>
<th>Fairly often</th>
<th>Frequently, if not always</th>
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<tbody>
<tr>
<td>1) I make others feel good to be around me.</td>
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<td>2) I express with a few simple words what we could and should do.</td>
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<td>3) I enable others to think about old problems in new ways.</td>
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<td>4) I help others develop themselves.</td>
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<td>5) I tell others what to do if they want to be rewarded for their work.</td>
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<td>6) I am satisfied when others meet agreed-upon standards.</td>
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<td>7) I am content to let others continue working in the same way as always.</td>
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<tr>
<td>8) Others have complete faith in me</td>
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<td>9) I provide appealing images about what we can do</td>
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<td>10) I provide others with new ways of looking at puzzling things</td>
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<td>11) I let others know how I think they are doing</td>
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<tr>
<td>12) I provide recognition/rewards when others reach their goals</td>
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<tr>
<td>13) As long as things are working, I do not try to change anything</td>
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<tr>
<td>14) Whatever others want to do is O.K. with me</td>
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<tr>
<td>15) Others are proud to be associated with me</td>
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<td>16) I help others find meaning in their work</td>
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<td>17) I get others to rethink ideas that they had never questioned before</td>
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<td>18) I give personal attention to others who seem rejected</td>
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<td>19) I call attention to what others can get for what they accomplish</td>
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<tr>
<td>20) I tell others the standards they have to know to carry out their work</td>
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<tr>
<td>21) I ask no more of others than what is absolutely essential</td>
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</table>
## APPENDIX J

### CODING PROGRESSION TABLE

<table>
<thead>
<tr>
<th>Open Codes</th>
<th>Substantive Codes</th>
<th>Themes</th>
<th>Thematic Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions to be a better leader</td>
<td><strong>Description of leadership theory</strong></td>
<td>• Professionals identified their leadership style as servant leadership, either directly or indirectly.</td>
<td>Leadership Philosophy</td>
</tr>
<tr>
<td>Awareness of weaknesses, areas for growth</td>
<td>• Supportive</td>
<td>• Effective leaders encouraged growth and created an environment conducive to success.</td>
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<tr>
<td>Becoming more involved in strategic planning</td>
<td>• Collaborative</td>
<td>• Acknowledging mistakes is a key aspect of providing effective leadership.</td>
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<tr>
<td>Conviction regarding your work</td>
<td>• Encourage growth</td>
<td>• Keeping a patient-centered focus is key.</td>
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<tr>
<td>Core qualities sought in leaders</td>
<td>• Ability to connect</td>
<td>• Shared governance and teamwork are fundamental to the decision-making process.</td>
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</tr>
<tr>
<td>Courage in CNOs</td>
<td>• Contextual leadership</td>
<td>Subtheme: Shared governance is a primary tenet of Magnet designation, and one of the 14 ‘forces’ driving Magnet philosophy.</td>
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<tr>
<td>Create environment conducive to success</td>
<td>• Servant leadership</td>
<td>• Honesty and</td>
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<tr>
<td>Culture</td>
<td>• Empowering</td>
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<tr>
<td>Encourage growth</td>
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<tr>
<td>Garnering respect</td>
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<td>Grooming future leaders</td>
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<tr>
<td>Interruptions</td>
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<tr>
<td>Meeting key staff</td>
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<tr>
<td>Mentoring</td>
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<tr>
<td>Modeling good leadership</td>
<td>Strategies Used with Staff</td>
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<tr>
<td>Relationship building</td>
<td>• Articulates a clear vision</td>
<td>Strategies for Safe and Effective Work Environments</td>
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<tr>
<td>Servant leadership</td>
<td>• Shared governance</td>
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<tr>
<td>Showing gratitude</td>
<td>• Patient centered focus</td>
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<tr>
<td>Studying performance data</td>
<td>• Transparency</td>
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<tr>
<td>Support</td>
<td>• Honest</td>
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<tr>
<td>Tailoring leadership style to context</td>
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</tr>
</tbody>
</table>

Communication

- Decision making process
- Honesty and Transparency
- Keeping patient centered focus
- Safe and effective work environments
- Shared governance
<table>
<thead>
<tr>
<th>Balancing demands</th>
<th><strong>Actions Implemented</strong></th>
<th><strong>Actions for Safe and Effective Work Environments</strong></th>
</tr>
</thead>
</table>
| Being available to staff | • Available to staff  
• Visible to staff  
• Accessible  
• Balancing demands  
• Present | • Leaders must be visible and available to staff. |
| Being visible | | |
| Cross-departmental leadership success | | |
| Methods to help staff improve safe and effective work environments | | |

<table>
<thead>
<tr>
<th>Area for improvement of leadership</th>
<th><strong>Favoritism</strong></th>
<th><strong>Ineffective Leadership</strong></th>
</tr>
</thead>
</table>
| Challenges to leadership | Inability to effectively influence peers  
Punitive leadership  
Transactional | Partiality was divisive within teams.  
Punitive leadership was not effective within nursing leadership.  
Ineffective leaders lacked patience, struggle with compromise and can be reactionary in their decision actions. |
| Favoritism | | |
| Inability to effectively influence peers | | |
| Punitive leadership | | |
| Transactional | | |
| Lacking influence over peers | | |
| Punitive leadership | | |
| Gender and healthcare leadership | | |
| Understanding impact of healthcare | | |