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An Ethnographic Investigation on How Chief Nursing Officers Use Transformational  
Leadership to Lead and Support New Nurse Graduates

A Dissertation by

Susan Paillet

Brandman University

Irvine, California

School of Education

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Education in Organizational Leadership

November 2016

Committee in charge:

Jeffrey Lee, Ed.D., Committee Chair

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November 2016

An Ethnographic Investigation on How Chief Nursing Officers Use Transformational  
Leadership to Lead and Support New Nurse Graduates

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## ACKNOWLEDGEMENTS

I would like to thank all of the family, friends, coworkers, and educators who encourage and inspire me daily. It is only with their support that I have come this far as I continue on my journey of lifelong learning. My family: Mark, William, Shane, Shirley, Matthew, and Sheila, whose unconditional love I count on every day. My friends: Celia, Tatiana, Darcy, Marilyn, and Valerie, who listened to endless discussions about leadership and nursing. My team: Kim, Mario, Tina, and Chini for being the absolute best team I have ever worked with in my life. Mary Sanchez, Robyn Nelson, and Julie France for their expertise and knowledge. Dr. Lee for your endless patience, strength, and commitment to excellence. Dr. Guzman and Dr. Enomoto for your support and feedback. David Pyle for believing in me and giving me the opportunity to pursue my passion while helping others, and most importantly, to all the nurses who dedicate their lives to improving the lives of others.

## ABSTRACT

### An Ethnographic Investigation on How Chief Nursing Officers Use Transformational Leadership to Lead and Support New Nurse Graduates

by Susan Paillet

**Purpose:** The purpose of this ethnographic study was to examine how chief nursing officers (CNOs) use transformational leadership to lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012).

**Methodology:** The sample for this qualitative ethnographic study included 13 CNOs in 4 counties in California (Los Angeles, Orange, San Bernardino, and Riverside) working for hospitals and other healthcare settings. The data sources for this study included observations, interviews, and artifact reviews. Data were analyzed using a thematic analysis.

**Findings:** 8 major findings emerged: (a) CNOs participate in rounds and take time to listen to new nurses, (b) CNOs create a culture of caring and compassion with new nurses, (c) CNOs use storytelling to create sustainable change, (d) CNOs meet with new nurses regularly, (e) CNOs recognize generational differences, (f) CNOs hire new nurses with critical thinking and soft skills, (g) CNOs support evidence-based decision making, and (h) CNOs encourage teamwork and collaboration through shared governance.

**Conclusions:** Based on the findings, it can be concluded that new nurses thrive when CNOs communicate with them by rounding and listening to them; new nurses understand their responsibility to patient outcomes when CNOs create a culture of caring; new nurses are retained when CNOs adapt rapidly to change; new nurses thrive when they feel like

they are able to share their opinions, thoughts, and experiences with their CNOs; CNOs are working to engage older generations with the new millennial generation of nurses; patient satisfaction increases when CNOs focus on ensuring new nurses have good customer service and critical thinking skills; new nurses make fewer medical errors when CNOs support evidence-based decision making; and new nurses thrive when CNOs encourage teamwork and collaboration through shared governance.

**Recommendations:** Further research is recommended in other geographical areas, with other types of nursing facilities, on factors that influence new nurses to leave the profession within 2 years of graduating nursing school, using new nurses as the population to understand their perspective, on nurses who have at least 5 years of experience, and to further correlate patient satisfaction surveys to employee satisfaction surveys.



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## CHAPTER I: INTRODUCTION

According to the American Nurses Association (ANA), the demand for high-quality and affordable healthcare is at an all-time high due to scientific advances in healthcare, the Affordable Care Act, and an aging population (Li, Stauffer, & Fang, 2015). Healthcare is a top priority for the Obama administration, and the expectation includes that all people who live in the United States have access to healthcare as a basic human right. Nurses make up the largest population of the workforce within healthcare in the United States, representing four times the number of physicians (Avalere Health LLC, 2015). The ANA has established goals for 80% of all nurses to have a minimum of a baccalaureate degree and to double the number of doctorate nurses (Institute of Medicine [IOM], 2011). Due to the realization that nurse graduates cannot keep up with the need, various associations (e.g., the American Association of Community Colleges [AACCC], Association of Community College Trustees [ACCT], American Association of Colleges of Nursing [AACN], National League for Nursing [NLN], and National Organization for Associate Degree Nursing [N-OADN]) have joined forces to share information that can influence schools and colleges to accept and enroll more nursing students.

Aside from the fact that there is a shortage of new nurses, a radical increase in demand for nursing care has become amplified by the Patient Protection and Affordable Care Act (ACA; Li et al., 2015) and the intricate evolution of advances in the healthcare system (The National Academies of Sciences, Engineering, and Medicine, 2010). The ACA broadened the goal that every American has access to healthcare, adding to the need for more nurses and other healthcare professionals (Li et al., 2015). Additionally,

nurses and nurse educators who put off retirement due to the economic problems of the late 2000s have started to retire, creating a dire need for qualified nurses (Li et al., 2015).

A national nursing shortage is enhancing the need for hospitals and other healthcare facilities to focus their attention on hiring, training, and retaining qualified new nurse graduates (Dolan, 2011). Even more troublesome is the fact that nursing schools are struggling to keep up with the demand for nurses (American Association of Colleges of Nursing [AACN], 2015c). The AACN (2015c) reported that more than half of nursing colleges have indicated that a lack of sufficient nursing faculty is the primary reason for the inability of colleges to admit qualified applicants to their schools, along with budget restrictions, insufficient space in the classroom, and a lack of sites for clinical practice. Nursing colleges in California have resorted to establishing random lottery systems to select qualified applicants to enroll in their registered nurse programs (Ohlone College, 2016).

In conjunction with the enrollment troubles facing nursing colleges is the implementation of the ACA and the new vision and growing demands of healthcare that it implies (IOM, 2011). The ACA demands that quality care be provided and accessible to all Americans, not just those who can afford it (Wakefield, 2010). Correspondingly, patient wellness, health outcome improvement, and prevention of disease represent priorities for patient care. Further, benevolent care should be given to all (IOM, 2011).

Faced with pressure from the ANA, the Institute of Medicine (IOM), and the NLN to focus on advancing nurse education, chief nursing officers (CNOs) can become a vital part of the mission of these organizations by ensuring quality leadership and support, resulting in high retention of quality nurses (Falter, 2012). Retaining quality



nurses may improve patient experiences and surveys, lower costs, and lower hospital injuries and falls (J. Bailey, 2014). CNOs' ability to lead and support new graduates will improve the overall health of patients and will keep turnover costs down (J. Bailey, 2014).

## **Background**

### **Nursing Shortage**

The ACA specifically makes a “call to action” to the nursing community to ensure primary care provision is bolstered, to ensure the provision of quality care, and to guarantee that costs are driven down (IOM, 2011, p. 22). The “call to action” is a primal scream to the nursing fellowship, and more specifically to nursing executives to lead the way. The CNO in all healthcare facilities, whether in a hospital, ambulatory care, public community health, or any other employment setting, establishes the policy and procedural tone for the nurses who work for him or her and is the highest ranking nurse in the organization, and as such, the CNO is best positioned to heed the call to action for reform (Hader, 2009).

Leading, supporting, and training new nurse graduates represent important issues in today's healthcare environment. Support of new nurses remains of particular significance because of the national nursing shortage experienced at many hospitals and other healthcare facilities (AACN, 2016c). Nurse turnover decreases productivity, increases staff workload, and increases costs due to overtime, separation process costs, and candidate search costs (C. Jones & Gates, 2007). In addition to the added cost, a difference in employee skill sets may exist; for example, the replacement nurse may not be as skilled or have as much potential as the new nurse graduate who left the company

(Schnotz, n.d.). The expense of nurse turnover is high, and in tandem with the national nursing shortage, overcoming the loss of new nurses remains even more crucial (AACN, 2016c).

### **Chief Nursing Officers**

CNOs are responsible for the care and leadership for all nurses in their organization (Frandsen, 2014). As such, CNOs must inspire those who work for them to achieve a common goal set in alignment with corporate objectives of the healthcare organization (Hughes-Rease, 2015) and must also focus on retention of current nurses through providing support, mentoring, and training (Adamek, 2015). The role of a CNO is to offer the nursing workforce transformational leadership that energizes their nursing personnel to exhibit exceptional qualities that drive remarkable patient care. Transformational leadership is a management style that engenders inspiration, evokes relationship building, and encourages staff to be more than they ever thought they could be (Frandsen, 2014).

As a result of the emerging transformation of the U.S. nursing healthcare topography, CNOs, responsible for the leadership of nurses and the development and mentoring of nurse graduates, play a major role in influencing the future of medicine. A CNO is an executive, the highest nursing position in an organization, tasked with the responsibility for ensuring that evidence-based care is delivered in the healthcare facility on a daily basis (Hader, 2011).

CNOs foster proactive programs that invest in new nurse graduates through the creation of strong mentorship programs. They create safe havens where the new nurse graduates can discuss their concerns, talk about what is working and what is not working,

and learn new strategies for how to deal with common and irregular workplace situations. These programs will allow researchers to see the impact that such programs will have on the bottom line (Sherman & Pross, 2010). Having support remains imperative to successful onboarding of new nurses and ensuring stabilization. A study at Mount Carmel School of Nursing in Ohio known as the Learning Trails program had improved retention, helping new nurse graduates succeed in their new jobs (AACN, 2001).

Providing guidance and mentorship for nurses who have recently graduated is of paramount importance because as new members of the workforce, many will need to “learn the ropes,” gain a sense of inclusion, advance from initial feelings of uncertainty, and develop the wherewithal to deal with some in the community who view new nurses as threats to their positions (Frost, Nickolai, Desir, & Fairchild, 2013). Although many new nurses have amazing and highly rewarding initial experiences as they enter the field, the first year of a nursing career can be stressful. One example of a negative experience includes “bullying and belittling from senior nursing staff” (Frost et al., 2013, para. 3). When young nurses suffer negative experiences in the workplace or feel unsupported and alone, they often seek new opportunities (Frost et al., 2013). The cost of losing a nurse for hospitals can equate to \$36,000 or more, which can result in a loss of over \$4.9 million per facility (AACN, 2016c).

The IOM’s (2011) mandate for more and better educated nurses makes the issue of nurse retention critical to the future of healthcare. CNOs need to proactively seek out, invest in, and, in some instances, protect new nurse graduates who enter their facilities. Frost et al. (2013) mentioned that some new nurses even experience *covert lateral violence*, where colleagues engage in verbal or nonverbal aggression with the goal of

undermining the new nurses with others, including those in authority, by restricting or withholding important information needed to do their job, creating unfair schedules, engaging in backstabbing behaviors, and sabotaging new nurses (Aleccia, 2008). There is a wide chasm between current nurse leadership and the nurse leadership of the future. Hospitals need to take responsibility for how new nurses are trained to ensure patient care remains a top priority (Grant, 2016). The researcher documented how CNOs lead and support new nurse graduates in order to add to the literature available on the importance of leading, supporting, and training new nurse graduates.

### **Nursing Schools**

The paths to achieving a registered nurse (RN) degree are varied. Most nurses achieve their initial education through an associate degree program, quite often through a community college (Aiken, Cheung, & Olds, 2009). A smaller portion of nurses receive their Bachelor of Science in Nursing (BSN) through 4-year university programs. An even smaller set of nurses enter colleges with a Bachelor of Arts (BA) degree in another field and then earn their BSN in 12 to 18 months (Aiken et al., 2009).

The number of nursing school baccalaureate applicants has increased by more than 70% since 2004 (IOM, 2011). Thus, the desire for entry into nursing programs exists and remains quite vibrant. The unfortunate news is that nursing colleges are overwhelmed by the number of qualified applicants, only a small number of whom they can accept, and are forced to turn applicants away by the tens of thousands (AACN, 2015c).

Nursing schools primarily fall in one of four categories: public colleges, which are often state run; private colleges, which are generally research or educational nonprofit

organizations—though some private colleges are for-profit; community colleges, which are generally 2-year colleges; and for-profit colleges, which are generally operated by profit-based businesses (Kineer, 2014). Public, private, and community nursing colleges have a longer history than for-profit nursing colleges. For-profit nursing colleges have emerged more recently (IOM, 2010). For a variety of reasons, for-profit nursing institutions appear to be viewed by those charged with recruitment responsibility as providing nurses who are more practical and have more “street smarts” than those who graduate from public institutions (Kineer, 2014).

Recent nurse graduates represent the next entrants into the field of nursing and, as such, represent the next generation of patient caregivers and candidates ready to alter the nursing paradigm and respond to the national call for change (IOM, 2011).

### **Transformational Leadership**

Transformational leadership is a managerial approach in which the ideal strategic outcome is transforming followers (i.e., nursing staff members) into leaders (Kapu & Jones, 2016). Transformational leaders accomplish their goals through increasing motivation, enhancing the morale, and strengthening the performance of staff (Bass & Riggio, 2006). A leadership goal is to tie the staff members’ sense of self to the global mission and unified personality of the organization, act as an inspirational role model for the nurses, challenge healthcare staff to own their work, and evaluate staff competencies so that performance is aligned with ability (Justin, Pearce, & Vecchio, 2008).

The four *Is* are foundational elements for transformational leadership:

1. Individualized consideration: The leader is empathetic toward his or her followers, keeps the lines of communication open, and makes certain to challenge his or her workers (Cossin & Caballero, 2013).
2. Intellectual stimulation: The transformational leader wants to encourage independent thought; as a result, the leader will challenge assumptions the group makes, encourage creativity, and not avoid risk taking (Cossin & Caballero, 2013).
3. Inspirational motivation: Here the transformational leader provides inspiration to the troops. The leader's goal is to communicate a vision that allows healthcare workers to invest substantial effort into their tasks, bolstered by excitement and energized about the success to come (Hughes, 2014).
4. Idealized influence: Through encouragement of a strong sense of affinity, influence, and personal rapport, resulting from treating staff as individuals and giving them respect and trust, the transformational leader can instill a sense of pride in his or her workforce, which can convert into team success (Hughes, 2014).

In sum, transformational leadership theories diverge in their emphasis on key attributes of leaders and their style of leadership (Bass & Riggio, 2006). Accordingly, transformative leadership is about the process of motivating followers to act and commit to a cause, thereby transforming the status quo and bringing to light a new standard of behavior and thought through noble vision, growth mindset, creativity, authenticity, and strategic risk (Cossin & Caballero, 2013).

## **Statement of the Research Problem**

The national nursing shortage represents a current issue that hospitals face. While colleges and universities are in the position to train new nurses, CNOs are in a unique position to hire and retain new nurses. There is little research available to address how the national nursing shortage is enhancing the need for CNOs to focus their attention on hiring, training, and retaining qualified new nurse graduates (Dolan, 2011). More troublesome is the fact that insurance coverage to millions of previously uninsured people, due to the ACA, may cause an even greater chasm between nurse supply and demand, making new nurse retention valuable to healthcare organizations (Watt & Pascoe, 2013). The general problem is that CNOs are not prepared to lead and support new nurse graduates at the level demanded by consumers, administrators, and government (Clavelle, Drenkard, Tullai-McGuinness, & Fitzpatrick, 2012). The nursing profession has a reputation for high burnout, bullying, and stress-related work claims (Vessey, Demarco, Gaffney, & Budin, 2009). CNO leadership training is a highly discussed subject among nurse experts; however, there is still a lack of professional new nurse training programs (Selanders & Crane, 2012). This lack of training in leadership and support is highlighted by the AACN, ANA, and NLN research, including the finding that staffing nurses with advanced degrees may result in fewer hospital-related falls, injuries, and deaths. All of these organizations are in support of funding and encouraging new nurse programs; nonetheless, there are few actual new nurse development programs that focus on new nurse graduates (Sherman & Pross, 2010).

Research to better understand this subject remains necessary because a lack of leadership impedes the ability for new nurses to grasp the necessary skills to compete and

to thrive in the high pressures of the nursing world. The current challenges of training and retaining new nurses include the need for knowledge that will help CNOs retain their new nurse graduates. The literature on the importance of leading, supporting, and training new nurse graduates plays a major role in the overall success of new nurses (Sherman & Pross, 2010).

### **Purpose Statement**

The purpose of this ethnographic study was to examine how CNOs use transformational leadership to lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012).

### **Research Question**

In order to examine, understand, and describe the best practices that CNOs utilize to ensure new nurse graduates are successful, the research question was as follows: How are transformational leadership skills used by CNOs in hospitals to lead and support new nurse graduates?

### **Significance of the Problem**

There were several contributions to the findings of this study. Conducting a study on understanding the support for new nurses was significant and timely because of the national nursing shortage experienced at many hospitals and other healthcare facilities (AACN, 2016c). Through this study, the findings may advance knowledge in the discipline of nursing practice and improve the quality of nursing services based on empirical data (e.g., observations and interviews). Moreover, through this study, the professional practice of nursing, specifically CNOs and hospitals, may develop possible



improvements in policies, programs, and procedures. Furthermore, there may be positive social changes that occur, such as improved social knowledge on the phenomenon of supporting and helping new nurse graduates. As the expectation of quality healthcare continues to rise, the demand for leaders to fulfill this need will grow. The unknown factors such as the impact of the ACA, retiring rate of nurse leaders, faculty shortages, and the demand for future nurse leaders call for transformational leadership, thus making this study significant.

### **Definitions**

**Chief nursing officer (CNO).** A CNO is the leader and visionary for all nurses in a healthcare organization (Frandsen, 2014). These CNOs include nurses and other personnel who work for and with them to achieve a common goal set in alignment with corporate objectives of the healthcare organization (Hughes-Rease, 2015).

**New nurse graduate.** A new nurse graduate is a nurse who is practicing his or her nursing profession for the first time (e.g., less than 1 year) after graduating and passing the licensure examination (Pineau, Stam, Spence Laschinger, Regan, & Wong, 2015).

**Nursing schools.** Nursing schools are institutions that offer courses for students who want to become nurses.

**Nursing shortage.** Nursing shortage refers to the phenomenon of experiencing a lack of supply of competent nurses in hospitals to meet the demands of patients (Li et al., 2015).

**Rounding.** A term used in hospitals and other healthcare facilities that means managing patient care by walking around with members of the healthcare team to observe, advise, and ensure quality of care.

**Transformational leadership.** Transformational leadership is a form or style of managing and supervising people to arrive at an ideal strategic outcome of helping followers to become effective leaders (Cossin & Caballero, 2013). For the purpose of this study, the CNO who uses transformational leadership helps nursing staff members, including new ones, become effective leaders.

**Transformational Leadership Skills Inventory (TLSi).** A transformational leadership framework developed by Larick and White (2012) that helps measure skills and behaviors related to transformational leadership.

### **Delimitations**

Delimitations explain what the researcher controls as it relates to how and when the study is conducted (Patton, 2015). This study was delimited to CNOs working in Southern California, specifically in Los Angeles, Orange, San Bernardino, and Riverside Counties. This study delimitation was based on the accessibility and proximity of the study population and sample to the researcher.

### **Organization of the Study**

This chapter explained how the study was organized, beginning with an overview of the problem, its significance within nursing, and the importance of transformational leadership within the nursing field. In Chapter II, a comprehensive review of literature related to the topic of CNOs' support of new nurse graduates is presented. This literature includes the history of nursing, the importance of CNOs, the nursing shortage, and how

transformational leadership is important to the future of healthcare. Chapter III contains information regarding the methodology and processes that were implemented in order to answer the research question of the study. Chapter IV contains information regarding the findings that answered the research questions of the study. Chapter V includes a summary of the study, a discussion of the major findings, and conclusions, along with implications for action, recommendations for future research, and the concluding remarks and reflections of the researcher.

## CHAPTER II: REVIEW OF THE LITERATURE

Chapter I gave a background on the topic of transformational leadership and nursing, stated the research problem, and put forth the purpose statement. The research question and significance along with definitions and delimitations were introduced, and the organization of the study was summarized. Chapter II provides a comprehensive review of the scholarly literature related to research topics surrounding chief nursing officers (CNOs), leadership, nursing education, and the nursing shortage. It is focused on topics pertaining to nurse leadership and CNOs' role in nurse education and the future of new nurse graduates.

The information is provided to give the reader a good understanding of the multifaceted topics that influence nurse leadership and nurse education. The following databases were used for this study: ProQuest Educational Journals, ERIC, Ovid Nursing Full Text Plus, ProQuest Dissertations, American Nurses Association (ANA) journal archives, Commission on Collegiate Nursing Education (CCNE) journal archives, and a multitude of current newspaper articles that reflected the most current information regarding these topics. Search terms used included *nursing education*, *chief nursing officers*, *healthcare reform*, *trust in nursing*, *transformational leadership in nursing*, *Affordable Care Act*, *future of healthcare*, *nursing shortage*, and *quality of nursing*.

This literature review examines CNOs; the nursing shortage, including factors influencing retention rates, the impact of the Patient Protection and Affordable Care Act (ACA), and measures to combat the shortage; the role of nursing schools and faculty in the nursing shortage; transformational leadership as a potential solution to the nursing shortage; and implications of the nursing shortage on the American healthcare system.

The chapter concludes with an explanation of gaps in current literature and a summary of the literature review on this topic.

### **History of Nursing**

The history of nursing usually starts with a look back at the story of Florence Nightingale (American Nurses Association [ANA], n.d.). Nightingale was a British woman raised in England's upper class who banded together a group of female nurses to provide medical services to the British soldiers in Crimea (Arnstein, 1956). Nightingale created a number of educational programs for nurses in several hospitals in her area and had specific ideas regarding how the nurses should be trained; as a result, her curriculum was named the "Nightingale Principles" (Arnstein, 1956). Nightingale taught the locals that women who were trained in healthcare could provide patient care through the implementation of specific principles (McDonald, 2014). Although Nightingale was not the first to care for patients, she was responsible for modernizing the profession (Arnstein, 1956). She sought help from the British government to ensure proper hygiene on the battlefield (Fee & Garofalo, 2010). With this change, the death rate due to infections dropped significantly (Fee & Garofalo, 2010). After the war, Nightingale spent her life advocating for sanitary patient conditions and requesting the same in hospital facilities, a principle that is still implemented today (McDonald, 2014).

In Europe, nursing was often the practice of Catholic nuns (Orkiszewski & Pollitt, 2016). However, in the United States, this practice did not continue. The first formalized nursing program began in the 1700s in Philadelphia, in what was called an almshouse (Crihfield & Grace, 2011). The nurses in these settings generally took care of the elderly and those with the flu or colds (Wall, n.d.). As the Civil War progressed, nurses provided

care and compassion for the soldiers, tending to their wounds, and became a part of the American Red Cross once the war was over (Wall, n.d.).

Before long, hospitals controlled the education of nurses, providing them with hands-on training (Wall, n.d.). Soon nurses started to earn degrees, and the numbers of well-trained nurses started to increase (Wall, n.d.). Women still composed the largest segment of the community (Lewenson, 2015). Mary Breckinridge was instrumental in bringing the Frontier Nursing Service to America, which focused on patient care for individuals living in the more rural areas of the United States (Goan, 2008).

World War II advanced the cause of nursing (Bellafaire & Graf, 2009). Many nurses were able to advance in rank through lieutenant (American Military Medical Impression, n.d.). The thinking was that they had to endure the same horrors as the men, so they should be treated the same. The nursing profession as it exists today is primarily a result of the progress made during World War II (Lewenson, 2015). Women were anxious to provide care to the soldiers who were at war overseas, in addition to the perk that they were being referred to as heroes (Smith, 2015). Thousands of women volunteered to help the soldiers (Lewenson, 2015). Many did not have training but still benefitted from the experience they gained from dealing with sickness and injuries firsthand (Van, 2014). Upon returning home, these volunteer nurses had acquired a broad skill set that was needed in the medical profession.

The government responded to the return of the nurses and invested in the healthcare industry, which occurred simultaneously with the advance of technology and the advance of medical innovations (Van, 2014). In the 1950s, schools began offering master's degrees and doctoral training in nursing. Nurses' roles in society expanded as

areas of specialty care expanded, like trauma, pediatrics, and critical care (Pollitt & Reese, 1997). The transition from a doctor's assistant to a person able to perform procedures and give patients prescriptions for medication evolved with time. Today's nurse can train in numerous healthcare specialties.

### **Chief Nursing Officer**

A CNO is the leader and visionary for all nurses in a healthcare organization (Frandsen, 2014). As such, CNOs must inspire those who work for them to achieve a common goal set in alignment with corporate objectives of the healthcare organization (Hughes-Rease, 2015). The role of CNOs is to offer the nursing workforce transformational leadership that energizes their nursing personnel to exhibit exceptional qualities that drive remarkable patient care. Transformational leadership is a management style that engenders inspiration, evokes relationship building, and encourages staff to be more than they ever thought they could be (Frandsen, 2014).

As individuals with the highest nursing position in an organization, CNOs are tasked with the responsibility for ensuring that evidence-based care is delivered in the healthcare facility on a daily basis (Hader, 2011). Evidence-based practice is the conscientious use of current best evidence in making decisions about patient care (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Partially in response to the Institute of Medicine's study on preventable mistakes made in hospitals (Kohn, Corrigan, & Donaldson, 1999), the need to ensure that patients receive high-quality service delivery took on urgent significance. The position of CNO is comparatively new (Hader, 2011). A CNO must be a dynamic and strategic individual, who has extensive education and experience in both nursing and management. CNOs are responsible for establishing the

vision for all nurses in the healthcare system they manage, providing nursing governance, guaranteeing that quality is delivered at its highest levels, offering strategic management through the creation of goals with achievable targets, encouraging training and development, ensuring nurse credentialing, inspiring collaboration, and investing attention to budgetary requirements (Hader, 2011). CNOs are responsible for every aspect of nursing that occurs within the healthcare facility they govern.

### **CNOs Communicating the Vision of the Hospital**

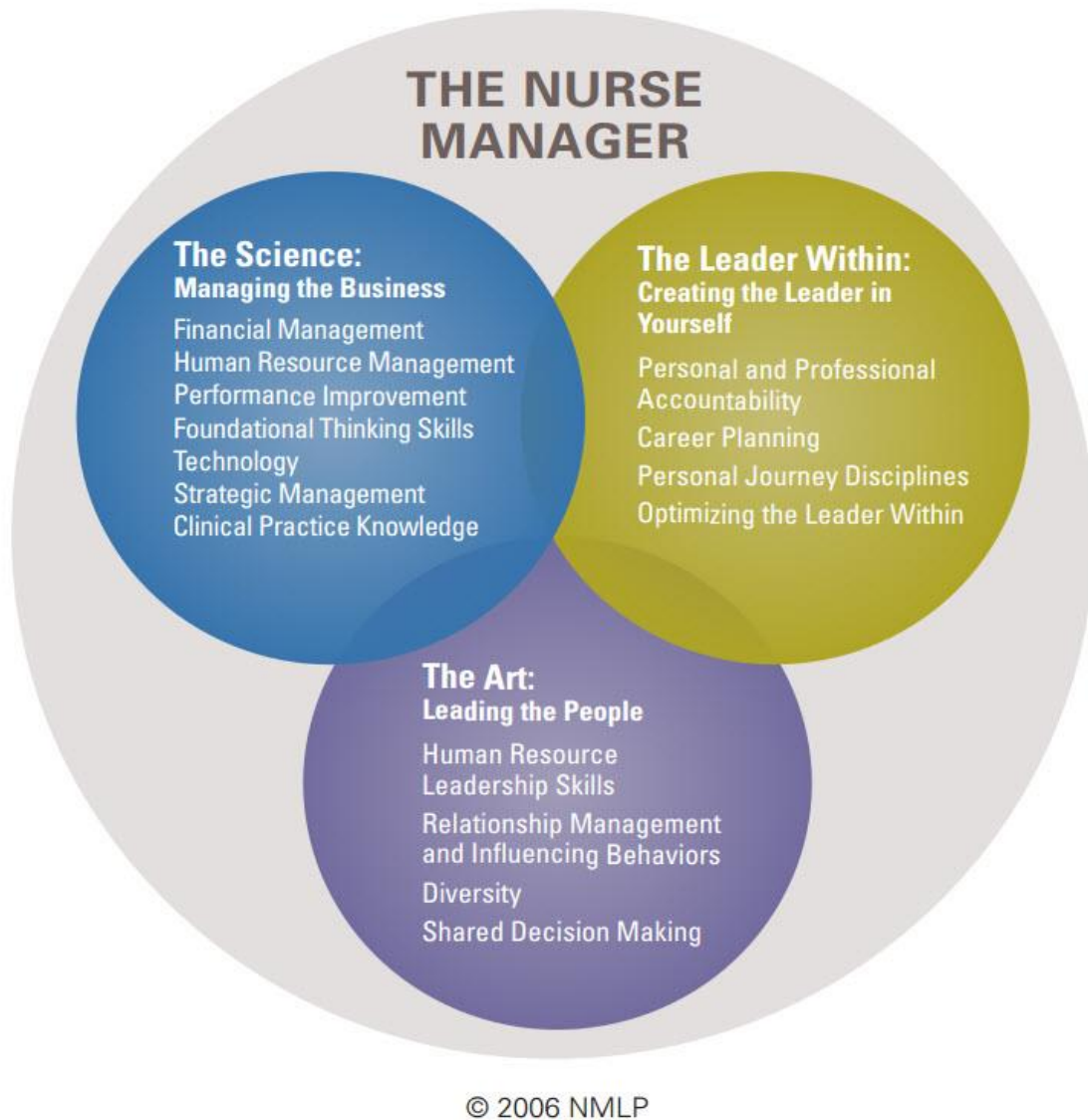
As the spokespersons for healthcare facilities and face of the future of nursing, CNOs must advance the profession through creating, articulating, and implementing a vision for nursing that is also consistent with the values, goals, and policies of the facilities they oversee (Hader, 2009). Hughes-Rease (2015) noted that the single most important skill that CNOs must have is the ability to articulate their vision so that those who work for them fully understand that there is a vision, fully understand the message behind the vision, and thoroughly comprehend how the vision can be translated into their day-to-day patient care activities. According to Posluszny (2014), nurse leaders must learn the direct impact their leadership can have to advance the overall health of patients. The first requirement of transformational leadership is to build relationships and motivate staff to share the strategic vision and mission. CNOs must demonstrate personal attributes that drive their workforce to the next level. Hughes-Rease (2015) asserted, “These attributes, known as the four I’s, are idealized influence, intellectual stimulation, individualized consideration, and inspirational motivation” (para. 1).

Dr. Martin Luther King is an example of a leader who did not inspire an organization but inspired a cultural movement (History.com Staff, 2009). His “I Have a



Dream” speech has been replayed, at least in part, every year since his death in 1968. When the speech is heard, many stop in their tracks, even now, and are moved by the power it contains. Why is this important for CNOs? As transformational leaders who seek to achieve Magnet recognition through the American Nurses Credentialing Center’s Magnet Recognition Program, CNOs must communicate their vision such that it resonates in the minds and souls of their staff each and every day (Hughes-Rease, 2015). The “I Have a Dream” speech should be the blueprint for the CNOs’ message, not for its content but for its ability to inspire action and percolate in the hearts and souls of those who must be transformed (Hughes-Rease, 2015). Another component of communicating the vision that can create the proper setting for inspiration is the amphitheater-like platform often shown when important messages are being communicated, similar to the backdrop for most TED talks, or the enormous Facebook screen behind Mark Zuckerberg or the Apple screen behind Steve Jobs when he was alive (Hughes-Rease, 2015). The point is that communicating the vision is truly an important touchstone in a CNO’s career, and the vision should be both substantively impactful and visually impressive.

**Nurse manager learning domain framework.** Leaders transform nursing organizations through the implementation of a framework (Nurse Manager Leadership Partnership, 2008). The nurse manager learning domain framework is the result of the combined efforts of the American Organization of Nurse Executives (AONE, 2015) and the American Association of Critical-Care Nurses. A depiction of the framework appears in Figure 1.



*Figure 1.* Nurse manager learning domain framework. From *AONE Nurse Manager Competencies*, by American Organization of Nurse Executives (AONE), 2015, p. 3, retrieved from <http://www.aone.org/resources/nurse-manager-competencies.pdf>.

The framework is composed of three intersecting circles that focus on an inventory of skills that CNOs will reference in their effort to grow and mentor future nurse leaders (Nurse Manager Leadership Partnership, 2008). Each circle contains an important area of nurse leadership development. The three areas of focus are the science, the art, and the leader within (Sherman & Pross, 2010). Sherman and Pross (2010)

explained how the science targets business management, the art targets leading people, and the leader within targets nurse leader personal internal leadership development. The science spotlights seven essential skills such as the ability to manage finances, including the development of an ability to understand healthcare economics and public policy with respect to patient care, budgeting as it relates to the unit or the department, and capital budgeting (AONE, 2015).

Another science essential skill is developing the ability to manage people, such as interviewing, recruiting, understanding laws and regulations, human resource hiring policies, and employee onboarding. An additional science essential skill is developing the ability to manage performance improvement, such as total quality management and Six Sigma, patient and workplace safety, and the evidence of an ability to promote inter- and intradepartmental communication (Gittner et al., 2015). Further, science essential skills include developing thinking skills that are foundational, such as the use of a system approach; applying a complex adaptive systems approach; facility with organizational methods such as planning, organizing, and conflict resolution; making decisions; and problem solving. The fifth science essential skill is technology use (Anderson-Dean, 2012). The final science essential skills are strategic management and clinical practice knowledge (AONE, 2015).

The art spotlights four essential skills such as the ability to demonstrate human resource management capabilities, including mentoring others, offering guidance and coaching, facilitating staff development, managing performance, and succession planning. Moss (2005) said that an additional essential skill is influencing others and engaging in relationship management, including demonstrating evidence of

communication competencies, self-awareness, collaboration skills, understanding team dynamics, and skilled conflict resolution. According to the American Association of Critical-Care Nurses (2005), the third and fourth art essential skills are demonstrating awareness of diversity issues and implications, including demonstration of capacity for social justice, cultural competency, and diversity as it applies to multiple age groupings, and the ability to demonstrate shared decision-making capacity (AONE, 2015).

Furthermore, the American Association of Critical-Care Nurses (2005) noted that the leader within spotlights four essential skills, including personal career planning, personal journey mapping, demonstrating personal and professional accountability, and establishing tenets such as integrity as a central value and embracing self-exploration and self-development.

**Provide nursing governance.** CNOs must ensure that patient care is delivered in a comprehensive and homogeneous manner (Hader, 2011). This requires that challenges be discussed and examined, issues be addressed, and problems be resolved in a consistent and structured framework that establishes policies and procedures to ensure consistent and positive healthcare outcomes.

**Guarantee quality service.** Healthcare reform insists on quality care provision to patients (Hader, 2011). Nursing best practices must be established, monitored, and reviewed for needed adjustments. The Medicare and Medicaid regulatory framework, along with the Joint Commission and the American Nurses Credentialing Center's Magnet Recognition Program, offers strong incentives to healthcare facilities for delivering and ensuring thoughtful, evidence-based care (Hader, 2011).

**Strategic management.** CNOs are also responsible for establishing goals and ensuring that they are properly articulated, translated, and transferable to the floor (Hader, 2011). Overall, the objective is to appraise administrative and clinical procedures and benchmark results throughout the system to ensure best practices are implemented throughout the facility.

**Nurse leadership training and development.** Nursing education, training, and development are key to ensuring a healthy future for the healthcare system (Hader, 2011). It is the job of the CNOs to ensure that all aspects of this initiative are carried out and that the nursing workforce is a well-educated one. This includes creating partnerships that ensure the flow needed for recruitment, establishing creative partnership programs, or developing clinical scholarship initiatives. CNOs must ensure that the nursing workforce is educated, properly trained, and competent, and evidence of this fact must be verified and recorded (Hader, 2011). CNOs are responsible for nurse staffing workloads and budget preparation (Hader, 2011).

The level of responsibility and oversight under supervision by CNOs is extraordinary. CNOs are not only the face of nursing within their healthcare facilities, but they are also nursing spokespersons system-wide, including at governmental events, on the state and federal level, at conferences, in court, and in all settings that require executive attendance (Hader, 2011).

**Nursing leadership generation gap.** There is a lack of leadership development and a wide gap of knowledge between current nurse leaders and the new generation of nurses who graduate from school with a license and fundamentals (Dyess, Sherman, Pratt, & Chiang-Hanisko, 2016). The expectation that these graduates have leadership

skills that experienced nurses have spent countless hours developing is causing disappointment for both the graduates and the nurse leaders (D. Hutchinson, Brown, & Longworth, 2012). Nurse leaders expect new graduates to come out of school with the ability to think independently and critically, while the new nurses expect support in further developing these skills (RN Work Project, 2014). The newest nurse generation, Generation Y, also known as millennials—those who reached young adulthood around the year 2000—has expectations that are different and higher than those of the nurse generations that expected less from their employers and work life as a whole. New nurses from Generation Y are more likely to leave if they are not completely satisfied with their work situation (Tourangeau, Thomson, Cummings, & Cranley, 2013). A study by Stringer (2014) showed that Generation Y nurses will likely stay in the nursing field; however, they do not possess the same amount of loyalty shared by past generations.

### **Nursing Shortage**

A national nursing shortage is enhancing the need for hospitals and other healthcare facilities to focus on hiring, training, and leading qualified new nurse graduates. According to the American Association of Colleges of Nursing (AACN), nursing schools are struggling to keep up with the demand for nurses (Li et al., 2015). The public and nonprofit schools have limited enrollment due to a lack of qualified faculty, retention of nursing faculty, and clinical education requirements (Li et al., 2015).

CNOs use transformational leadership to ensure that proper onboarding of new nurses results in quality care and retention (Henderson & Eaton, 2013). The lack of qualified nurses available makes every new hire more valuable, and CNOs are continually working on ways to onboard new nurse staff to reduce turnover (M. W.

Edmunds, 2016). CNOs need to focus on hiring, training, and retaining qualified new nurse graduates (Dolan, 2011). More troublesome is the fact that nursing schools are struggling to keep up with the demand for nurses (AACN, 2015c). The AACN (2015c) reported that more than half of reporting nursing colleges have indicated that a lack of sufficient nursing faculty is the primary reason for the inability of colleges to admit qualified applicants to their schools, along with budget restrictions, insufficient space in the classroom, and a lack of sites for clinical practice. Nursing colleges in California have resorted to establishing random lottery systems to select qualified applicants to enroll in their registered nurse programs (Ohlone College, 2016).

In conjunction with the enrollment troubles facing nursing colleges is the implementation of the ACA and the new vision and demands of healthcare that it implies (IOM, 2011). The ACA demands that quality care be provided and accessible to all Americans, not just those who can afford it. Also, patient wellness, health outcome improvement, and prevention of disease are now priorities for patient care. Furthermore, the act requires that benevolent care should be given to all (IOM, 2010).

Over the past decade, healthcare decision makers and nursing leaders have become more aware of nursing shortage problems (IOM, 2010). These discoveries have provoked the identification of numerous barriers that have a negative influence on occupational growth rates associated with nursing jobs. Regardless of the industry in question, if organizations attract individuals with the necessary knowledge, skills, and abilities, they can overcome staffing deficits, meet performance objectives, and attain sustainability (Ababneh & Shrafat, 2014; Ankrah & Sokro, 2012). Similarly, employee retention is also a necessity to prevent incoming staff members from merely being used to

equalize the number of staff members leaving. If the turnover rate is high, there is little to be gained by the organization. Recruitment is currently a problem in the United States, which is compounded by issues of retention among nursing staff members (Mor, Intrator, Feng, & Grabowski, 2010).

In order to ensure that healthcare facilities have the staff needed to adequately provide for the needs of patients, policymakers and decision makers must take action to combat the nursing shortage in the United States (Anderson-Dean, 2012). To deal with this problem, research has revealed strategies that can be used to combat the nursing shortage. The two most obvious and effective strategies are to recruit and to retain nurses more effectively (Keenan, 2003). In order to do this, policymakers must examine the current structure and environment in which nurses are recruited and retained. It is clear that the current system is not working the way it should (Anderson-Dean, 2012). However, an examination of research in comparison to current best practices for recruitment and retention can guide policymakers in the best methods to combat the nursing shortage that comes from an insufficient number of nurses and high turnover rates in healthcare facilities (Anderson-Dean, 2012).

Transformational leadership skills have been documented as critical skills CNOs can use to ensure quality nursing skills and proper onboarding of new nurses. Sherman and Pross (2010) highlighted this idea, saying it is important for all nursing leaders to start now to groom future leaders. These emerging leaders will ultimately replace them and continue the very important work that is being done to improve nursing work environments and, most importantly, patient outcomes. This study adds to the body of



literature by helping to identify how CNOs view their transformational leadership skills as they relate to new nurse graduates.

As the nursing shortage has become a more significant problem in the United States, nursing and nursing education organizations have developed and recommended strategies to combat the shortage and promote nursing education and practice. The AACN (2015b) is attempting to address the problem by using its resources to secure federal funding for faculty development, explore strategies to address the nursing shortage, and help gain attention from the media on this situation. It is not necessarily intended that these measures will fix the problem, but they are still significant (AACN, 2015b). Not only is the organization attempting to draw attention to the problem in order to fix it, but the AACN's efforts can be used as a foundation for other organizations that wish to become involved in combating the nursing shortage in the United States.

Along the same lines, the Joint Commission on Accreditation of Healthcare Organizations has also developed standards by which organizations can determine the effectiveness of their staffing policies (Keenan, 2003). Some measures have been taken in the government as well. In 2002, President Bush enacted the Nurse Reinvestment Act, which addressed recruitment and retention policies (Keenan, 2003). Legislative bodies recognize the need to investigate the nursing shortage and take action that reverses this problem to improve access to care and improve the quality of care provided by nurses. However, it is also necessary for changes to be made at the facility level to apply the legislative measures and actively combat the nursing shortage through staffing recruitment and retention.

The ACA specifically makes a “call to action” to the nursing community to ensure primary care provision is bolstered, to ensure the provision of quality care, and to guarantee that costs are driven down (IOM, 2010). The “call to action” is a primal scream to the nursing fellowship, and more specifically to nursing executives to lead the way. The CNO in all healthcare facilities, whether in a hospital, ambulatory care, public community health, or any other employment setting, establishes the policy and procedural tone for the nurses who work for him or her and is the highest ranking nurse in the organization, and as such, the CNO is best positioned to heed the call to action for reform (Hader, 2009).

### **Factors Influencing Retention Rates**

Research has revealed three key factors that influence nurse retention: financial compensation, excessive work hours, and diversity (Khamisa, Oldenburg, Peltzer, & Ilic, 2015; Kovner, Brewer, Fatehi, & Jun, 2014; Yoder, 2010). First, the costs associated with substandard nurse retention rates are draining to organizations. The cost not only includes the financial burden but also the time and energy spent recruiting, hiring, and training qualified new nurses. C. Jones and Gates (2007) investigated rates of turnover among registered nurses in the United States and determined that the total cost associated with turnover ranges between \$1.4 and \$2.1 billion, with replacement costs per nurse as high as \$88,000. Initially, it may be difficult to imagine that turnover would be so costly. However, some of the factors involved include financial consequences of turnover, costs associated with employment marketing, payroll for recruitment staff, background check processes, and overtime payroll expenses to compensate for other nursing staff members covering the shortage, among others (Yoder, 2010).

Second, it is also important to understand that the connections between excessive work hours, patient and staff injuries, and financial ramifications do not typically figure into the costs of turnover. In addition, evidence from current literature indicates that nurses who remain with hospitals and medical facilities in spite of negative factors tend to experience chronic fatigue, frustration, and even animosity toward other coworkers (Vessey et al., 2009). As a result, nurses facing these conditions for extended lengths of time also tend to be associated with higher levels of patient falls, pressure ulcers, and fatalities among patients (Khamisa et al., 2015; Kovner et al., 2014). Based on these findings, it is important to note that although some nurses may possess the traits necessary for managing intense working conditions, these types of working conditions are not sustainable, and allowing the conditions to continue without appropriate intervention strategies is likely to discourage nurses and lead to ongoing frustrations (Vessey et al., 2009).

Finally, diversity factors contributing to the nursing shortage are the changes that have occurred in society in the past several decades. In early American history through the 1950s, there were only a few professions that were suitable for women: teacher, secretary, and nurse (Keenan, 2003). However, following the women's feminist movement of the 20th century, many more job opportunities are open to women that were not open before, even in the healthcare field. Women have demanded equality in the workplace, which has allowed them to branch into many other areas of healthcare. As a result, there have been fewer women seeking positions as nurses than there once were. There has been an increase in the number of male nurses in recent decades, but the small

increase in the percentage of male nurses does not adequately offset the decrease in the number of female nurses.

Collectively, the challenges accompanying nursing shortages envelop a number of moral, ethical, and sustainability issues for CNOs to consider and address. Since problems with nursing shortages are typically systemic, solutions to issues related to the nursing shortage will likely require a significant amount of time to fully implement, so there will be aftereffects (Cimiotti, Aiken, Sloane, & Wu, 2012). Nevertheless, lacking a broad, comprehensive, and quick-working solution to the national nursing shortage problem does not mean nursing leaders and hospital decision makers cannot implement other solutions to alleviate tensions arising from the problems with shortages (Cimiotti et al., 2012; Penoyer, 2010). This is discussed in later sections.

### **Patient Wellness**

One of the most important implications of the nursing shortage is the impact it has on patient health and safety. A shortage of nurses leads to an increased workload for existing nurses. This may manifest in fewer breaks, longer shifts, or fewer nurses on a shift. Unfortunately, an increased workload for nurses can, and often does, have an adverse effect on patient health and safety (Carayon & Gurses, 2008). When nurses have heavy workloads, they may be unable to check on patients as often as they should or may make errors in reporting and documentation. This can lead to accidents, health problems, or other implications having an adverse impact on patient health and safety. In other words, when nurses have a heavy workload, they may be unable to meet the standards of care necessary to protect patient health and safety (Carayon & Gurses, 2008). This then

has further implications because of the liability of the healthcare facility as it relates to accidents, health problems that develop, and even patient deaths.

### **Health Outcomes**

Patients are not the only ones who are impacted negatively by the nursing shortage. Heavy workloads due to the nursing shortage can lead to a greater likelihood of burnout among nurses (Spence Laschinger & Leiter, 2006). The nursing shortage is a contributing factor to poorer work conditions. When nurses have increased workloads, they may feel overwhelmed, as if they have no support, and may have an increasing sense of job dissatisfaction. When nurses experience job dissatisfaction, they may begin to feel burned out, which can ultimately lead to nurses leaving the job, the facility, or even leaving nursing altogether. This then further contributes to the nursing shortage, which simply perpetuates the cycle.

### **Nursing and Job Satisfaction**

An important consideration in the implications of the nursing shortage is that there is not an easy solution to the problem. There are many complex factors that contribute to the nursing shortage, and many of them are interlocked with others. For example, the nursing shortage increases nurse workloads, which increases job dissatisfaction. Job dissatisfaction leads to higher turnover rates, which increases nurse workloads. Because of the complex issues at hand, it is impossible to design a simple solution, such as in a written policy or compensation measure, to address the problem (Peterson, 2001). However, one thing is clear: In order for this problem to be adequately addressed and solved, policymakers must address the various components contributing to the nursing shortage and its implications. Studies have shown that job satisfaction is not

easy to quantify and explain (Woolliams & Moseley, 1999). Satisfaction with one's job has different meanings depending on many different variables.

One of the reasons transformational leadership could be effective to combat the nursing shortage is that it improves the work environment in which nurses practice (Hasmilller & Cozine, 2006; Ramey, 2002). Improving the work environment makes working as a nurse in a healthcare setting more attractive to new nurses and potential nurses. In addition, improving the work environment improves the quality of care provided to patients (Hasmilller & Cozine, 2006). This improves patient satisfaction, which can have an impact on funding for a healthcare facility.

The nursing shortage also has economic implications that cannot be ignored. High turnover rates among staff, recruiting costs, and the risks associated with implications in the quality of care provided all have a financial impact on healthcare facilities (Kowalski & Kelley, 2013). In order to combat this element of the nursing shortage, healthcare facilities must view nurses and nursing education as an investment in the healthcare field with a return on investment when done properly (Kowalski & Kelley, 2013).

Another significant factor contributing to the nursing shortage is the nursing school environment. Nardi and Gyurko (2013) explained that the shortage of nurses is not only significant in the United States but all over the world. According to the researchers, "In addition to a shortage of nurses with at least a baccalaureate degree, there is also a shortage of academically qualified faculty available to teach in schools of nursing" (Nardi & Gyurko, 2013, p. 317). The International Council of Nurses has

indicated that this is a serious concern and that it has a negative impact on healthcare (Nardi & Gyurko, 2013).

### **Nurse Bullying**

A major concern among CNOs is the increase in bullying common in the nursing field (Rocker, 2012). As the focus on controlling costs continues to rise in healthcare, there is an increasing awareness of the cost of bullying that results in new nurse turnover, lawsuits, and loss of productivity (Simons & Mawn, 2010). Many nurse leaders have increased their awareness and are proactive in their approach to workplace bullying (Rocker, 2012). In high-stress and competitive environments such as nursing, it is important to create an environment that is focused on the safety of all employees. Healthcare leaders continue to increase education and budget resources appropriately to decrease incidents of bullying in their hospitals (Griffin & Clark, 2014; Lipscomb & London, 2015; Porath & Pearson, 2012).

In 2015, the ANA came out with a plan to publicly acknowledge the frequency of nurse bullying in the nursing profession (Professional Issues Panel on Incivility, Bullying, and Workplace Violence, 2015). The ANA recommended education and leadership to combat the problem and said it will no longer tolerate incivility, bullying, or workplace violence in the nursing profession. As new nurses enter the nursing profession, an emphasis on workplace safety and an encouraging environment will be important for CNOs to encourage to nurse leaders and those working directly with new nurse graduates (Longo, Dean, Norris, Wexner, & Kent, 2011). The financial costs of turnover, retention, and training of new nurses increase the risk of not having a sufficient

and well-trained staff that will keep up with the demands of the nursing profession (Griffin & Clark, 2014; Lipscomb & London, 2015; Porath & Pearson, 2012).

### **Nursing School Environment**

Another significant factor contributing to the nursing shortage is the nursing school environment. Nardi and Gyurko (2013) explained that the shortage of nurses is not only significant in the United States but all over the world. According to the researchers, “In addition to a shortage of nurses with at least a baccalaureate degree, there is also a shortage of academically qualified faculty available to teach in schools of nursing” (Nardi & Gyurko, 2013, p. 317). The International Council of Nurses has indicated that this is a serious concern and that it has a negative impact on healthcare (Nardi & Gyurko, 2013).

Along the same lines, there is a shortage of educational institutions and programs to accommodate the increased need for nurses to be educated and licensed in the United States. The passage of the ACA increased the patient load, but the educational systems did not change nearly as quickly. As a result, even if there were enough students to combat the nursing shortage, there are not enough available spots in nursing programs to educate nursing students, a fact that is only further complicated by the shortage of nursing faculty.

**Collaboration.** In an effort to provide nursing students with rich and rewarding experiences in a real working environment, the AACN and the Centers for Disease Control and Prevention (CDC) have entered into a partnership to provide a 1-year fellowship program, now in its second year (AACN, 2014b). The program is similar to the fellowship opportunity provided to doctors. The nurses will work onsite at the CDC



headquarters in Atlanta for one year (AACN, 2013a). The overarching goal of the partnership is to build capacity in the public health field (AACN, 2013a).

**Nursing faculty shortage.** The nursing shortage cannot be addressed until the lack of nursing faculty is considered. The average age of nurse faculty is 62.5 years, and the retirement outlook over the next few years is one reason for this shortage (Li et al., 2015). The nurse faculty shortage, along with advancements in healthcare, nurse retirements, and those moving into administrative and leadership roles leaving openings for clinical nurses and nurse educators, results in a “perfect storm” (Korcok, 2002). The lack of nursing faculty to train new nurses makes it more important to focus on current and new nurse retention (C. Jones & Gates, 2007).

The necessary growth in nursing schools is being hampered by the longstanding shortage of nursing faculty, a direct function of salaries that are not competitive and an insufficient number of doctoral-prepared nurses (AACN, 2013b). The average age of U.S. nurse faculty is 53 years (AACN, 2016b). As are many of the so-called baby boomers, nursing faculty members are aging, reaching retirement, and consequently creating a bottleneck of unmet educational services at the colleges (Grant, 2016).

Also, the AANC (2016b) reported that approximately two thirds of colleges report they do not have the funding necessary to hire extra faculty. Nursing colleges responding to a survey conducted by the AACN reported a 7.6% faculty vacancy rate in 2012 (AACN, 2013b). Most of the vacancies were for faculty positions requiring a doctorate (AACN, 2013b). Except for a few very minor dips, the nurse faculty vacancy rate increased year after year between 2005 and 2014 (AACN, 2016b). In 2014, there were 1,328 faculty vacancies (AACN, 2016c).

Approximately two thirds of the nation's schools have reported that the nursing vacancy rate is the basis for failing to accept many qualified candidates in their baccalaureate degree programs (U.S. Department of Health & Human Services, Health Resources and Services Administration, 2013). The IOM (2011) nursing mandate, expressed in the iconic report *The Future of Nursing: Leading Change, Advancing Health*, to increase the number of nurses with baccalaureate degrees to 80% of all nurses by 2020 and to double the number of nurses with doctoral degrees will not be met if the nursing faculty shortage remains as it currently exists. A bright note, though, is that in 2013, the Jonas Center for Nursing Excellence and the AACN advised of a new scholarship fund for PhD and DNP doctoral candidates who are willing to pursue a faculty position after they graduate (AACN, 2013b). One hundred fifty nursing students will be selected to receive the scholarship through the Jonas Nurse Leaders Scholars Program (AACN, 2013b). In addition, Johnson and Johnson is providing financial support to minority graduate students willing to teach in a nursing school upon graduation (AACN, 2016a).

The most prevalent aspect of the role of education in the nursing shortage is the problem of the faculty shortage (Henderson & Eaton, 2013). When addressing the issue of the faculty shortage as a contributing factor to the nursing shortage in the United States, faculty members face similar issues in nursing education that contribute to the nursing shortage. In the midst of a nursing shortage, there is also a shortage in individuals who can teach student nurses and prepare them for their careers. There are a number of factors contributing to this shortage, including the retirement of faculty members, funding constraints, and increasing job competition from clinical sites (AACN,

2015b). It is also expensive for nurses to move from practice to academia due to the advanced degrees required to become nurse educators (McDermid, Peters, Jackson, & Daly, 2012). Financial considerations may prevent nurses from pursuing or completing advanced degrees and becoming nurse educators. Then, when current faculty members retire, there are no new, qualified educators to take their places.

Unfortunately, the nursing faculty shortage essentially feeds into itself. Since there is a shortage of nursing faculty, nurse educators who are teaching often carry heavy workloads (Chung & Kowalski, 2012). These heavy workloads increase job stress and job dissatisfaction, which contributes to higher turnover rates (Gerolamo & Roemer, 2011). Due to the high turnover rates, faculty members face higher workloads, and the cycle begins again.

Understanding the reasons why there is a shortage of nurse faculty can help educational institutions combat the problem and improve nursing education in the United States. The National Advisory Council on Nurse Education and Practice (2010) identified six specific challenges faced by nurse educational institutions in providing adequate nursing faculty to meet the increased demand for nurses in the United States. These challenges include (a) the inability to recruit and retain qualified faculty, (b) the inability to improve diversity among faculty, (c) the lack of knowledge about nurse education as a viable career path, (d) the lack of adequate educational preparation for nurse educators, (e) financial considerations to support faculty programs, and (f) age and retirement of nurse faculty (National Advisory Council on Nurse Education and Practice, 2010). It is hoped that knowledge about these challenges can guide policymakers and educators and that the knowledge can be used to combat them more effectively, thereby

training, recruiting, and retaining qualified nurse educators to train nursing students and reduce the nursing shortage in the United States.

**Nurse faculty compensation.** Nurse faculty compensation ranks eighth when compared with 11 other nursing jobs in a survey by registered nurses (RNs; Toth-Lewis, 2014). A nurse anesthetist received 33% higher pay than a faculty member with a master's degree. A head nurse and midwife received 17% higher pay than a faculty member, and a nurse practitioner received 12% higher pay than a faculty educator. In 2011, the median salary of a nurse practitioner was just over \$91,000. A faculty member with a master's degree earned a median salary of \$72,028. More than 50% of faculty educators indicated that they had two or more jobs, while close to 20% had three or more jobs (Toth-Lewis, 2014).

Nurse educators, when compared to faculty who teach in other areas, receive much lower compensation (National League for Nursing [NLN], 2014). When compared to earnings of faculty in public colleges and universities, nurse educators earn just 79% of their salary. When compared to the earnings of faculty in private schools, nurse educators earn 32% less. In the case of over 50% of the nurses who planned to leave their positions as nurse educators within 1 year, earnings dissatisfaction was cited as the reason. The same was true for those planning to leave in the next 5-10 years. In addition to realizing that their worth as an important component of the nursing academic environment is not recognized, many faculty members cited their workload as another contributing factor to their desire to leave their position (NLN, 2014).

**Nurse faculty workload.** A 2005-2006 report showed that nurse educators generally worked about 53.3 hours per week (Toth-Lewis, 2014). They reported working

25 hours per week during vacations or during break. Nursing professors performed instruction, researched, and provided service. The majority of their time was spent actually teaching, followed by clinical supervision of their students, with consulting and mentorship being the next category of activities before clinical practice, providing some form of service on behalf of the institution, and finally, administrative and research responsibilities. A 12-credit-hour semester was found to be the typical faculty workload. Nurse educators who taught undergraduate students spent three times as much time as professors of graduate-level students in clinical settings. Clinical settings are more taxing because of the supervisory responsibilities of the faculty member (Toth-Lewis, 2014).

Surprisingly, faculty who taught online had a heavier workload than those who taught through traditional methods. Online instructors interfaced with students over 50% of the time, while on-campus instructors interfaced with students only 37% of the time (Toth-Lewis, 2014).

**Nursing school enrollment.** The number of basic RN nursing school programs has increased nationally over the years, from a low of 1,444 in 2003 to a high of 1,869 in 2014 (NLN, 2014). In 2014, there were 710 baccalaureate, 67 diploma, and 1,092 associate degree programs (NLN, 2014). In its 2014 annual report, the AACN (2014b) surveyed 776 schools, representing 90% of all nursing programs in the United States with baccalaureate and graduate programs. The respondents indicated that 271,179 applications were submitted to baccalaureate educational institutions offering entry-level nursing programs. Of these applications, 170,559 were in accord with admission requirements, and of those, 112,615 candidates were accepted for admission to nursing programs, representing an acceptance rate of just over 40%. Just under 300,000 students

were enrolled in a baccalaureate degree program, which showed an increase from enrollment figures from 2012. Over 180,000 nursing students were in entry-level baccalaureate programs, just over 180 students were in master's degree programs, over 14,000 students were enrolled in practice-based doctoral programs, and over 5,000 students were in research-based doctoral programs (AACN, 2014b).

Nursing schools have evidenced an increase in their minority student population of at least 25% in all degree programs since 2013, including entry-level baccalaureate, master's, and research-based and practice-based doctoral programs (AACN, 2014b). Men, extremely underrepresented as a category in nursing schools, also represent an increasing candidate population, with at least 10% in all degree programs (entry-level baccalaureate, master's, and practice-based doctoral programs) except research-based doctoral programs where men represent 8.7%. Nursing schools are offering creative solutions to students who want to enter the nursing workforce, and they now offer accelerated programs, where individuals who already have degrees in other subject areas are able to apply some of the credits from their former programs toward a nursing degree (AACN, 2014b). There has been an increase in enrollment in accelerated nursing programs, with over 1,600 students in baccalaureate programs and close to 6,000 in master's degree programs. Nurses have heeded the call to extend their education through enrollment in degree completion programs, and nursing schools have seen a steady increase in working nurses returning to the classroom to continue their higher education over the last 11 years (AACN, 2014b). There are 95 clinical nurse leader programs offered nationally, with over 3,000 students enrolled in these master's-degree-level programs (AACN, 2014b).

The paths to achieving an RN degree are varied. Most nurses achieve their initial education through an associate degree program, quite often through a community college (Aiken et al., 2009). A smaller portion of nurses receive their Bachelor of Science in Nursing (BSN) through 4-year university programs. An even smaller set of nurses enter colleges with a Bachelor of Arts (BA) degree in another field and then earn their BSN in 12 to 18 months (Aiken et al., 2009).

The number of nursing school baccalaureate applicants has increased by more than 70% since 2004 (IOM, 2011). Thus, the desire for entry into nursing programs exists and remains quite vibrant. The unfortunate news is that nursing colleges are overwhelmed by the number of qualified applicants, only a small number of whom they can accept, and are forced to turn applicants away by the tens of thousands (AACN, 2015c).

Nursing schools primarily fall in one of four categories: public colleges, which are often state run; private colleges, which are generally research or educational nonprofit organizations—though some private colleges are for-profit; community colleges, which are generally 2-year colleges; and for-profit colleges, which are generally operated by profit-based businesses (Kineer, 2014). Public, private, and community nursing colleges have a longer history than for-profit nursing colleges. These colleges are often referred to and viewed as the more traditional nursing colleges and universities (Kineer, 2014). For-profit nursing colleges have emerged more recently due to the lack of availability at public and nonprofit colleges (IOM, 2010). For a variety of reasons, for-profit nursing institutions appear to provide more opportunities for those who wish to enroll in nursing school (Kineer, 2014).

## **For-Profit Nursing Schools**

For-profit nursing schools have been identified as an integral part of the solution to achieving 80% BSN readiness by 2020 (IOM, 2010). The IOM (2010) views for-profit educational organizations as part of the instructional mix that will be relied upon to achieve a more educated nursing workforce. Hospitals and other healthcare facilities are finding the need to depend on for-profit nursing schools to provide them with nursing staff necessary to continue the level of care demanded by the government, community, and the public (IOM, 2010). In a U.S. Government Accountability Office (GAO, 2011) study on nursing pass rates during the period from 2008-2010, pass rates for those taking nursing exams nationally showed that graduates who had either a bachelor's degree or an associate's degree from a for-profit college did not demonstrate a significantly lower passing rate on their RN licensing examination than nurse graduates with degrees that were either from public schools or nonprofit schools.

Nurse graduates who took the licensed practical nurse (LPN) licensing examination had pass rates that were similar to those of nurse graduates who attended nonprofit schools (GAO, 2011). Billions of federally funded dollars are distributed to for-profit, nonprofit, and public colleges annually, yet the funding has grown fastest at for-profit schools (GAO, 2011). Although educational quality is difficult to determine through singular analysis methodologies, it has been measured indirectly through indicators such as gainful employment rates, pass rates on state and national licensing exams, graduation rates, and loan default percentages (GAO, 2011).

**Changes in for-profit education.** As the United States has experienced continued turmoil in the economy, education and healthcare are at the forefront of local



and national debates regarding a right to an education and healthcare versus a for-profit model. This has led to significant internal change within the for-profit school sector. According to the U.S. Department of Education (2014), gainful employment laws will push for tighter regulations to rid the sector of bad for-profit institutions and support those who offer quality education and focus on job placement outcomes.

**For-profit school history.** For-profit institutions have been a component of the postsecondary education landscape in the United States for more than 300 years (Morey, 2004; Ruch, 2001). Traditionally, these institutions provided technical and vocational training at the subbaccalaureate level. Proprietary education dates back to the 5th century B.C. in Greece, a time when teachers traveled to areas where students would pay for instruction. These educators taught whatever was in demand at the time. This system was very successful, and Athens had a very advanced educational system and a high literacy percentage at that time. The nimbleness of proprietary education has allowed it to grow by offering what large government-run schools are either slow to adopt or unwilling to offer in their curriculums in order to match the changes of society. In the mid-18th century, the Dutch settlers in the United States began teaching subjects and skills that were not taught at the traditional colleges at the time, such as navigation, surveying, and accounting (Morey, 2004; Ruch, 2001).

Traditional colleges in the United States, such as Yale, Harvard, and William and Mary, were built on religious studies and did not offer technical training, which opened the door for commerce in education (Shenandoah, 2002). The Industrial Revolution created a demand for marketable skills that were not offered in a traditional setting (Carl, 2009). Industry started to grow following World War II, when government assistance

programs like the GI Bill became available to help veterans acclimate to their environment upon returning to the states (U.S. Department of Veteran Affairs, 2013). A few decades later, Pell grants and other subsidies were authorized for proprietary college students who needed financial assistance to help them afford school (Pell Institute, n.d.).

Within the past 20 years, however, for-profit institutions have begun granting an ever-increasing share of the baccalaureate degrees earned in the United States (Sheffield, 2015). Within the past 10 years, these institutions have experienced tremendous growth at the master's degree level and above (Turner, 2006). For-profit enrollment growth has been attributed to several factors, including aggressive recruitment strategies employed by some for-profit institutions, federal student aid policies, access to funding for expansion, and the customer service focus of for-profit institutions (T. Bailey, Badway, & Gumport, 2003; Kinser, 2006; Morey, 2004; Turner, 2006).

**Challenges of perception.** Most of the challenges the proprietary education industry has faced surrounded the suspicion of fraud and greed from detractors who did not believe education should be in a for-profit setting (Nonprofit Colleges Online, n.d.). With lax regulations during the 1970s and 1980s, greedy profiteers found ways to entice students to enroll and apply for financial aid, cash the checks, and then forget about the quality of education (Quinlan, 2015). In 1991, the Maxine Waters Act enacted strict guidelines and regulations that put over 50% of for-profit schools out of business. Over the past 20 years, schools found a way to work around the rules, and many old habits returned, despite accreditation standards and watchdogs. The industry spends millions of dollars on lobbyists to influence decision makers to be fairer to them. According to David Waldron (2015), for-profit education needs to reinvent itself, similar to how Japan

used total quality management to create a new standard in the automobile industry, with a focus on customer service and quality. On October 30, 2014, the U.S. Department of Education announced the implementation of new regulations on gainful employment. The regulations hold educational institutions accountable for the quality of education their students receive. For schools qualifying for federal student aid, success will be measured by a variety of metrics, but particular focus will be placed on student protection, cost-cutting measures employed, and student outcomes with respect to gainful employment (U.S. Department of Education, 2014). There has been continued turmoil in the U.S. economy and significant internal change within the for-profit sector. According to the U.S. Department of Education, the Obama administration is pushing for tighter regulations to rid the sector of bad actors that leave students saddled with debt and without the necessary skills to obtain employment (Kamenetz, 2015). One argument from the proponents of for-profit schools is that nonprofit schools do not have the same requirement and are not held accountable for outcomes, even though some nonprofit college graduates often suffer from student debt and low-paying jobs (Quinlan, 2015).

**Gainful employment regulations.** The political/legal/regulatory environment is at the top of the list as far as importance to the future of for-profit colleges (Quinlan, 2015). The GAO (2011) noted that 90% of the students who attend for-profit colleges apply for funding through Title IV of the Higher Education Amendments (1998), which provides for government student loans and grants. There are many rules and regulations that must be followed in order for schools to remain compliant and in good standing. Gainful employment regulations require that institutions must certify that all gainful employment programs meet applicable accreditation requirements and state or federal

licensure standards (Thomason, 2013). All curricula described as gainful employment programs must pass metrics to continue eligibility in the student financial aid program. This requirement includes that the estimated annual loan payment of typical graduates does not exceed 20% of their discretionary earnings or 8% of their total earnings and that the default rate for former students does not exceed 30%. Additionally, institutions must publicly disclose information about the program costs, debt, and performance of their gainful employment programs so that students can make informed decisions (Thomason, 2013).

As the United States has experienced continued turmoil in the economy, education and healthcare are at the forefront of local and national debates regarding a right to an education and healthcare versus a for-profit model. This has led to significant internal change within the for-profit school sector. According to the U.S. Department of Education (2014), gainful employment laws will push for tighter regulations to rid the sector of bad for-profit institutions that leave students saddled with debt and without the necessary skills to obtain employment.

Title IV of the Higher Education Amendments (1998) requires that programs that provide federal student financial aid to support student attendance at institutions of higher education meet Title IV eligibility requirements. To participate in these programs, proprietary (for-profit) institutions must meet requirements included in Section 102 of the Higher Education Act, including requirements that proprietary institutions have been in existence for at least 2 years and derive at least 10% of school revenue from non-Title IV funds (Higher Education Amendments, 1998). This latter requirement forms the basis of the 90/10 rule (U.S. Department of Education, Office of Federal Student Aid, n.d.). The

cohort default rate is defined as the share of borrowers at each school who enter into repayment on federal loans during a 12-month period and subsequently default in the next 2 (or 3) years (U.S. Department of Education, Office of Federal Student Aid, 2015). Institutions with a 2-year cohort default rate that exceeds 40% in 1 year, or 25% for 3 consecutive years, lose their eligibility for Title IV aid for 1-3 years (U.S. Department of Education, Office of Federal Student Aid, 2015).

### **Nonprofit Nursing Schools**

**Community college nursing programs.** There are several paths to becoming an RN. A candidate can attend a hospital-provided 3-year diploma program, obtain an associate degree at a community college, or study for a 4-year baccalaureate degree at a college or university (AACN, 2015a). Upon program completion, the student must sit for the NCLEX-RN licensing examination and fulfill his or her state's requirements (AACN, 2015a). Community colleges have historically provided a less expensive educational option for obtaining career training.

With the advent of the IOM mandate (Kohn et al., 1999), more collaborative partnerships between 2-year community colleges and 4-year colleges are being established whereby students can start at a community college but earn their baccalaureate nursing degree (BSN) through a partnership between the community college and a senior college or university. In addition, *articulation agreements* are instruments created to allow for the consistent transference of education credits obtained at a community or other associate degree college and a nursing program that issues a BSN (AACN, 2014a). The agreement is worked out between the faculty from the community college and the senior college or university to ensure that the students receive

the proper training in preparation for extending their education beyond the associate degree (AACN, 2014a).

**Public nursing programs.** Public institutions of higher learning are state-funded schools that often receive federal funding as well (Rebeccac, 2011). Like community colleges, public universities are less expensive than private institutions. In addition, state-funded public colleges and universities are often large facilities and have extensive campuses, enroll a large and diverse student population, and often offer a variety of academic choices (Rebeccac, 2011). For those looking for a lower cost way to get a nursing education, nursing programs offered at public colleges or universities provide a cost-effective way to achieve their educational objective.

### **Leadership**

Northouse (2004) outlined many leadership styles, such as autocratic, laissez-faire, democratic, situational, transactional, and transformational. A transactional leader is focused on supervision and organization and utilizes discipline, reward, and punishment to get things done (House, 1971). The transactional leader is not interested in change but in maintaining the status quo (Ingram, n.d.). Although mutually exclusive, it has been shown that some leaders can demonstrate both transformational and transactional styles, although in differing circumstances (House, 1971).

### **Transformational Leadership**

According to Rahn (2015), the transformational leadership style has the ability to combat factors that lead to nurse turnover rates, which results in greater retention. When nurses are retained, the quality of care provided is better for patients, and job satisfaction is increased because other nurses do not have heavier workloads (Rahn, 2015). There is a

mutual exclusivity between a leader who is transformational and a leader who is transactional (*Transformational Leadership*, 2010). A transformational leader creates extensive change in the lives of individuals and in the life of the organization. Perceptions are changed, values are distinguished, expectations are redesigned, and aspirations are shifted (Hughes, 2014). A leader who is transformational relies on his or her personality, character, traits, ability to model desired behavioral outcomes, and ability to articulate a vision that is energizing and inspiring (House, 1971). A transactional leader, on the other hand, is focused on supervision and organization and utilizes discipline, reward, and punishment to get things done (House, 1971). The transactional leader is not interested in change but in maintaining the status quo (Ingram, n.d.). Although mutually exclusive, it has been shown that some leaders can demonstrate both transformational and transactional styles, although in differing circumstances (House, 1971).

Transformational leadership is a managerial approach in which the ideal strategic outcome is transforming followers (i.e., nursing staff members) into leaders (*Transformational Leadership*, 2010). Transformational leaders accomplish their goals through increasing motivation, enhancing the morale, and strengthening the performance of staff. A leadership goal is to tie the staff members' sense of self to the global mission and unified personality of the organization, act as an inspirational role model for the nurses, challenge healthcare staff to own their work, and evaluate staff competencies so that performance is aligned with ability (Justin et al., 2008). Transformational leaders create strategies to take their followers to the next level of performance and success (Ingram, n.d.).

The four *Is* are foundational elements for transformational leadership. These include individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence.

**Individualized consideration.** Leaders who employ individualized consideration are concerned with their staff members' individual needs, and they get involved with the nurses through mentoring and/or coaching and respond to what the nurse managers have to say or what their concerns are (Cossin & Caballero, 2013). These leaders are empathetic toward their followers, keep the lines of communication open, and make certain to challenge their workers.

**Intellectual stimulation.** Transformational leaders want to encourage independent thought; as a result, they will challenge assumptions the group makes, encourage creativity, and not avoid risk taking (Cossin & Caballero, 2013). Nurses' ideas are sought out. Staff members are encouraged to figure out on their own the best solutions to problems regarding tasks they need to accomplish. Paul Allen, cofounder of Microsoft, might be viewed as a leader who used intellectual stimulation as a leadership element. Both Allen and Bill Gates created software that allowed computers to do things no one thought was possible at the time (Wingfield, 2015). First, they engaged in their own intellectual stimulation, and then they built a business that was based on intellectual stimulation. Current revenues of \$98.58 billion indicate that there was some level of intellectual stimulation going on (Wingfield, 2015).

**Inspirational motivation.** Through inspirational motivation, transformational leaders provide inspiration to the troops. The leaders' goal is to communicate a vision that allows healthcare workers to invest substantial effort into their tasks, bolstered by



excitement and energized about the success to come (Hughes, 2014). Team spirit is evoked through inspiration, and enthusiasm is translated into motivation. Richard Branson of Virgin Atlantic Airways and Virgin Mobile is viewed as an inspirational and motivational leader to his workforce and to many others worldwide (K. B. Jones, 2015).

**Idealized influence.** The idealized influence element of transformational leadership is where the leaders' charismatic nature comes into play. Through encouragement of a strong sense of affinity, influence, and personal rapport, resulting from treating staff members as individuals and giving them respect and trust, transformational leaders can instill a sense of pride in their workforce, which can convert into team success (Hughes, 2014).

Leaders with idealized influence display a sense of confidence and power, and others embrace those characteristics because it gives them confidence. Steve Jobs might be referred to as having an idealized influence; he was always on point (all about the product), he had a vision that everyone embraced, and he knew how to get everyone excited about it (Wingfield, 2015).

According to the IOM's (2010) goal to achieve 80% BSN readiness by 2020, the scarcity of leadership among nurses is a very real threat for the safety and expectations of good healthcare for the future. This predicament revolves around the fact that there is a shortage of new nurses, yet there has been a radical increase in demand for nursing care, amplified by the ACA and the intricate evolution of advances in the healthcare system (The National Academies of Sciences, Engineering, and Medicine, 2010). As a result of the emerging transformation of the U.S. nursing healthcare, CNOs are responsible for the leadership of nurses and the development and mentoring of nurse graduates, and they

play a major role in influencing the future of medicine. Recent nurse graduates represent the next entrants into the field of nursing and, as such, represent the next generation of patient caregivers and ripe candidates ready to alter the nursing paradigm and respond to the national call for change (IOM, 2011).

**Transformational Leadership Skill Inventory (TLSi).** Transformational leadership has been defined in many different ways. One inventory tool that was developed and has been useful in research is the TLSi, created by Larick and White (2012). The TLSi breaks down the definition of transformational leadership into 10 distinct domains. This tool has been used by researchers to study transformational leadership in other professions. Flores (2015) utilized this tool to study how cohort mentors use transformational leadership to mentor students and studied principals. The 10 areas of focus are defined as follows:

***Visionary leadership.*** Visionary leaders are leaders who help others believe in them. What makes them unique is that the vision includes everyone and that people are often excited to support and get behind visionary leaders (Mhoon-Walker, 2013). Visionary leaders are constantly working on ways to increase the level of engagement.

***Communication.*** It is nearly impossible to overcommunicate. Communication is the most basic of transformational leadership skills and the easiest one to overlook (Weber, 2013). There are many vehicles available to assist in communication, but the first thing transformational leaders need to figure out is what is the best way to communicate with their team. Open communication is often used by leaders to engage and inform followers. A key ingredient that can be improved through leadership is to

inspire communication and foster the trust needed to empower both leaders and employees to enhance their own ability to do their jobs (McLagan, 2014).

***Problem solving and decision making.*** It is imperative for transformational leaders to properly identify the problems affecting the organization in order to properly diagnose and solve issues. Poor decision making results in loss of revenue, morale, and job satisfaction, not to mention the potential loss of employment (Beer, 2009).

***Personal and interpersonal skills.*** Goleman (1997) explained that self-awareness, self-control, empathy, social skill, and motivation are important aspects of intelligence, called emotional intelligence.

***Character and integrity.*** It is the leader's job to ensure that business is conducted ethically and is consistent with policies. In nursing, there are very clear protocols and rules that must be followed. It is common knowledge that nursing is the most trusted profession (Schwartz, Spencer, Wilson, & Wood, 2011).

***Collaboration.*** In the world of constant change, transformational leaders need to be collaborative (Hawkins, 2014). When contemplating a change, one of the most important aspects is to make sure that there is a win for every group of people who have a stake in the decision. People will buy into ideas when they feel they are part of them. Collaboration uses consensus and creative ideas that are constantly building upon each other (Anderson, 2015).

***Diversity.*** Increasing diversity is a factor that can help build loyalty. Allowing and supporting associates from all different backgrounds and cultures to share their ideas shows followers that leaders are committed to employees and customers (Larick & White, 2012).

***Creativity and sustained innovation.*** Creativity and innovativeness are very important attributes for transformational leaders. Change is constant, and in order to stay viable and competitive in today's marketplace, it is a must. In healthcare, there is constant innovation, and transformational leaders need to embrace change and constant improvement (Lewis, 2011).

***Team building.*** Teamwork is an essential element for the success of any leader. Teams have purposes that increase the success of advanced goals or visions. Leaders can improve teamwork by using a team planning process. Teamwork is the “how” or the part of the “what” that teams set out to achieve (Lencioni, 2009). Teams and teamwork involve leveraging talents and skills of individuals in order to achieve results together (Belbin, 2010). Teams improve the way business works today by using team protocols and decision-making guidelines (Beyerlein, 2002). Team practices and tools provide the dependability, accuracy, and reliability needed to carry out activities and events.

***Political intelligence.*** In order to be politically successful, one must work as closely with the opposition as with supporters (White, Harvey, & Kemper, 2007). This can take getting used to, but it is a mandate for transformational leadership.

### **Transformational Leadership and CNOs**

Transformational leadership is a type of leadership that creates change through the cooperative efforts of leaders and employees. Research has indicated that this type of leadership is effective in healthcare settings, particularly because of the need to adapt to evidence-based practice changes (Pickerell, 2014). Due to the emphasis on building positive relationships, transformational leadership in healthcare settings can improve job satisfaction (Ramey, 2002).

Within the scope of the nursing shortage, transformational leadership could be the key to improving staffing levels and, in turn, improving the quality of care available to patients. According to Thyer (2003), nurses have different perspectives than they used to and frequently prefer a relationship-based leadership style that not only offers adequate support but also rewards engagement and values input.

Even within settings that have nursing shortages, transformational leadership may help improve the quality of care (Ross, Fitzpatrick, Click, Krouse, & Clavelle, 2014). Leaders can work with employees to discover the practical impact of the shortage on the practice in the facility. Together, they can make changes to policies and procedures that ensure that the needs of the patients can be appropriately met within the limitations of staffing levels (Toth-Lewis, 2014). Policies cannot force leaders to use transformational leadership in healthcare settings. However, through evidence of the benefits of transformational leadership in healthcare settings, leaders may be more likely to use the leadership style in order to improve operations in their own facilities (M. Hutchinson & Jackson, 2013).

One of the reasons transformational leadership could be effective to combat the nursing shortage is that it improves the work environment in which nurses practice (Hasmiller & Cozine, 2006; Ramey, 2002). Improving the work environment makes working as a nurse in a healthcare setting more attractive to new nurses and potential nurses. In addition, improving the work environment improves the quality of care provided to patients (Hasmiller & Cozine, 2006). This improves patient satisfaction, which can have an impact on funding for a healthcare facility.

## **CNOs, Leadership, and New Nurse Graduates**

There are four seminal works related to this study. These studies focused on transformational leadership in Magnet hospitals, new nurse graduates, their need to be successful, and the current leadership gap in C-level healthcare executives. The findings correlate with the importance of the needed leadership for new nurse graduates in order to provide quality healthcare that is demanded by the public and government.

A study published in *The Journal of Nursing Administration* (Clavelle et al., 2012) focused on transformational leadership practices of Magnet CNOs and how these practices influenced the quality required to receive Magnet status. The literature explained that the challenges of CNOs continue to rise, as many aspects of the future of healthcare are not just hyper-turbulent but unknowable as well. Transformational leadership is needed to help guide future nurses. The conclusions of this study indicated that experienced CNOs exhibit higher levels of transformational leadership and are better equipped to lead the healthcare organizations of tomorrow. CNOs who were over the age of 60 scored significantly higher in the areas of sharing a vision and challenging the process. The study confirmed the need to prepare new nurse graduates for the future and recommended that hospitals that want to achieve or maintain Magnet status should take heed and ensure their leaders exhibit the values of transformational leadership. The study further highlighted the importance of more research on how CNOs can use this leadership to improve the outcomes of new nurse graduates, ultimately resulting in quality healthcare (Clavelle et al., 2012).

A study by E. Edmunds (2014) described the leadership style of nurse managers in a Magnet hospital and measured the difference between nurse leaders' own self-

perception compared to the perceptions of their supervisors and peers. The results indicated that transformational leadership aligns with success in patient outcomes and nursing excellence. The study added to the body of literature by recommending that nurse leaders be proactive in meeting their goals by practicing transformational leadership. One area of particular interest is the importance of building confidence in CNOs and nurse leaders to properly model transformational leadership to new nurse graduates. This research had an impact on this study by showing that improving the transformational leadership skills of nurse leaders can have a positive impact on improving healthcare overall and that new nurse graduates will be the ones who will need to lead in the future (E. Edmunds, 2014).

Henderson and Eaton (2013) published an article that focused on what new nurse graduates needed to be successful at the bedside. They found that activities associated with new nurse graduates in the community have a direct correlation to their learning. As the demand for nursing professionals continues to rise, it is important to recognize that learners need appropriate mentors and leaders to meet the demand of the future. This study found that when poor behaviors are taught, the negative impact is poor patient care, increased medical errors, and a lack of motivation. The recommendations of this study suggested that senior leadership establish a culture of transformational leadership, further emphasizing the need for CNOs, as the top nurses in hospitals, to focus on new nurse graduates (Henderson & Eaton, 2013).

One interesting study that did not focus on transformational leadership but rather transactional leadership was conducted by Mhoon-Walker (2013). It centered on the current leadership gap within healthcare as it relates to C-level executives with a goal of

identifying and developing up-and-coming leaders to help fill the gap. The findings showed a correlation between transactional leadership traits and leadership potential (Mhoon-Walker, 2013). CNOs are in a critical position and must develop leadership skills within new nurses in order to grow and meet healthcare quality expectations.

These four seminal works provided a foundation of literature that confirmed that CNOs need and are expected to use transformational leadership in order to prepare new nurse graduates for the future of healthcare. CNOs not only have the expectation but also the obligation to ensure new graduates are hired, trained, and ready to grow as leaders for the successful future of healthcare. Without the leadership of tomorrow, the nursing situation will continue to be in dire straits, and the overall healthcare of the future will be at risk. The first three studies explored how Magnet hospital success related to transformational leadership (Clavelle et al., 2012), how CNOs' views of their own leadership compared with those of their peers and coworkers (E. Edmunds, 2014), and how new nurse graduates need transformational leadership to ensure quality (Henderson & Eaton, 2013). The last study focused on how C-level executives and their success were correlated to transactional leadership (Mhoon-Walker, 2013). The majority of seminal works related transformational leadership with success of nurses and nursing leadership.

In conclusion, the findings in these studies confirmed the need for research that provides findings that will enable CNOs to use transformational leadership with new nurse graduates in order to grow and develop these nurses for the leadership roles that will be needed to meet the demand for healthcare.



## **Summary of Reviewed Literature**

The hyper-turbulent healthcare environment caused by a number of factors, such as retiring baby boomers, nursing faculty shortages, the ACA, and scientific advancements, is resulting in a long-term nursing shortage (Clavelle et al., 2012). CNOs in hospitals are charged with leading new nurses and preparing them for the future. Transformational leadership is needed to ensure that new nurses onboard, train, and grow within their field (Henderson & Eaton, 2013). New nurses often experience bullying, confusion, and a general lack of confidence that can be overcome by transformational leadership.

It is up to the CNOs in hospitals to ensure that all staff members are practicing transformational leadership to prepare nurses for the healthcare challenges of tomorrow. Without the proper leadership, the nursing shortage will result in less quality healthcare, an increase in errors, and poor patient care. Hospitals need CNOs who practice transformational leadership to lead the future of healthcare.

## CHAPTER III: METHODOLOGY

### **Overview**

The goal of this ethnographic study was to examine the experiences of hospital chief nursing officers (CNOs) regarding how they lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012). To facilitate this purpose, the researcher used a qualitative methodology with an ethnographic research design.

The details of this methodology and research design are presented in this chapter. In Chapter I, the purpose of the study and the research question were introduced. In Chapter II, a review of literature related to the topic of CNOs' support of new nurse graduates was presented. Chapter III begins with a restatement of the purpose of the study and the research question. This is followed by a discussion of the research design and the role of the researcher as the main data collector and analyst of the study. Then the population, sample, and sampling frame are discussed. The succeeding sections discuss the instrumentation, procedures for recruitment and data collection, and the data analysis and ethical considerations. The last two sections of this chapter are relevant to the methodology, including the validity and reliability and the limitations of the research design. This chapter ends with a summary of the chapter.

### **Purpose Statement**

The purpose of this ethnographic study was to examine how CNOs use transformational leadership to lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012).

## **Research Question**

In order to examine, understand, and describe the best practices that CNOs utilize to ensure new nurse graduates are successful, the research question was as follows: How are transformational leadership skills used by CNOs in hospitals to lead and support new nurse graduates?

## **Research Design**

The researcher used a qualitative methodology to address the purpose of the study. Using a qualitative methodology allows a researcher to understand the experiences and perceptions of individuals or a group of individuals concerning culture, history, socioeconomic status, and community or organizational dynamics (Katz, Friedman, & Lucan, 2015). Moreover, a qualitative methodology allows for the analysis and exploration of the different aspects of a culture, which in the case of this study included CNOs leading and supporting new nurse graduates who work in hospitals. For this study, rich stories from CNOs were needed to properly understand what is happening in hospitals. Rich stories can be obtained from qualitative interview tools using interviews and observations. Thus, the need for such qualitative interview tools to obtain rich stories was the reason a qualitative methodology was used for this current study.

Because of the need to explore a culture, a qualitative methodology was appropriate (Silverman, 2013). When dealing with a culture, a researcher usually chooses between qualitative or mixed-methods research because these two methodologies are appropriate for gathering and analyzing in-depth data (Mertens, 2014). However, because the research question did not imply the need for numerical data and analysis of relationships between variables, no quantitative component existed that was needed to

accomplish the goals of the study (Mertens, 2014). Therefore, a quantitative methodology was not appropriate for this study. The researcher did not need to collect and analyze numerical data and statistics to address the problem and research question of the study (Katz et al., 2015; Mertens, 2014). Instead, the researcher had to gather qualitative data based on observations and interactions with individuals involved in the culture and experiences of using transformational leadership with new nurses. Through qualitative data, as opposed to quantitative data, the researcher was able to gather more substantial and richer explanations from observing participants (Katz et al., 2015).

Three potential qualitative methodologies—ethnography, phenomenology, and heuristic inquiry—were considered for this study, and each method was reviewed for applicability. Phenomenology requires that the subject give a description of a lived experience. The researcher determined this approach to be inappropriate for this study because the ultimate goal of this study was to obtain the most authentic data (Munhall, 2012), and this method of inquiry risked the desire on the part of the subject to provide a purported desired result (i.e., a response that would make the CNO look good; Patton, 2015). Heuristic inquiry requires the contemplations and experiences of the researcher. This inquiry methodology was also determined to be inappropriate for this study because this form of inquiry would have been insufficient, impractical, and not optimal for this research. The researcher selected ethnographic inquiry for this study.

Ethnographic inquiry, which comprises observation of the target population in its own environment, was selected because it allowed for drawing empirical conclusions. In the case of CNOs and their relationship to new nurse graduates, ethnographic inquiry represented the most appropriate research strategy. Ethnography is used when

researchers study the culture of particular groups (Rubin & Rubin, 2012). The blueprint for this study was a qualitative research design, including ethnographic and evaluative ingredients to express the study outcomes (Angen, 2000). Qualitative research involves observation and description of behaviors and the driving perceptions behind them as these instances occur within a population (Patton, 2015). In this case, an in-depth analysis of CNOs' views on leadership and support of recent graduates took place to help describe the culture of transformational leadership as it relates to new nurse graduates.

### **Population, Target Population, and Sample**

#### **Population**

A research population is a well-defined collection of individuals or objects known to have similar characteristics (Patton, 2015). The population for this study was CNOs leading and supporting new nurse graduates in hospitals located in Southern California, specifically in the four counties of Los Angeles, Orange, San Bernardino, and Riverside. According to the California Office of Statewide Health Planning and Development (OSHPD, 2016), there are a total of 193 hospitals and 179 CNOs in these four counties in the state of California. The reason there are fewer CNOs than hospitals is because some hospitals are managed by one CNO. As a result, the population for this study was 179 CNOs in Los Angeles, Orange, San Bernardino, and Riverside Counties (see Figure 2).

#### **Target Population**

A target population is the total group of individuals from which a sample may be drawn (Patton, 2015). The target population for this study was the 84 CNOs who managed facilities with between 150 and 450 beds located in hospitals in Southern California (see Figure 2). This population was selected for this study because it included

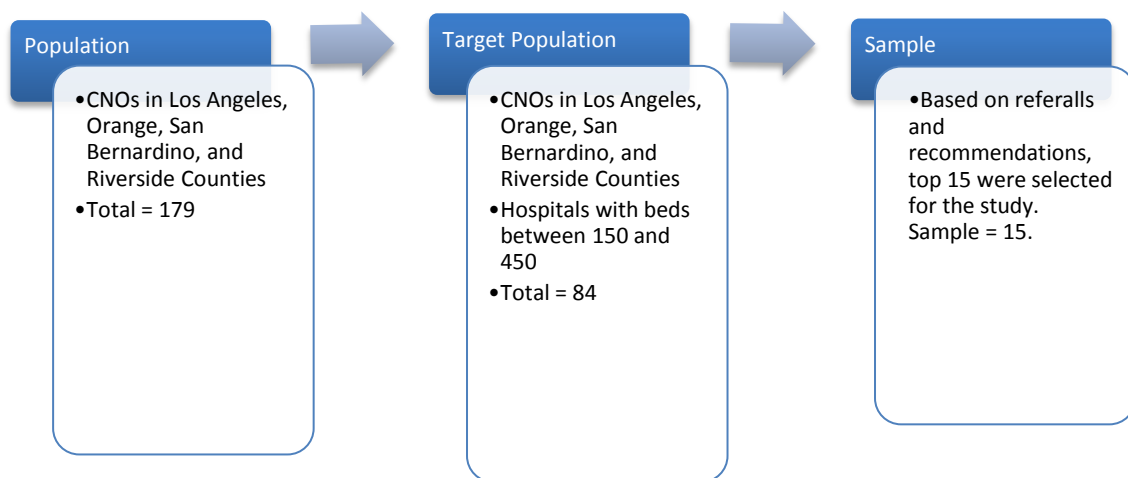


Figure 2. Population, target population, sample.

individuals who performed the relevant tasks of helping and supporting new nurse graduates in their first work experience, which the researcher had to observe to address the research question of the study.

### Sample

A sample is “defined . . . as a smaller group within the target population that the researcher plans to study for the purpose of generalizing the findings” (Flores, 2015, p. 90). According to Polkinghorne (2005), the recommended sample size for qualitative studies ranges from five to 25. The sample for this study was 13 CNOs. Data were collected from 13 interviews, eight observations, and artifacts. The sample was selected using criterion sampling, which means the sample met very specific criteria (Patton, 2015). The criterion sample for this study was 13 CNOs who were selected based on recommendations from local nursing leaders. One particular CEO personally reached out to CNOs she deemed as exemplar leaders and asked them to take part in this study because using transformational leadership with new nurse graduates is her expertise. She

is a well-known nurse leader and educator who is extremely influential within healthcare, and her recommendations on who to sample brought credibility to the study.

### **Background of Researcher**

Patton (2015) stated that researchers in qualitative research are responsible for ensuring quality interviews as they themselves are the research tool. With over 24 years of experience in postsecondary education, the researcher possesses a wide variety of experience, including roles as vice president of admissions and marketing, executive director, and executive director of corporate culture and morale. She has expertise in budgeting, creative projects, and improving corporate and campus teamwork by training and motivating teams to achieve their goals as they relate to student outcomes.

### **Instrumentation**

#### **Expert Panel**

The expert panel comprised three nurse experts who brought a wealth of experience to the study of leadership, CNOs, and new nurses. They included the CEO and former CEO of the Association of California Nurse Leaders, the California Nursing Students' Association, and the California Association of Colleges of Nursing, and a former CNO who, at the time of the study, was a dean of a large nursing institution whose specialty was nurse incivility. These experts were part of the committee that contributed to the *Future of Nursing: Campaign for Action*, which “mark[ed] an unprecedented initiative to address the increased demands for care by utilizing all the skills, talents, knowledge and experience of nurses” (Illinois Center for Nursing, 2011, p. 1).

## **Observations**

Firsthand observations, even though they took an inordinate amount of time, provided deep findings about current leadership and support practices among CNOs and how they develop new graduates (Patton, 2015). In this circumstance, researcher observations, from the perspective of the subjects, proved invaluable in identifying the essence of the relationship between the CNO and the new nurse graduate. The researcher used an observation protocol (Appendix A), which served as a guide whenever an observation session occurred. The researcher conducted eight different observation sessions.

The observations focused on the tasks that CNOs performed within a workday. The research included eight observation sessions for each CNO, each of which lasted for 1-2 hours. The first observation occurred during peak hours of a regular workday, while the other sessions occurred during off-peak hours on regular workdays. To examine the different types of work and tasks that CNOs performed regularly, the researcher observed meetings, onboarding, training, and break-room interactions with new nurses.

## **Interviews**

The interview protocol contained the list of questions for the interviews based on the research question of the study (Rubin & Rubin, 2012). Using semistructured interviews allowed the researcher to practice flexibility when interviewing participants. The semistructured interview questions (Appendix B) were drafted according to the research question of the study. Flexibility in interviews translates to enabling the interviewer to ask follow-up questions that are related to the answers to questions listed in the interview protocol. The items in the interview protocol ensured that there was



consistency when phrasing the follow-up questions. While conducting the interviews, the researcher took notes that supplemented the transcripts of the interviews. The interview questions were pilot tested prior to the actual data collection. This was done to ensure that the interview questions had acceptable validity.

Once each potential participant in the study submitted a signed consent form, the researcher set a schedule for the interviews with the interested CNOs. The interviews were scheduled at a time, date, and place agreed on by the researcher and the participants, who signed an informed consent form.

The researcher conducted a 30-minute interview session with each of the participants. The interview session was conducted at the office or conference room of the participant. During the interviews, the researcher asked questions based on an interview protocol (Appendix B), which served as a guide in asking questions during the interviews. The researcher also asked follow-up questions in order to gather more details in relation to the answers of the participants and to be able to answer the research question more completely. After all the questions were asked, the researcher informed the participants that there were no more questions. Before leaving the premises, the participants were allowed to ask questions; the researcher addressed any questions they had. The researcher then thanked the participants for taking the time to participate in the study.

All interviews were recorded digitally for the purpose of documentation. The researcher recorded the interviews using a digital recording device. Each interview session was audio-recorded to capture the word-for-word responses of the participants in order to create a transcript of the interview responses. The names of the CNOs were not

recorded so as to preserve the anonymity and confidentiality of the respondents. All the interviews were encoded and organized in NVivo.

### **Artifact Review**

In addition to observations and interviews, the researcher also conducted an artifact review. The artifacts included relevant documents that pertained to the assistance provided by CNOs to new nurses. Examples of these documents that showed how new nurses were onboarded included leadership curriculum, new nurse training manuals, and so forth. The researcher asked for these artifacts from the CNOs. The researcher reviewed these documents to gather information that supported or opposed the data gathered from either or both the observations and the interviews. The researcher allotted 2 weeks to complete the artifact review.

## **Data Collection**

### **Procedures for Recruitment**

Brandman University Institutional Review Board (BUIRB) approval was granted prior to data collection. To begin sampling, the researcher performed introductions through organizations such as Healthcare Executives and the American Nurses Association (ANA) and through personal connections. The site selection was determined by focusing on hospitals and other healthcare settings located in four counties in California: Los Angeles, Orange, San Bernardino, and Riverside. The researcher obtained permission from the organizations to conduct data collection (e.g., observations) within their facilities. The selection process garnered CNOs who worked and resided in the four counties in California.

After obtaining permission, the researcher asked the organizations for a list of CNOs assigned to help and support at least one to two new nurse graduates. The researcher reached out by phone to set appointments, and those who were interested in participating in the study were asked to sign an informed consent form and return it to the researcher in person or through e-mail. The researcher contacted each potential participant using the information provided by the person who referred him or her for the study. Those who conformed to the inclusion criteria while considering the exclusion criteria were scheduled for observation and interview sessions. Once the participants submitted the signed copy of the informed consent form, the researcher proceeded with the observations and interviews.

### **Interview Procedures**

The following steps were taken to conduct the interviews:

1. The researcher called the CNOs to schedule personal interviews. The interviews took place at the hospitals in which the CNOs worked. If the interviewees managed more than one hospital, the most convenient location was chosen as the place for the interview. The interviews took place in a private office or conference room. The hospitals were the most natural location due to the busy workday of CNOs.
2. The scope of the study was explained to provide an understanding of the goal to comprehend the culture of transformational leadership of CNOs and how they lead and support new nurse graduates. The researcher explained that participation in the interviews was voluntary and that the participants could stop the interviews at any time for any reason. There was then an opportunity for the interviewees to ask any questions before moving forward.

3. After gaining agreement to move forward, the researcher obtained permission to record the interviews, which the interviewees acknowledged by signing the informed consent form. To comply with the BUIRB requirements, the interviews were anonymous, and recordings were locked in a private safe and will be destroyed in 5 years.
4. The interviews lasted from 30 to 45 minutes. At the end of the interviews, the researcher asked whether the interviewees had any further questions. If not, the researcher thanked them, reiterated the purpose of the study, and let them know that a copy of the transcript would be e-mailed to them within 2 weeks to ensure accuracy.

### **Observation Procedures**

The following steps were taken to conduct the observations:

1. The researcher met with the hospital CNOs to identify appropriate settings to observe. Appropriate settings included CNO and leadership staff meetings, new nurse hire orientations, training sessions, break rooms that were utilized by new nurse graduates, and nursing stations where new nurse graduates were being trained and coached.
2. After the settings were agreed upon, the researcher gained informed consent, if necessary. In order to ensure the comfort of participants, the researcher asked whether they had any questions or concerns.
3. If appropriate, depending on the type of observation, the researcher provided an introduction and detailed explanation of the observation. The researcher verified that participants understood that all observations would be recorded and anonymous as prescribed by the BUIRB. In most cases, the researcher sat quietly at the back of the room, listened, and recorded without any interruption.

4. Observations of the 10 skills on the TLSi (Larick & White, 2012) were recorded for the number of times each skill was observed, and the details of what was witnessed were recorded.
5. The researcher observed CNOs in the most natural setting possible so as not to disrupt the participants in their duties.
6. The researcher thanked the participants at the end of the observations.

### **Artifact Collection Procedures**

The following steps were taken to collect and review the artifacts:

1. The researcher identified what artifacts would be available and valuable to the study.

An expert panel that consisted of three nurses who were current or past presidents of national nursing associations and had experience as nursing faculty members

recommended the following:

- a. new hire training manual,
  - b. orientation paperwork,
  - c. nursing journals and/or articles recommended to new nurse hires,
  - d. nurse preceptor training manual,
  - e. company handbooks, and
  - f. policies and procedures.
2. The researcher asked permission to review and copy these artifacts. Assurance was given that all personal and company information would be removed and anonymous and that the artifacts would only be used for the purposes of this study.

## **Data Analysis**

Data were analyzed using the constant comparative method to generate themes from face-to-face interviews, observations, and materials used for training programs. The constant comparative method has three stages: (a) open coding, (b) axial coding, and (c) selective coding (Kolb, 2014; Trulsson, Strandmark, Mohlin, & Berggren, 2002). The researcher performed open coding by reviewing the encoded data from observations for all the relevant information detected from the manual analysis of the data (Fram, 2013; Harris & Harper, 2015).

The researcher was the one to conduct the coding of the interview responses. The researcher grouped the data by identifying recurring words or phrases. The researcher used an open-coding system to analyze interview responses of the participants in order to create themes and eliminate researcher bias from the responses (Saldaña, 2013). Coding of interview responses was conducted to create categories of the interview responses based on similar topics. The codes that emerged from the interview responses were obtained by arranging and grouping interview responses into categories of themes by similar ideas, phrases, or relevant information. These categories became the themes of the interview responses. After the results of the coding were summarized in a list of open codes, axial coding was accomplished by analyzing that list for possible interconnections. For axial coding, the researcher generated thematic categories based on several interrelated open codes (Kolb, 2014; Liu, Hansen, & Tu, 2014).

Once the data were coded, they were analyzed for themes and the frequencies of the themes to make sense of the data. The analysis included coding by thematic categories to the research question to generate a narrative of the results (Berge et al.,

2012; Kolb, 2014). The final stage of the analysis involved analyzing the themes and frequencies in order to draw conclusions and provide implications for action.

### **Limitations**

There are several limitations that may have impacted the validity of the study. The following discusses researcher bias, self-reported information, size of sample size, and time for data collection.

#### **Researcher Bias**

The first limitation of the study was that the researcher may have introduced personal biases into the data collection and analysis of the study. To avoid any potential bias, the researcher created a list of expected outcomes of data collection, analysis, and interpretations related to the study. Through this process, the researcher was able to avoid making hasty conclusions, developing findings that remained similar to the expectations on the list. The researcher also followed the observation protocol and interview protocol as a guide to keep the data gathered aligned with the topic of the study.

There may have been some potential biases in the data analysis. The researcher collected the data in a trustworthy manner to mitigate biases. Open coding of interview responses was conducted to eliminate bias in the analysis of interviews. Also, ensuring similar themes were repeated in interviews, observations, and artifacts helped ensure data were reliable.

#### **Self-Reported Information**

Gathering data through 13 interviews, eight observations, and artifacts triangulated the data to limit the repeated themes and to ensure reliability. A limitation

could have been the subject matter that was discussed; however, with quality data and effective questioning and coding, this was not a risk to the study. To mitigate this limitation, the researcher attempted to create an environment where acceptance and empathy were communicated to the interviewees. Repeated themes were triangulated with artifacts and observations to ensure reliability.

### **Size of Sample and Time for Data Collection**

Another limitation was the size of the sample and the short time for data collection. Small samples are common for qualitative studies because of the emphasis on in-depth information from the participants (Creswell, 2014). Because a small sample was used, the results cannot be generalized beyond the sample. Findings of the study cannot be generalized to other groups that are beyond the scope of the inclusion criteria of the study. In line with this limitation, the researcher ensured that detailed explanations exist of the processes and methods in conducting the study.

## **Validity and Reliability**

### **Validity**

Validity is an important measure to understand widespread applicability and replicability of findings (Torrance, 2012). To increase the rigor of the qualitative results, several measures related to enhancing the credibility, dependability, transferability, and conformability of the study were conducted. To enhance credibility, the organized and encoded observation notes were e-mailed to the participants with the request that they review the accuracy of the document and make the necessary corrections or clarifications (Houghton, Casey, Shaw, & Murphy, 2010). Member checking was conducted to ensure that the transcribed interview responses were accurate (Torrance, 2012).



To enhance the dependability of the results, every step and procedure that occurred was properly documented in this chapter (Watkins, 2012). To increase the transferability of the results, the researcher provided an accurate description and discussion of the context of the research (Houghton et al., 2010). Finally, the researcher enhanced the conformability of the results by identifying any personal biases so that other people can evaluate the objectivity of the analysis (Watkins, 2012). Proper steps were taken to provide as much certainty as possible that the work's findings were the result of the experiences and ideas of the informants and data rather than the characteristics and preferences of the researcher. Open coding was conducted to analyze the interview data to promote the conformability in this study to reduce the effect of investigator bias.

**Content validity.** To ensure content validity, all questions in the interview protocol were reviewed by an expert review. The expert panel included three nursing leaders who had been in the field of nursing and academic research for at least 10 years. One expert was the former president of the ANA for California. Other expert nurses reviewed the appropriateness and correctness of the content and structure of the questions in relation to answering the research question of the study. The review by the expert panel tested the external validity of the interview questionnaire using a two-step approach. First, the panelists were asked to examine each question on the interview protocol and then evaluate it based on the overall comprehension, clarity, ambiguity, and potential difficulty in responding. Each panelist was asked if the questions were clear and concise enough to capture what was asked of the respondents. In the second step, reliability was determined by testing and retesting the questionnaire, more commonly known as test-retest reliability. In this step, the panelists were asked if the items in the

questionnaire asked the right question in terms of the objective of the study. The comments received were used to improve the interview questions.

**Pilot interview.** A practice interview with an expert researcher validated the researcher's interview skills and techniques. The expert was a hospital nurse executive with 30 years of experience, a past president of the National Association of Schools and Colleges, and an expert author on nursing. This expert validated the pilot interview and gave feedback. The researcher listened carefully to each answer and asked follow-up questions. The researcher asked for clarification of understanding before asking the next question. This feedback ensured that the proper questions were asked in the CNO interviews and ensured that they were focused on transformational leadership as it relates to new nurse graduates.

### **Reliability**

Reliability in this research study refers to the measures in place to ensure the reliability of the data (Greiver, Barnsley, Glazier, Harvey, & Moineddin, 2012). To mitigate the potential for inaccurate or missing data, the same questions were asked to all interview respondents, and the questions were asked in the same order. Thought and care in developing standard operating procedures and interview methodologies was ensured in this study. This strategy helped to ensure that although collected data varied with each interview, the method of collecting data was consistent and did not have an adverse influence on the quality of collected data.

**Internal reliability of data.** Internal reliability of the data was ensured by conducting triangulation. Triangulation involves using multiple types of data (Patton,

2015). For this study, the data came from observations, interviews, and artifacts. The findings of each type of data were compared to ensure the reliability of the results.

**External reliability of data.** Campbell and Stanley (1966) stated the definition of external validity as follows: “External validity asks the question of generalizability: To what populations, settings, treatment variables and measurement variables can this effect be generalized?” (p. 21). Since qualitative research is not concerned with external reliability of data, this study did not rely on this type of reliability.

**Intercoder reliability.** Lombard, Synder-Duch, and Bracken (2010) explained, “It is widely acknowledged that intercoder reliability is a critical component of content analysis, and that although it does not insure validity, when it is not established properly, the data and interpretation of the data cannot be considered valid” (para. 5). A second coder who was a qualified researcher, a fellow doctoral candidate, and a college teacher coded 10% of the data and verified a minimum of 80% accuracy.

The limitations of the study are those characteristics of design or methodology that set parameters on the application or interpretation of the results of the study—that is, the constraints on generalizability and utility of findings that are the result of the design or method that establish internal and external validity. The most obvious limitation would relate to the ability to draw descriptive or inferential conclusions from sample data about a larger group.

### **Summary**

The objective of this ethnographic study was to examine the experiences of hospital CNOs regarding how they lead and support new nurse graduates based on the TLSi tool developed by Larick and White (2012). The researcher used a qualitative

ethnographic research design for this study. Data were collected through interviews of 13 CNOs who satisfied the following criteria: (a) must be a CNO in a specific area of Southern California, (b) must have hired a minimum of two new nurse graduates in the hospital within the past 12 months, and (c) must have been supporting new graduates for at least 12 consecutive months. The data collected included observations, interview responses, and artifacts. Coding was conducted to analyze the different qualitative data. In addition, triangulation of the findings from the different types of data (i.e., observations, interview responses, and artifacts) was conducted to ensure that the findings were consistent, reliable, and valid.

## CHAPTER IV: RESEARCH, DATA COLLECTION, AND FINDINGS

### **Overview**

This study examined and explained the behaviors, beliefs, and culture of chief nursing officers (CNOs) and how they use transformational leadership to lead and support new nurse graduates. Chapter I began with an overview of the problem, its significance within healthcare, and the topic of transformational leadership used by CNOs to ensure the success of new nurses. The second chapter reviewed literature that examined CNOs; the nursing shortage, including factors influencing retention rates, the impact of the Patient Protection and Affordable Care Act (ACA), and measures to combat the shortage; the role of nursing schools and faculty in the nursing shortage; transformational leadership as a potential solution to the nursing shortage; and implications of the nursing shortage on the American healthcare system. The third chapter discussed the research design and the role of the researcher as the main data collector and analyst of the study, the population and sample, procedures for recruitment and data collection, and the data analysis and ethical considerations. The last two sections shared the validity and reliability and the limitations of the research design. This chapter reports out themes and subthemes from the research. It concludes with a summary of findings.

### **Purpose Statement**

The purpose of this ethnographic study was to examine how CNOs use transformational leadership to lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012).

### **Research Question**

In order to examine, understand, and describe the best practices that CNOs utilize to ensure new nurse graduates are successful, the research question was as follows: How are transformational leadership skills used by CNOs in hospitals to lead and support new nurse graduates?

### **Research Methods**

The researcher used a qualitative methodology to address the purpose of the study. Using a qualitative methodology allows a researcher to understand the experiences and perceptions of individuals or a group of individuals concerning culture, history, socioeconomic status, and community or organizational dynamics (Katz et al., 2015). Moreover, a qualitative methodology allows for the analysis and exploration of the different aspects of a culture, which in the case of this study included CNOs leading and supporting new nurse graduates who work in hospitals. For this study, rich stories from CNOs were needed to properly understand what is happening in hospitals. Rich stories can be obtained from qualitative interview tools using interviews and observations. Thus, the need for such qualitative interview tools to obtain rich stories was the reason a qualitative methodology was used for this current study.

### **Population and Sample**

The population for this study was 179 CNOs leading and supporting new nurse graduates in hospitals located in Southern California, specifically in the four counties of Los Angeles, Orange, San Bernardino, and Riverside. The sample size was 13 CNOs working in hospitals with 150 to 450 beds.

## **Data Collection**

The data collection process began in September 2016 following approval from the Brandman University Institutional Review Board (BUIRB). Semistructured interviews of CNOs were used as the main source of data collection. Interview questions were preset; however, based on the answers, the researcher was able to ask follow-up questions to allow breadth and depth of the subject matter. The researcher met individually with 13 CNOs during the month of September. All interviewees gave verbal and written consent, and all interviews were recorded and transcribed. Follow-up meetings during the first week of October took place, where each CNO was given a copy of the transcript to ensure accuracy. All 13 approved their transcript. Each transcript was input into NVivo, a software program that assists with coding. The researcher then coded the data for themes and subthemes.

Eight observations of new nurse orientations, following rounds, and staff meetings were conducted during the month of September 2016. The researcher visited the different hospital locations during regular business hours and observed quietly. The researcher noted (a) description of setting, (b) description of people involved, (c) customer service, (d) physical environment, (e) verbal conversations, (f) nonverbal communication, and (g) observations related to transformational leadership. The TLSi framework (Larick & White, 2012) was used to take notes regarding examples of the transformational leadership. These observations were conducted at eight hospitals in Southern California. Each observation lasted approximately two hours. The researcher's notes were then uploaded into NVivo for coding themes and subthemes.

## Demographic Data

CNOs interviewed for this study had an average of over 25 years of nursing leadership experience. The longest tenure was 40 years, and the shortest was 12. There were three male and 10 female CNOs interviewed for this study. Seven interviewees worked in Orange County, four in Los Angeles County, and two in Riverside County. There were four Magnet status hospital CNOs interviewed, and the average bed size was 265. Table 1 shows time of interviews and observations.

Table 1

*Method and Time of Interviews and Observations*

Method	<i>n</i>	Time
Interviews	13	15.5 hours
Observations	8	16.0 hours

## Data Analysis

The interview transcripts and observation notes were downloaded into NVivo software. The researcher then analyzed the data for common themes and frequencies. The first step was to do word counts to look for recurring words, beginning with exact words and then searching for synonyms. The researcher then looked for common phrases and meanings, dividing the themes that were evident and grouping the less obvious quotes and phrases. Eight overall themes emerged from the TLSi framework (Larick & White, 2012; see Table 2 and Figure 3). Themes mentioned by eight or more CNOs emerged with a minimum of 10 frequencies. Two skills, political intelligence and creativity and innovation, were mentioned less than eight times, and even though these



skills may be utilized by CNOs to lead and support new nurse graduates, this study did not reflect that.

Table 2

*Frequency of Themes*

Theme	TLSi domain	Frequency
Meets regularly with new nurses and educators	Teamwork and collaboration	29
Creates sustainable change	Visionary leadership	26
Focuses on patient care	Character and integrity	24
Open to listening to new nurses	Communication	24
Hires for soft skills	Personal and interpersonal skills	19
Creates culture of caring	Character and integrity	18
Encourages teamwork and collaboration	Problem solving and decision making	18
Recognizes generational differences	Diversity	17
Hires for critical thinking skills	Personal and interpersonal skills	16
Regularly does rounds	Communication	14
Shares vision by storytelling	Visionary leadership	13
Supports evidence-based decision making	Problem solving and decision making	13

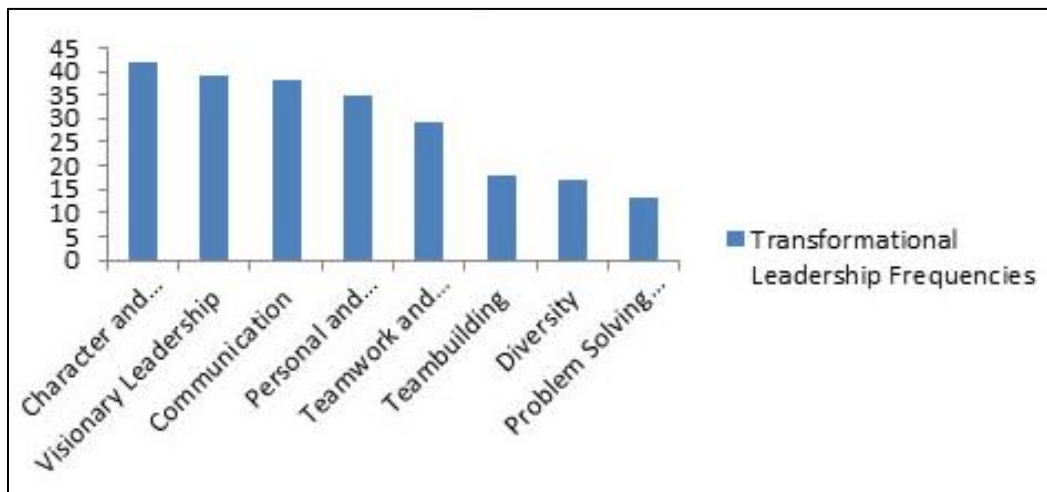


Figure 3. Transformational leadership frequencies.

## CNOs' Character and Integrity

According to Larick and White (2012), it is the leader's job to ensure that business is conducted ethically and is consistent with policies. In nursing, there are very clear protocols and rules that must be followed. Table 3 shows character and integrity themes.

Table 3

*Frequency of Themes for Character and Integrity*

Theme	Frequency
Creates culture of caring and compassion	18
Focuses on patient care and outcomes	24

**Creates culture of caring and compassion.** Compassion is a vital characteristic for supporting the development of a healthful practice work environment and was mentioned 18 times in the interviews. CNOs believe compassion embodies the idea that “healthcare staff want to be able to care for patients with humanity and decency and to give patients the same kind of care that they would want for themselves or their loved ones” (Cornwell & Goodrich, 2010, p. 23). In the tradition of the transformational leader, the CNO must maintain compassion and share its importance with new nurses. Transformational leadership is a relationship-based approach to leadership. It is built on the fundamental recognition that people are human beings with diverse emotions and psychological needs. To promote a healthful practice work environment, the CNO leader must always be sensitive to the basic humanity of everyone. Showing and expressing compassion helps remind members of the nursing staff about the importance and value of their professional contributions. The CNOs interviewed for this study had a significant

and positive influence on nursing staff retention due to their ability to create a culture of caring and compassion.

Every CNO interviewed gave examples of how they created a caring and compassionate culture. For example, Interviewee 1 shared that she believed wholeheartedly that what she was doing was helpful to others and that she was doing the right thing. She shared an example:

Because it's very easy to think that a confused 85-year-old man is trying to swing at you when all they're trying to do is feel their way around, because the glaucoma and stuff are over their eyes. Sometimes you don't see that as quickly as when this is happening to you.

Interviewee 10 emphasized that nursing has become task oriented, and he wanted to make sure he was preparing nurses for the new reality and worked to ensure nurses would never forget that there was a patient sitting in front of them. One hospital CNO modeled the "Disney way" and gave every employee at every hospital \$100 that they could use to make a patient's stay there a good, memorable stay. For example, one of the nurses had a patient who was spending his/her birthday in the hospital, and a new nurse used that \$100 to buy a birthday cake, and they had a little party on the unit for that patient.

CNOs want their new nurses to be empowered to share their caring and compassion and to take risks that weigh in favor of the patients' comfort. Interviewee 4 said, "Although it's happening slowly, but the nurses feel empowered now. Are some of them comfortable with that power? No, they're not. Again, it's working with them every day and asking them, 'What's working and what's not working?'"

Looking at the world through a servant's heart was a theme echoed by several CNOs. They believed that patients should be treated as if they were extended family members. Interviewee 8 said,

This is not a new concept, but I really emphasize that to them. You have to approach the patient with a servant's heart. Even the patients that are disrespectful and they don't deserve your respect, respect them anyway. Give them their space, if that's the case, if that's what they need.

The CNOs wanted their new nurses to be humble and kind, keeping in mind that the new nurses were strangers to the patients, and always keep in mind that the patients' personal space was being invaded. Interviewee 3 shared,

They [patients] may not say, "Thank you." They may not appreciate it while they're here, because they're going through a stressful event being hospitalized. When you do that, it just makes your day go better. Think about, "I'm here for them. I'm here for the patients."

Interviewee 10 tried to impart that nurses could provide good nursing care and be good clinicians. He tried to humanize the situation, focusing on human caring, and said, "Human kindness is critical." Interviewee 11 posed the questions,

"If you've got somebody dying, what do you do?" "OK. I stick the family in the other room over there." That doesn't show me much caring or compassion. If they say, "I'll take the extra time to go sit with the patient and talk to them."

**Focuses on patient satisfaction and care.** Patient satisfaction and care is a key element for supporting the development of a healthful practice work environment. Ensuring patient satisfaction involves many factors in the complex equation of

interprofessional collaboration. Yet, research has shown that patient satisfaction can be greatly enhanced by simple visibility of CNO leaders. Specifically, a growing body of research has indicated that nurse leader rounds with patients represent an evidence-based practice that is strongly associated with improvements in patients' satisfaction regarding their healthcare experience (Morton, Brekhus, Reynolds, & Dykes, 2014; Otani et al., 2009). Thus, patient satisfaction can be best understood as a function of personal care and concern for the patient as demonstrated by transformational CNO leaders.

A recurring theme among all CNOs interviewed was that patient care and satisfaction is at the heart of everything that has to do with nursing. The consensus was that patient care comes first and is the only reason hospitals exist. The emphasis is on a good outcome and ensuring the patient has a good experience. Interviewee 12 said,

Put the patient first. What I talk to the nurses about is that, when you come to work in the morning, come in with a servant's heart. When you do that and you humanize yourself and then you humanize the patient, you're going to provide good care. Treat all patients as if they're an extended family member.

Even though this is not a new concept, it did need to be emphasized with new nurses.

The overall message to new nurses was that the majority of the patients were scared and not well, and even though the nurses saw many patients, it was very personal for the individual patients.

Interviewee 3 wanted to ensure she was creating a center of excellence for nursing and emphasized that the patient comes first, that nurses were supposed to do everything they could for the patients and make sure that they were having a good experience while they were in the hospital. Nurses should not treat patients as though they are just a body.

Interviewee 8 stated, “You go and you give them their medicine, and you take their blood pressure or you do your assessment, but that’s a real human being laying there in that bed.”

The idea that everybody who works at the hospital should treat anybody who comes to the facility as if they are family was how Interviewee 4 described the culture. Whether it is a patient, visitor, doctor, or another staff member, people should be treated with respect and dignity. The CNO believed that if he promoted healing and caring, his hospital would have a healthier environment for both the staff and the patients. Through empowerment, CNOs shared that new nurses really understood what their professional commitment was to patient care and were proud and confident in their ability to use their nursing skills as professionals and to add to that interprofessional team in all kinds of ways.

Interviewee 11 believed that new nurse graduates coming into her hospital had the basics of communication that they had received from their preceptors, their clinical trials, and their peers, which was great, but the key to communication was having them soak it up as a sponge, as a new graduate staff. She constantly communicated to them that they had to communicate to get resources and that it was important not just to communicate what they needed but also to communicate for the patient care and be the advocate. She stated,

Culture, obviously patient-centered care. When I meet with, for example, the nurses who come through orientation or through the residency, I get a chance to stop in and say, “This is what patient-centered care means here. It’s honoring the dignity of each person.”

CNOs believe effective change management represents a crucial element for supporting the development of a healthful practice work environment. This is due to the fact that the modern healthcare environment is constantly changing and evolving. Yet, research has consistently shown that members of the nursing staff often feel that change is simply imposed on them from administrators and supervisors (Dievernich, Tokarski, & Gong, 2015). For changes in the healthcare setting to be effective, however, CNOs recognize that nursing staff must be involved. In this respect, the CNO leaders should engage nursing staff in the change process. This begins by communicating the need for specific changes. It is further supported by asking members of the nursing staff for input, feedback, and support during the change initiative. All 13 CNOs interviewed used change leadership and agreed that CNO leaders play a critical role in ensuring that change promotes a healthful practice work environment and results in improvements in new nursing staff retention.

### **CNOs' Visionary Leadership**

Larick and White (2012) described visionary leaders as leaders who help others believe in them. What makes them unique is that the vision includes everyone and that people are often excited to support and get behind visionary leaders. CNOs use their visionary leadership to lead and support new nurses by being change agents and sharing their vision through storytelling. Table 4 shows visionary leadership themes.

**Change agents.** The CNOs in this study promoted effective change management and noted that it represents a crucial element for supporting the development of a healthful practice work environment for new nurses. This is due to the fact that the

Table 4

*Frequency of Themes for Visionary Leadership*

Theme	Frequency
Change agents	26
Shares vision by storytelling	13

modern healthcare environment is constantly changing and evolving. Yet, research has consistently shown that members of the nursing staff often feel that change is simply imposed on them from administrators and supervisors (Dievernich et al., 2015). For changes in the healthcare setting to be effective, however, nursing staff must be involved. In this respect, the CNO leaders should engage nursing staff in the change process. This begins by communicating the need for specific changes. It is further supported by asking members of the nursing staff for input, feedback, and support during the change initiative. In sum, CNO leaders play a critical role in ensuring that change promotes a healthful practice work environment and results in improvements in nursing staff retention.

Interviewees 1, 3, and 7 had very specific change leadership philosophies, such as Kurt Lewin’s change theory, which involved freezing and unfreezing. All CNOs agreed that getting buy-in is the most important aspect in change. Interviewee 6 explained that in nursing, having blinders on is very common: “We have to knock those blinders off and be able to say, ‘This is why we need to do it this way.’”

Interviewee 2 agreed that the first thing that is needed is buy-in. She said that the CNO has to go in, talk to the staff, and talk to leadership in order to get buy-in, and then it trickles down. She went on to explain, “To get buy-in, you have to explain how that



continuum works. If you think about the adult theory of learning—What’s in it for me? That’s the piece we have to think about.”

An analogy that was shared by Interviewee 8 was that of a seesaw; on one end are people who will not move, and on the other end of the seesaw are people who are willing to change and wanting to change. The goal is to get the change seesaw headed downward so that the people in the middle sort of just fall toward that change.

Interviewee 8 explained,

Sometimes there are groups who say, “No, we’ve done it this way forever.” You can see the group that’s embracing change, and you see this larger group in the middle, and like I said, once you start to make the change, it’s just like a seesaw, and when it starts to come down, you can see people slowly changing.

CNOs who create change have to get people committed and involved in the change. The CNOs made it very clear that they knew the dictatorial leadership style is over with, as nobody wants to be dictated to. Interviewee 10 said, “People want to be involved, they want to know, they want to be informed; and I think if that happens, then they’re more likely to comply and be a part of the change that you want to take place.”

Twelve of the interviewees discussed specific changes they were able to implement that involved new nurses at their hospitals. Interviewee 4 discussed many changes, and one in particular related directly to new nurse graduates. She said,

I think one of the biggest changes was due to a lack of resources, we assumed that the preceptor, so to speak, that they knew what the responsibilities were. We would give them a checklist, and we would say, “OK, this is what we want you to do.” They would nod their heads and say, “Yes, we got it.”

She learned that that was not enough, and she was having to go back to remediate and train over and over. The hospital leadership increased the number of hours in the new nurse orientation. The change occurred because this CNO changed the entire format of how to educate someone to be a preceptor. Interviewee 7 created a new nurse preceptor course, and after going through that change process, when she focused on new nurses, she said their knowledge level appeared to be higher than that of the graduates who did not have the preceptors who went through training.

**Shares vision of leadership through storytelling.** CNOs use storytelling to relate to, motivate, and engage their new nurses. Eight of the 13 CNOs interviewed shared a life-changing moment in their nursing career with their new nurses. When Interviewee 7 was just starting out in her nursing career, she had a situation she faced while managing a small community hospital. She inherited a lot of poor nurses, and she came in and fired all of them because she did not want to tolerate poor nursing performance. She found herself working 60 straight days because she was left with no staff. She learned that she should have dealt with the staff in a different way. She realized that nurses do not want to be poor performers, but rather she believed there are three simple reasons people do not do things. The first one is that there is a lack of education or training, the second is a lack of motivation, and the third is that they choose not to do things. Interviewee 7 shared with new nurses that a person could “spend all your time trying to convince someone who chooses not to, for whatever reason, to come and join the team, or you can spend your time educating and motivating, and that’s hard to disseminate sometimes.”

Interviewee 2 liked to motivate his new nurses to continue their education. He remembered a director telling him that he did not have enough initials after his name and that in order to be successful he needed to go back to school. The interviewee encouraged all of his nurses to learn to the best of their ability. Interviewee 4 tried to share and mentor by sharing a story about a patient whose family was unable to visit and had nobody to launder her clothes. The interviewee took the clothes home, washed and folded them, and was going to wait until the next day to deliver them. At the last minute, he decided to take the clothes back at dinner time, and the patient was overwhelmed with gratitude. The interviewee called it sharing a “memorable moment” for patients. He was not saying that all nurses do laundry, but he wanted them to be observant of the patients and always go the extra mile. He wanted the new nurses to embrace that concept and create their own “memorable moments” that they would share one day. He went on to share, “Because to me, nursing is not just about giving your medications and doing your tests, it’s about really being human and connecting with that patient to create a memorable moment.”

Interviewee 3 used a story about a very busy hospital where she was working with open-heart patients in critical care. She was overwhelmed as a new nurse and told the head of the operating room (OR) that she could not get enough beds ready for the number of patients that she had. The OR director told her,

“You will get out of here, and you will go and you will make those beds because you know who runs this hospital.” She said, “Those administrators don’t run this hospital.” She said, “The nurses and doctors run this hospital, and you keep that

in mind. Your job as an administrator is to make those beds so that the doctors and nurses can take care of those patients. Now, get out of here.”

What Interviewee 3 learned was that anything can be done and that the job of the nurse is to take care of patients no matter what, and that was a story she shared with her new nurses to drive home the point.

### **CNOs’ Communication**

According to Larick and White (2012), communication is the most basic skill of transformational leadership. CNOs ensure good communication with their new nurses by doing regular rounds and by being open to listening to new nurses. Table 5 shows communication themes.

Table 5

*Frequency of Themes for Communication*

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Theme	Frequency
Regularly does rounds	14
Open to listening to new nurses	24

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The CNOs interviewed recognized that a communication-rich environment represents a key element for supporting the development of new nurses. Two themes that emerged from the interviews were regularly doing rounds and being open to listening to new nurses. A communication-rich environment is characterized by openness in communication. Fundamentally, this means that communication flows freely without constraints from organizational politics, personal agendas, personality conflicts, and other factors that inhibit professional expression.

CNOs use these rounds and listening skills as an important key to promoting a communication-rich environment with new nurses. People communicate continuously through verbal and nonverbal behaviors. All behaviors are influenced by the emotional state of the communicator. The CNO leaders interviewed were exemplary in understanding that effective communication stems from healthy and appropriate emotional states (Arnold & Underman Boggs, 2016). A communication-rich environment is most influenced by the emotionally intelligent CNO leader.

**Rounds frequently with new nurses.** CNOs lead and support new nurses by communicating with new nursing staff by participating in rounds. By making regular rounds, CNOs are able to observe, evaluate, and connect with new nursing staff in their natural environment. All CNOs interviewed reported that they did regular rounds, some more than once a day. During this time, they could find out what, if any, were the needs of the staff, and they were able to make recommendations. All of the CNOs interviewed rounded, and 10 of the 13 CNOs interviewed rounded daily.

Interviewee 5 rounded three to five times a week on most floors. She reported that she worked a lot of evenings and sometimes into the middle of the night. This allowed her to go up to the floor and talk to every single new nurse and ask what their needs were. She wanted to know what she could do to help them. Questions included, “What can I do to help you?” and “How can I facilitate your patient movement in an efficient way?” In her experience, it took a few times before the new nurses understood that she was serious about caring, and only then did they start sharing their feelings and thoughts they wanted to share.

Interviewee 2 tried to interact with new nursing staff more than once a day and usually found someone who needed his help. He used these rounds as an opportunity to speak to a couple of new nurses on the unit, because everyone was busy. He explained that it was chaotic and that doctors were rounding and so forth, so it was important to talk with the nurses and find out, “How are your patients today? Are you having any issues with your patients? How do you feel today? Are things going OK? How are you feeling today? How are you doing today?”

All 13 CNOs tried to spend as much time rounding as possible, especially when there were days with few or no meetings, as they wanted to spend as much time on the floor as possible. This was how they were able to connect with the new graduates. New nurses were aware that the CNOs were approachable and used this time to share their patient caseload, concerns, and questions. All CNOs interviewed used rounding for the purpose of connecting with new nurses and ensuring they were aware of what was happening in their hospitals. This came from modeling it as leaders. If new nurses saw that executive leaders partnered with one another, that helped to build trust and expectations. It showed that they were there side by side with their staff.

Six of the 13 CNOs interviewed rounded more than once a day. One interviewee used rounding as an opportunity to interact with new nurses, clinical coordinators, and managers to hear about the challenges of the day, census challenges, what was going great, or where the celebrations were that day. She rounded a minimum of three units a day. Another CNO would come in at 5:00 a.m. and stay until 9:00 p.m. if she needed to because she felt like she needed to be connected to the staff and that if they did not see her, then all the rest of the time she spent in the hospital was useless.

Nine of the CNOs interviewed stressed the point that the patient is the most important person in the hospital, and therefore it was imperative that they did rounds regularly and ensured excellence with patient care.

**Open to listening to new nurses.** The ability to listen to new nurses was a skill used by all 13 CNOs interviewed. Interviewee 1 was a fan of Stephen Covey and learned a long time ago from him that it is important to listen before one seeks to understand. She used this as one of her major philosophies and then shared that with the people she communicated with, including the new graduates and new nurses. She usually spent about an hour and a half with them, in addition to the rounding. Spending time with them and talking to them about the importance of listening and not needing to know everything helped them all learn from each other and appreciate each other.

Interviewee 10 listened to find out what ideas the new nurses could bring to his hospital. One new nurse suggested a cohort of new nurses to earn a master's degree in nursing. The CNO surveyed the new nurses and found that this would be something the new nurses would be very interested in pursuing. This led to a partnership between the hospital and a university that would offer a cohort for advanced practice. This was due to the fact that the CNO was very interested in hearing what the new nurses had to share.

One of the CNOs from a Magnet hospital liked to put new nurse graduates in a leadership role. She wanted to know what the needs were and then asked them for their opinion: "What is your opinion? How do we fix this? How do we do it?" She shared her reason for doing this: "Because they know best, they are boots on the ground—although, they refer to me as their boots-on-the-ground CNO—but they truly are the boots on the ground, they are the captains of the ship, so I go to them."

Some hospitals had monthly forums to talk about the work environment.

Interviewee 6 explained that this was how she empowered new nurses. She explained that this was a safe place, a safe zone for them to come and talk about issues. She shared, “We believe in the just culture methodology. We don’t use names or anything like that, but they’ll talk about a situation and how they would have handled it differently.”

Listening to new nurses allowed the CNOs to make changes due to recommendations and new ideas. For example, one issue that came up at one of the clinical practice forums at Interviewee 6’s hospital was, “‘We really don’t like working on Fridays.’ ‘Well, why not?’ ‘Well, because that’s picture day, that’s wound care picture day.’” The CNO explained that there were a lot of discharges on Friday, and it was difficult to be able to do a job and do everything the nurses needed to do to discharge the patients, because they were running around taking pictures. She asked the nurses,

What do you do about that? How do we change it? How do we fix it? How about if we move picture day to Saturdays? More of us will come to work, and we’d be able to get our discharges done more efficiently.

The change happened, and the new nurses were responsible for that policy change. The interviewee stated, “That’s just a small example of what happens when we make an effort, a concerted effort, to have our primary care nurses take on more of a leadership role.”

A CNO at a large Magnet hospital was able to ensure she put the new nurses in the right spots by listening. She asked them for ways to improve, and a lot of times, new graduates would move into other areas of the hospital, and so they were each other’s support in a lot of cases as well as just taking advantage of the opportunities in nursing.



The interviewee explained, “They start off in one area where they think this is where they want to be but realize this isn’t what they thought it was going to be.” The CNOs listened to learn how to constantly improve new nurses’ experiences and skills to ultimately improve patient outcomes. Interviewee 9 shared,

After each residency class, we learned more and more and more, and what we learned was that wasn’t enough. What we had to do was, we had to go back and retrain or orient them. It’s an 8-hour class that we do now.

CNOs are very open and share their openness by rounding and listening to their new nurses. They exhibit outstanding communication skills that show they care about what new graduates think and are able to improve their hospital outcomes using excellent communication skills.

### **CNOs’ Personal and Interpersonal Skills**

Larick and White (2012) described personal and interpersonal skills of leaders as being approachable, being likeable, and demonstrating high emotional intelligence in motivating others toward excellence. CNOs use their personal and interpersonal skills with new nurses by ensuring they hire those who have excellent critical thinking and soft skills. Table 6 shows personal and interpersonal skills themes.

Table 6

*Frequency of Themes for Personal and Interpersonal Skills*

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Theme	Frequency
Hires new nurses for critical thinking skills	16
Hires new nurses for soft skills	19

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**Hires new nurses for critical thinking skills.** Critical thinking represents another key element for supporting the development of a healthful practice work environment. Critical thinking refers to the ability to identify and solve problems through the application of cognitive skills, knowledge, logic, and sound reasoning. In the complex healthcare environment, critical thinking requires a broad knowledge base and skill set. Most importantly, nurses and other professionals learn by observing CNOs and healthcare leaders in action. To promote critical thinking, CNOs must therefore commit themselves to lifelong learning. By doing so, CNO leaders are leading and supporting new nurses and helping them maintain their skills necessary for demonstrating proper clinical judgments and decisions on a daily basis (Benner, Hughes, & Sutphen, 2008).

The CNOs interviewed led and supported new nurses by hiring for critical thinking skills and then building on that foundation to grow their new nurses. Interviewee 1 was always looking for the ability to think critically and believed it was the number one attribute of a new nurse. She said,

I can teach you the skills. If you've got to learn the skills, I can teach you the skills. I can't teach you to think that A leads to B, leads to C. That's the piece that I need, first and foremost, if we're looking at a new grad.

CNOs rely on new nurses to be able to use their critical thinking skills to go above and beyond a patient's health and understand that the world has changed. For example, not every patient goes to bed at 9:00 p.m.; CNOs want new nurses to give the patients a choice, to be able to negotiate a bedtime. Interviewee 1 explained, "It's not always black and white." The CNO stressed the idea that the patients were not in prison and that a hospital should be concerned with the patients' needs as long as the law is followed.

CNOs ask a lot of behavioral-based questions to determine if a nurse has an inclination to learn. Interviewee 3 had a background in psychology and explained critical thinking as any decision made in life. She said,

Everything in life, when you do any critical thinking, is the nursing process.

You're grabbing all the information, you're filtering it down, and you're making a decision based upon that information. A lot of the questions that I'll ask deal with being able to grab a scenario or grab a group of data, filter that down, and come up with a response.

There is more emphasis on critical thinking now than there was years ago, and CNOs are using the ability to critically think as a springboard to find the future nurse leaders. There are many opportunities for growth, and CNOs want their new nurses to come in with a plan. Interviewee 2 used role playing to scope out critical thinking skills. She asked new nurses, “‘How would you react?’ Give them a little blood sugar, ‘How would you react?’ Or you walk by, you see a changing condition, ‘How would you react?’”

New nurses need to be able to make decisions that could make the difference between life and death. For new graduates or new team members coming into a hospital, CNOs explain to them that this means much more than having a license and nursing skills. CNOs are looking for new nurses who want to find ways to improve their knowledge, skills, and partnerships on daily basis. Interviewee 3 took it back to risk taking:

Not waiting for permission but activating the conversation, and again, to the depth and breadth of your license without going over the line, but truly, I think I have

some people who have a longevity in nursing that said, “If he doesn’t bring it up today, we’ll see if he brings it up tomorrow.”

Six of the 13 interviewed CNOs tested for critical thinking skills through simulation situations. Interviewee 5 proposed a scenario so she could assess new nurses’ ability to think critically. The CNOs agreed that critical thinking skills are in high demand, and they believed, “You just can’t buy it. You just have it or you don’t. It can be cultivated, but a certain aspect of it.”

**Hires new nurses for soft skills.** There is a consensus among CNOs that they need to hire for personality and train for skill. This was a recurring theme mentioned 25 times during the 13 interviews. Traits such as “high energy,” “good personality,” and “good customer service” are in high demand. CNOs look for these traits during the interviewing process and ask situational and behavioral questions. There is an overall belief that it is difficult to train someone to have a good personality, and therefore these skills are in high demand.

Interviewee 9 looked at new nurses’ communication skills, which she referred to as a higher sign of intelligence. CNOs use their own soft skills to ensure their new nurses are equipped to deal with the future of healthcare. A new nurse comes into a hospital with a license and fundamentals, but soft skills are needed in today’s market. Patient satisfaction rates are posted publicly, and hospitals are more geared toward customer service now than at any time in the past. Twelve of the 13 interviewed CNOs did not look at grades when making their hiring decisions. In fact, they did not care much about academics, but the qualities that cannot be taught are in high demand.

Interviewee 4 wanted to know what type of job his nurse candidates had before they were nurses. He believed that if someone knew how to serve tables, then customer service would be a good transferable skill. This was one way to determine if a nurse would be equipped to deal with patients and hospital staff. Interviewee 4 said, “I think passion, commitment, dedication, those words, the buzz words, would be what you are looking for in a nursing student.” This theme was repeated and agreed on by all 13 CNOs interviewed. Interviewee 8 agreed, “You want somebody with a positive attitude. You want somebody that can explain to you what is caring. You look for those cues.”

CNOs look first to personality. They look for people with personality because “you can’t give somebody a new personality.” Interviewee 7 agreed,

The thing that I look for is really their personality because you can get a feel from a person to see if they’re into nursing because they want to be into nursing or if they’re doing it because your mom and dad is a nurse, your mom and dad is a doctor. They don’t want to be a doctor. Not that it’s a special person, but if you come in and you’re just, “Yeah,” I don’t feel it for you. The patients aren’t going to feel it. It’s not just about quality, but it’s about service too because I’m radioed out there by HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems]; everybody gets a survey when they leave.

CNOs look for soft skills to lead new nurses and believe that encouragement of professional practice and continued growth/development represent key elements for supporting the development of healthful practice work environments. Like all people, nurses are motivated by intrinsic factors. All human beings have an inner desire to grow and become better at what they do. CNOs view professional development as vital to

improving the work environment. Along these lines, research has shown that “a continued investment in nursing leadership development across all levels—executives, managers and front-line staff—is necessary in an increasingly complex and demanding workplace” (O’Neil, Morjikian, Cherner, Hirschhorn, & West, 2008, p. 179). This type of commitment helps to assure CNO leaders of improvements in nursing staff retention.

**CNOs’ Teamwork and Collaboration**

In the business world that is constantly changing, transformational leaders need to be collaborative (Larick & White, 2012). When contemplating a change, one of the most important aspects is to make sure that there is a win for every group of people who have a stake in the decision. People will buy into ideas when they feel they are part of them.

CNOs lead and support new nurse graduates by encouraging teamwork and collaboration.

Table 7 shows the teamwork and collaboration theme.

Table 7

*Frequency of Themes for Teamwork and Collaboration*

Theme	Frequency
Meets regularly with new staff	29

To support effective teamwork, the CNO leader must possess a special skill set. Like any organization, the healthcare environment is a political one. Interprofessional collaboration will, in other words, always present a certain amount of conflict. The CNO leader keeps in mind that individuals hold different points of view, and they come to the collaboration table with vested emotional interests in their work. Patience and empathy represent the highest virtues in the conflict resolution skill set. Most importantly, supporting teamwork with a focus on conflict resolution is worth the oftentimes

painstaking effort. Studies have consistently shown, more exactly, that the benefits of teamwork include “increased nursing job satisfaction and increased staff retention” (American Sentinel University, 2014, para. 3).

**Meets regularly with new nursing staff.** All 13 CNOs met regularly with their new nurses. Interviewee 12 boiled it down to sharing the simplest terms and said,

You have to be so active with your new graduates and your entire staff. You can be a leader from afar, or you can be a leader in the midst of. I’m a firm believer of leading by example, getting in and being able to demonstrate how to handle *x* and *y* situations.

Half of the CNOs interviewed had formal processes for meeting with new nurses.

Formal get-togethers allowed for an opportunity to get concerns on the record and then allowed time for feedback. Twelve of the interviewees allowed for informal meetings and looked for spontaneous opportunities to meet with new nurses. Interviewee 2 shared,

I might hang out with that. What I did the last time was I facilitated, so when they are walking in, I said, “Hey, how are you? So nice to meet you. Interviews are going in process; in about 10 minutes, we’re going to get you to an interview. How are you today? Are you feeling nervous?”

She wanted the new nurses to feel comfortable and also to make sure her presence was well known.

Interviewee 3 constructed a new nurse program that was robust and said, “I was the product of a new grad program in 1975, one of the first in San Francisco, and I’m eternally grateful to this day for the structured support that I was offered, and that’s what

we do here.” She met new nurses every time they were onboarded and personally welcomed them with a handwritten letter.

Interviewee 10 participated in and taught all new nurses with a customer service training and then continued to build relationships with new nurses. Interviewee 2 wanted to make sure all new nurses knew she was the CNO: “But it’s my message, it should come from me. It’s my expectation, it should come from me. I’m a big person—e-mail is great, phone conversations are great, but one-on-one personal conversations, group conversations, that means more.” Interviewee 4 referred to it as “street credit”:

I call it *street credit*. You need to have street credit. And so, going up there and showing all that you can do things too. A few weeks ago, I was up on the newborn nursery, and they are trying to put IV on the baby; they missed twice. Let me tell you, I dropped an IV on a 2-day-old. And again, what that does is gives me street credit: “He can actually do nursing skills.” And then that rumor spreads a little bit more.

All interviewees agreed that interacting and meeting with new nurses on a regular basis is a must for happy and healthy onboarding for new nurses. All of the CNOs said new nurses knew who the CNO was at the hospital. The Magnet hospitals were required to have a mentorship program of some kind for all nurses. One of the key components for new nurses was building in collaboration with educational partners. Interviewee 3 wanted her new nurses to know she was open and honest. She gave every new nurse her cell phone number. They could call or text her any time, and she took the time to respond and listen.



## CNOs' Team Building

According to Larick and White (2012), team building is an essential element for the success of any leader. Teams have purposes that increase the success of advanced goals or visions. CNOs encourage teamwork with their new nurses through shared governance and team meetings. Table 8 shows the team building theme.

Table 8

### *Frequency of Themes for Team Building*

Theme	Frequency
Encourages teamwork	18

Shared governance refers to “a dynamic staff-leader partnership that promotes collaboration, shared decision making and accountability for improving quality of care, safety, and enhancing work life” (Vanderbilt University Medical Center, 2016, para. 2). Shared governance helps nursing staff members recognize their critical importance in the healthcare setting. By promoting interprofessional decision making, CNO leaders, therefore, help members of the nursing staff experience improved motivation and job satisfaction. Improvements in nursing staff job satisfaction, in turn, help support the development of healthful practice work environments, which improve nursing staff retention (Sherman & Pross, 2010). The CNO leaders interviewed for this study agreed that shared governance and teamwork are of the utmost importance for mentoring new nurses and for improving new nursing staff retention.

At a large hospital in Orange County that was included in this study, employee forums were done monthly, and new nurses were assigned a team when they onboarded. The new nurses were there not only to observe but also to participate in meetings and

share their views. The CNO at this hospital said, “Shared governance has the say. We need our unit-based council shares in these workloads, in these action groups to save change in these five domains. We have to. It’s critical.” She explained that this meant there was no one department that was more important than another. It was a commitment from all, and all were involved. Interviewee 4 said, “Shared governance is great, and you can espouse it, give it the big talk, bring people together in groups, and have people represent their areas and talk a lot and discuss things, and never really have shared governance.” CNOs believe that when there is shared governance, teamwork is built in, and the best results are gained from that teamwork.

Interviewee 7 tried to leverage shared governance and unit-based councils. She had excelled in the past by using this process with the patient experience. She noted,

When I look at the council that I bring together, I see more and more directors filling the seats. I thought, “This is so not working because you all don’t take the time to go back. I know you don’t,” because I know how busy their time is.

Interviewee 11 gave the book *If Disney Were to Run Your Hospital* to all new nurses. She wanted her new nurses to work together as a team and modeled this daily by having human resources, information technology, and facilities staff help welcome her new nurses at orientation.

Team building is very important for new nurses, according to all 13 CNOs interviewed for this study. CNOs understand how new nurses can teach the older nurses about team building. Interviewee 3 met every week with all directors for interdepartmental meetings, and the new nurses were a big part of her process.

Interviewee 10 built a system to orient new nurses by having them meet with all departments and report back every 3 months. Interviewee 10 explained it like this:

Years ago, Marlene Kramer wrote “Reality Shock,” and it’s still not different.

When these young nurses come out, they feel it’s overwhelming and it’s not what they signed up for. “I don’t like it, so I have to quit and go someplace else

because it’s the hospital.” . . . We work together well, and we don’t get into anybody else’s business. We consult each other frequently. That’s part of it.

That leadership is cohesive and transparent with each other and with the staff.

New nurses need to be on staff for a year to become part of a unit-based council.

New nurses are motivated by the teamwork and gain access to other people who are leaders in the hospitals. According to Interviewee 10, “They’re not isolated in their own little world. We all get to hear the good work that the other places there do.”

### **CNOs’ Diversity**

Increasing diversity is a factor that can help build loyalty. Allowing and supporting associates from all different backgrounds and cultures to share their ideas shows followers that leaders are committed to employees and customers (Larick & White, 2012). CNOs appreciate generational differences to lead and support new nurses and ensure their success. Table 9 shows the diversity theme.

Table 9

#### *Frequency of Themes for Diversity*

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Theme	Frequency
Appreciates generational differences	17

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**Appreciates generational differences.** Ten of the 13 CNOs interviewed for this study recognized the challenges when dealing with nurses and patients from different generations including baby boomers, Gen Xers, and Gen Y, also known as millennials. It is important that new nurses, who are for the most part millennials, learn how to deal with a diverse population. Nine of the CNOs interviewed were baby boomers, and the remaining four were from Generation X.

Interviewee 2 believed that expectations must be discussed clearly up front. Chain of command, patience, and company culture are not the traits that come naturally to the millennials and Generation Y. The interviewee said these individuals are part of the “now generation” and expect things to come easily, and therefore they do not understand the need to learn the ropes and climb the ladder of success. Interviewee 2 noted,

My generation believes that if someone is loyal to a company, then the company will be loyal to them. In some ways, the Gen Y generation has shown that putting themselves first was better, especially when corporations are downsizing today regardless of tenure or performance.

Interviewee 1 wanted all of her staff to be open to learning from all generations. She embraced texting and wanted to make it work for her hospital. For example, an older patient was worried about a pain, and the nurse told him, “I’m going to text your doctor right now and ask him about this.” The doctor text messaged right back and relieved the patient’s concern. The idea is that text messaging can be a good thing as long as there are no privacy laws violated. This is where all CNO leaders agree that training is imperative to ensure compliance at all times.

Interviewee 5 said it used to bug her when she saw staff on their phones text messaging away, but she understood that they were experts at multitasking and meant no disrespect. As long as they got the job done, then that should be what matters. Now she found herself sometimes doing the same thing. There was so much great information she learned from them every day, and she was grateful to them for that. Of course, there were some high-level meetings for which everyone knew that phones and gadgets needed to be left in their office or car because most high-level executives were baby boomers or Gen Xers and would not appreciate seeing texting or e-mailing going on during their meetings.

CNOs acknowledged that nurses of the past came out of nursing school very technically sound. Interviewee 13 said they could operate any piece of equipment and could do any IV in the world, generally, but they did not understand much more than what the doctor told them. She shared that today's students are more prepared and believed it had a lot to do with technology and a general quest for knowledge.

The CNO at a large hospital in Orange County said that millennials left after 1 or 2 years and had different priorities than nurses who had been on the floor for 10 or more years. She believed it was imperative to support them and show her commitment to them because the future of healthcare depends on the new generation. Interviewee 5 said the older nurses did not understand customer service as well as the new nurses coming in. The interviewee explained that the older nurses had a philosophy of,

“I've been doing this for 25 years. You don't have to tell me what to do.” We've had to work through that change and say, “No, life is different now. Yes, you've bring [*sic*] great talent and skill, but there are newer ways to do it, because

expectations have changed.” The old way would be, “Hey, I’m saving your life. I don’t have to be nice to you.”

It came as a surprise to the older nurses to hear that millennials would not take an extra shift or come in on their day off for overtime. Interviewee 5 noted,

In fact, I just got a report on the age groups of where my nursing teams are.

People take personal offense to the younger generation of professional nurses who were like, “No, that’s all right. I don’t need a bonus day.” “No, that’s all right. I don’t need to . . .” “No, don’t call me if you’re looking for somebody for an incentive. I’ve got plans.”

CNO leaders understand and embrace the newest generation of nurses, and the expectation is that a new level of respect will be given to the philosophy of work and earning a paycheck. The overall theme is that all generations need to learn from one another. Change is constant, and communication is vital to growth. Companies need to listen to the “connected generation” because they and their children will be the decision makers for years to come. When CNOs and hospitals understand their new nurses’ desires and criteria, as well as their patients’ needs, they will be better equipped to serve them for years to come.

### **CNOs’ Problem Solving and Decision Making**

According to Larick and White (2012), transformational leaders properly identify the problems affecting the organization in order to properly diagnose and solve issues. CNOs support evidence-based decision making and train their new nurse graduates on the importance of this, as life and death decisions are made daily in nursing. Table 10 shows the problem-solving and decision-making theme.

Table 10

*Frequency of Themes for Problem Solving and Decision Making*

Theme	Frequency
Supports evidence-based decision making	13

**Supports evidence-based decision making.** This study confirmed that CNOs support evidence-based decision making and strive to teach this to their new nurses. Interviewee 2 found that new nurses were able to work in teams to share the evidence that they had read, things they may have seen from another facility, or knowledge they had from their education program. The CNOs wanted new nurses to bring these ideas forward and help the senior nurses to see the value and the new idea, the new fresh blood, regarding what is going on in the facility. Interviewee 4 replicated a study that was done at another hospital that was similar to his hospital with the same number of beds, almost the same number of employees, and so forth, and developed a new process.

Metrics are very important to measuring things. It starts with measuring things and recognizes that there is also a human element to ask, “How accurate are the numbers? Because there’s a human element.” The CNOs interviewed looked at all of the available information to make sure they really understood the problem first. They were experts at asking, ““Yeah, but who entered that number?” Also looking at the timing of situations before making decisions.” Interviewee 12 stressed that she asked, “What is the problem? Why is it a problem? And how are we going to fix that method?” Problem definition is key when dealing with ensuring good decision making, but more importantly, CNOs want to know why something is a problem. Interviewee 13 went on to explain,

“Hey, this is a problem, we have a problem with this. How are you going to fix it?” They might not even understand why it’s a problem, so we have to always tell them the why. If you understand the why, you can get to the how. And I always say the how has to be coupled with “How are we are going to correct it?” so that they understand that it’s a partnership. It’s not all on them to make the decision and come to a conclusion, but we, together, are involved.

The CNOs agreed that teaching new nurses exactly what evidence-based practice means is a key component to success. It is important to give the new nurses information on how to start a project and what to look for, because in the day-to-day work of new nurses, CNOs want to emphasize that this is about people and patient care. Interviewee 2 believed that new nurses were working together and relying on each other to make good decisions. She believed that new nurses should work in groups of three to five. That way, they are accountable to each other, and good decision making will come out of these groups.

CNOs want to make sure their decisions will add value in the future. As Interviewee 1 stated, “We assume it’s useful at the time and it made a difference at the time, but 3 months from now, is that information still going to be of value?” Interviewee 1 looked back on the new nurses’ first 3 months to ensure the learning of evidence-based decision making was working. She went on to share, “Was it enough to encourage them either to learn more or to implement practice?” Interviewee 4 wanted to hear about what the new nurses were dealing with:



How can they solve a problem . . . and what we don't do is run back to the director and say, "Oh, you know, Susie Smith on that shift is just having a terrible problem. You probably need to change the preceptor."

Evidence-based decision making means gathering all the information in the allotted time available and making the best decision possible.

### **CNOs' Creativity and Innovation**

According to Larick and White (2012), creativity and innovativeness are very important attributes for transformational leaders. Change is constant, and in order to stay viable and competitive in today's healthcare world, new nurses need to be ready for the future. CNOs understand innovation, and transformational leaders embrace creativity and innovation.

Six of the 13 CNOs discussed new technology and simulation with new nurse graduates. They believed that new nurses were coming out of school with an advanced knowledge of technology. Simulation is now becoming a more credible way of learning, and those who know how to run simulation labs are in high demand. Though there were only six references to technology, it does not mean CNOs do not use this with new nurses; however, it was not a recurring theme in this study.

### **CNOs' Political Intelligence**

In order to be politically successful, one must work as closely with the opposition as with supporters (Larick & White, 2012). The use of political intelligence was not a theme shared in this study. Two CNOs mentioned having to use political intelligence in their negotiation with human resources to recruit new graduates, but there was very little mention of how they used this skill with new nurses.

## **Summary**

In sum, this research showed that CNOs consistently practiced transformational leadership skills to lead and support new nurse graduates. CNOs found themselves in an important position in relation to the critical issue of new nurse development and retention. Specifically, CNOs promoted healthful practice work environments with new nurses by developing and promoting the following skills: (a) communication, (b) critical thinking, (c) shared governance, (d) change management, (e) compassion, (f) patient satisfaction, (g) professional development, and (h) teamwork.

## CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

### Overview

This study examined and explained the behaviors, beliefs, and culture of chief nursing officers (CNOs) and how they use transformational leadership to lead and support new nurse graduates. Chapter I began with an overview of the problem, its significance within healthcare, and the topic of transformational leadership used by CNOs to ensure the success of new nurses. Chapter II reviewed literature that examined CNOs; the nursing shortage, including factors influencing retention rates, the impact of the Patient Protection and Affordable Care Act (ACA), and measures to combat the shortage; the role of nursing schools and faculty in the nursing shortage; transformational leadership as a potential solution to the nursing shortage; and implications of the nursing shortage on the American healthcare system. Chapter III discussed the research design and the role of the researcher as the main data collector and analyst of the study, the population and sample, procedures for recruitment and data collection, and the data analysis and ethical considerations. The last two sections shared the validity and reliability and the limitations of the research design. The fourth chapter reported out themes and subthemes from the research and concluded with a summary of findings.

This chapter presents a summary of findings, provides conclusions, and makes recommendations. It begins with a restatement of the purpose statement, research questions, methods, population, and sample. The major findings and unexpected findings are presented and explored. Based on the key findings, the researcher outlines the implications of the findings. Lastly, the chapter concludes with recommendations for further research and reflections regarding the study.

### **Purpose Statement**

The purpose of this ethnographic study was to examine how CNOs use transformational leadership to lead and support new nurse graduates based on the Transformational Leadership Skills Inventory (TLSi) tool developed by Larick and White (2012).

### **Research Question**

In order to examine, understand, and describe the best practices that CNOs utilize to ensure new nurse graduates are successful, the research question was as follows: How are transformational leadership skills used by CNOs in hospitals to lead and support new nurse graduates?

### **Research Methods**

The researcher used a qualitative methodology to address the purpose of the study. Using a qualitative methodology allows a researcher to understand the experiences and perceptions of individuals or a group of individuals concerning culture, history, socioeconomic status, and community or organizational dynamics (Katz et al., 2015). Moreover, a qualitative methodology allows for the analysis and exploration of the different aspects of a culture, which in the case of this study included CNOs leading and supporting new nurse graduates who work in hospitals. For this study, rich stories from CNOs were needed to properly understand what is happening in hospitals. Rich stories can be obtained from qualitative interview tools using interviews and observations. Thus, the need for such qualitative interview tools to obtain rich stories was the reason a qualitative methodology was used for this current study.

## **Population and Sample**

The population for this study was 179 CNOs leading and supporting new nurse graduates in hospitals located in Southern California, specifically in the four counties of Los Angeles, Orange, San Bernardino, and Riverside. The sample size was 13 CNOs working in hospitals with 150 to 450 beds.

## **Major Findings**

The following were the eight major findings that emerged from the data collection and analysis of CNO interviews and observations. The major findings correlate to the literature on CNOs and transformational leadership.

### **CNOs Participate in Rounds and Take Time to Listen to New Nurses**

One hundred percent of the CNOs interviewed for this study agreed that a communication-rich environment is characterized by openness in communication. Fundamentally, this means that communication flows freely without constraints from organizational politics, personal agendas, personality conflicts, and other factors that inhibit professional expression. CNOs use these rounds and listening skills as an important key to promoting a communication-rich environment with new nurses. People communicate continuously through verbal and nonverbal behaviors. All behaviors are influenced by the emotional state of the communicator. A communication-rich environment is most influenced by the emotionally intelligent CNO leader.

CNOs communicate with new nurses by participating in rounds and taking time to listen to them. All 13 CNOs interviewed agreed that communication is an important aspect of ensuring new nurses are onboarded and able to perform their job duties. The CNO leaders understand that effective communication stems from healthy and

appropriate emotional states (Arnold & Underman Boggs, 2016). A communication-rich environment is most influenced by the emotionally intelligent CNO leader.

One hundred percent of the CNOs interviewed participated in rounds, and all took the time to listen to their new nurse graduates. During rounds, CNOs will inspect what is happening in their hospitals with firsthand observation. They are able to support, delegate, problem solve, and help patients in real time. Taking the time to listen to new graduates allows CNOs to gain trust and help drive change.

### **CNOs Create a Culture of Caring and Compassion With New Nurses**

One hundred percent of the CNOs interviewed created a culture of caring and compassion. They did this by modeling caring behavior and ensuring their mission of patient care was at the top of mind at all times. It is common knowledge that nursing is the most trusted profession (Schwartz et al., 2011). Creating a culture of caring and compassion and focusing on patient care and outcomes are the two themes that emerged from the CNOs who led and supported new nurses. Creating a culture of passion was referenced 18 times, and focusing on patient care was referenced 24 times.

### **CNOs Use Storytelling to Create Sustainable Change**

Eleven CNOs interviewed used visionary leadership by being change agents, referenced 26 times, and eight of the CNOs regularly shared their vision with new nurses by storytelling. CNOs recognize that they are the leaders and visionaries for all nurses in a healthcare organization, with an emphasis on new nurses (Frandsen, 2014). The CNOs in this study inspired those who worked for them to achieve a common goal set in alignment with corporate objectives of the healthcare organization (Hughes-Rease, 2015). The role of CNOs is to offer the nursing workforce transformational leadership that

energizes their nursing personnel to exhibit exceptional qualities that drive remarkable patient care.

### **CNOs Meet With New Nurses Regularly**

Over 90% of the CNOs interviewed for this study believed that a collaborative practice culture represents a key element for supporting the development of healthful practice work environments for new nurses. Teamwork refers to the collaborative efforts of nurses and other professionals in the healthcare environment. It is, therefore, best understood as an interprofessional activity that relies on communication and shared governance. Research has shown that encouragement of professional practice and continued growth/development represent key elements for supporting the development of healthful practice work environments (Sherman & Pross, 2010). Like all people, nurses are motivated by intrinsic factors.

### **CNOs Recognize Generational Differences**

Ten of the CNOs in this study recognized the generational differences among nursing staff, and the topic was referenced 17 times. Leaders must be able to promote these beliefs and demonstrate their appreciation to different ideas. The CNOs interviewed for this study believed the best way to have such leadership is to create a diverse leadership team. A weak leadership position or leadership team who does not believe in diversity can show signs of favoritism and intergroup fighting, and overall discord will consume the leadership team and not allow them to deal with the tasks at hand, which results in low morale and high employee turnover.

CNO leaders look for ways to connect the older generation to the newer generations of nurses. When there is an understanding of differences, respect and

learning will take place. According to the study, hospitals have two very distinct sets of nurses: those with many years of experience and brand new ones. CNOs who understand and embrace the newest generation of nurses have the expectation that a new level of respect will be given to the philosophy of work and earning a paycheck. When CNOs and hospitals understand their new nurses' desires and criteria, as well as their patients' needs, they will be better equipped to serve them for years to come.

### **CNOs Hire New Nurses With Critical Thinking and Soft Skills**

This study and previous research have shown that CNOs hire new nurses for critical thinking and soft skills. Over 50% of those interviewed shared more than once how they interviewed and asked behavioral-based questions to try to hire those with these skills. The CNO leaders interviewed for this study hired new nurse graduates for critical thinking and soft skills and viewed professional development as vital to improving the work environment. Along these lines, research has shown that “a continued investment in nursing leadership development across all levels—executives, managers and front-line staff—is necessary in an increasingly complex and demanding workplace” (O’Neil et al., 2008, p. 179). This type of commitment helps to assure CNO leaders of improvements in new nursing staff retention.

Critical thinking represents another key element for supporting the development of a healthful practice work environment. Critical thinking refers to the ability to identify and solve problems through the application of cognitive skills, knowledge, logic, and sound reasoning. In the complex healthcare environment, critical thinking requires a broad knowledge base and skill set. Most importantly, nurses and other professionals learn by observing CNOs and healthcare leaders in action. To promote critical thinking,



CNOs must therefore commit themselves to lifelong learning. By doing so, CNO leaders can develop and maintain the skills necessary for demonstrating proper clinical judgments and decisions on a daily basis (Benner et al., 2008).

### **CNOs Support Evidence-Based Decision Making**

Six of the CNOs interviewed for this study discussed the importance of evidence-based decision making in leading and supporting new nurses. Specifically, a growing body of research has indicated that nurse leader rounds with patients represent an evidence-based practice that is strongly associated with improvements in patients' satisfaction regarding their healthcare experience (Morton et al., 2014; Otani et al., 2009). Thus, patient satisfaction can be best understood as a function of personal care and concern for the patient as demonstrated by transformational CNO leaders.

CNOs interviewed in this study used crucial thinking and proven problem solving to lead and support new nurses. Specifically, a growing body of research has indicated that nurse leaders' good decision making represents an evidence-based practice that is strongly associated with improvements in patients' satisfaction regarding their healthcare experience (Morton et al., 2014; Otani et al., 2009).

### **CNOs Encourage Teamwork and Collaboration Through Shared Governance**

Shared governance refers to “a dynamic staff-leader partnership that promotes collaboration, shared decision making and accountability for improving quality of care, safety, and enhancing work life” (Vanderbilt University Medical Center, 2016, para. 2). Shared governance helps nursing staff members recognize their critical importance in the healthcare setting. Ten of the CNOs in this study promoted interprofessional decision making; CNO leaders, therefore, helped members of the nursing staff experience

improved motivation and job satisfaction. Improvements in nursing staff job satisfaction, in turn, help support the development of healthful practice work environments, which improve nursing staff retention (Sherman & Pross, 2010). Summarily, CNO leaders are advised to keep in mind that shared governance is one of the most important organizational elements for improving new nurse staff retention.

### **Conclusions**

Based on the findings of this study, several conclusions were drawn regarding how CNOs use transformational leadership to lead and support new nurse graduates based on the TLSi (Larick & White, 2012) domains of visionary leadership, communication, collaboration, diversity, team building, personal and interpersonal skills, political intelligence, problem solving and decision making, character and integrity, and creativity and innovation.

#### **Conclusion 1: New Nurses Thrive When CNOs Communicate With Them by Rounding and Listening to Them**

CNOs consistently round to meet with new nurses. CNOs consistently communicate with their new nursing staff, preceptors, and educators by rounding and listening to what is happening in their unit. CNOs take the time to listen to their nurses and invest the time to ensure they are doing so. The following is a summary of the key findings supporting this conclusion:

1. All 13 (100%) of the CNOs interviewed rounded regularly to find out firsthand how to best support new nurses.
2. All 13 (100%) of the CNOs regularly took the time to listen to their new nurses and understood the importance of building trust.

3. All 13 (100%) of the CNOs interviewed encouraged their staffs to round regularly and listened to their new nurses.

Based on these findings, CNOs understand and exemplify outstanding communication skills to ensure their new nurses are set up for success. A lack of communication results in a lack of commitment and an increase of attrition. The CNO leader should be exemplary in understanding that effective communication stems from healthy and appropriate emotional states (Arnold & Underman Boggs, 2016). A communication-rich environment is most influenced by the emotionally intelligent CNO leader. It is therefore concluded that CNOs need to consistently participate in rounds and listen to their new nurses.

### **Conclusion 2: New Nurses Understand Their Responsibility to Patient Outcomes When CNOs Create a Culture of Caring**

CNOs overwhelmingly believe that good patient outcomes and patient care are the most important goals of the nursing staff. Patient outcomes are the ultimate goal for CNOs and they understand that this takes place at the individual bedside. The following is a summary of the key findings supporting this conclusion:

1. All 13 (100%) of the CNOs interviewed stated that compassion was one of the most important attributes for a new nurse.
2. Eleven of the 13 CNOs interviewed (85%) specifically related patient care to the ability of a nurse to show compassion.
3. All 13 (100%) of the CNOs interviewed stated that they expect all of their nurses to focus on the patient outcome above all else.

Based on these findings, it can be concluded that new nurses understand their responsibility to patient outcomes when CNOs create a culture of caring and compassion and focus on patient care. Compassion is a vital characteristic for supporting the development of a healthful practice work environment. It embodies the idea that “healthcare staff want to be able to care for patients with humanity and decency and to give patients the same kind of care that they would want for themselves or their loved ones” (Cornwell & Goodrich, 2010, p. 23).

### **Conclusion 3: New Nurses Are Retained When CNOs Adapt Rapidly to Change**

CNOs understand that healthcare is changing constantly and work diligently to promote sustainable change. CNOs are the ones who are charged with making sure they are ready for change. The following is a summary of the key findings supporting this conclusion:

1. Eleven of the 13 CNOs interviewed (85%) discussed their specific change management philosophy.
2. Eleven of the 13 CNOs interviewed (85%) believed it takes an enormous amount of energy and time to have sustainable change.
3. Six of the 13 CNOs interviewed (61%) shared a personal story with their new nurses.

Based on the evidence above, the CNO leader should engage nursing staff in the change process. This begins by communicating the need for specific changes. It is further supported by asking members of the nursing staff for input, feedback, and support during the change initiative. In sum, CNO leaders play a critical role in ensuring that change promotes a healthful practice work environment and results in improvements in new nursing staff retention.

#### **Conclusion 4: New Nurses Thrive When They Feel Like They Are Able to Share Their Opinions, Thoughts, and Experiences With Their CNOs**

CNOs appreciate when new nurses share their ideas, opinions, and thoughts. Hospitals are constantly looking for ways to improve their environments, and CNOs understand that the new generation of nurses coming to them with good ideas that can be implemented. CNOs want to make sure new nurses are comfortable with sharing idea. The following is a summary of the key findings supporting this conclusion:

1. Twelve of the 13 CNOs interviewed for this study (92%) met regularly with their new nurse staff.
2. Twelve of the 13 CNOs interviewed for this study (92%) believed their new nurses felt comfortable approaching them directly with issues or concerns.
3. Twelve of the 13 CNOs interviewed for this study (92%) had used an idea brought forth by a new nurse to improve their hospital.

Based on these findings, CNOs who invest time with their new nurses improve new nurse retention and satisfaction. The more new nurses understand that their opinions and thoughts matter, the more engaged they will be on the job. When new nurses thrive, they are motivated to grow within the same hospital.

#### **Conclusion 5: CNOs Are Working to Engage Older Generations With the New Millennial Generation of Nurses**

CNOs recognize they have a generation gap in their hospitals and work to bridge the gap by modeling and mentoring a culture of acceptance. The generation gap is very large in nursing and this is a very recognizable fact for CNOs who lead new nurses. The following is a summary of the key findings supporting this conclusion:

1. Ten of the 13 CNOs interviewed (77%) recognized the importance of the nurse generation gap.
2. Ten of the 13 CNOs interviewed (77%) provided diversity training that went above and beyond the minimum requirement for compliance.

Based on the findings of this study, CNO leaders must keep in mind that individuals hold different points of view and that they come to the collaboration table with vested emotional interests in their work. Patience and empathy represent the highest virtues in the conflict resolution skill set. Studies have consistently shown, more exactly, that the benefits of a diverse team include “increased nursing job satisfaction and increased staff retention” (American Sentinel University, 2014, para. 3).

#### **Conclusion 6: Patient Satisfaction Increases When CNOs Focus on Ensuring New Nurses Have Good Customer Service and Critical Thinking Skills**

CNOs connect patient outcomes and satisfaction to the nurses who are caring for their patients. CNOs believe all new nurses have basic technical skills and recognize the need to hire for skills that are hard to train for such as critical thinking and soft skills. The following is a summary of the key findings supporting this conclusion:

1. All 13 (100%) of the CNOs interviewed believed that hiring the right nurses was key to the success of their hospital goals.
2. Seven of the 13 CNOs interviewed (54%) hired new nurses with excellent critical thinking skills.
3. Six of the 13 CNOs interviewed (46%) hired new nurses with excellent soft skills.

Based on the findings of this study, patient satisfaction is a key element for supporting the development of a healthful practice work environment. Ensuring patient

satisfaction involves many factors in the complex equation of interprofessional collaboration. Yet, research has shown that patient satisfaction can be greatly enhanced by simple visibility of CNO leaders. Specifically, a growing body of research has indicated that nurse leader rounds with patients represent evidence-based practice that is strongly associated with improvements in patients' satisfaction regarding their healthcare experience (Morton et al., 2014; Otani et al., 2009). Thus, patient satisfaction can be best understood as a function of personal care and concern for the patient as demonstrated by transformational CNO leaders.

**Conclusion 7: New Nurses Have the Perception of Making Fewer Medical Errors When CNOs Support Evidence-Based Decision Making**

Reducing medical errors is a goal that is achieved when new nurses are trained to make good decisions based on evidence. Every day there are new findings in medicine and it is important to always research all options when making decisions. The following is a summary of the key findings supporting this conclusion:

1. Ten of the 13 CNOs interviewed for this study (77%) used evidence-based decision making to lead and support new nurse graduates.
2. Nine of the 13 CNOs interviewed for this study (69%) shared a specific example of an evidence-based decision that was made while onboarding a new nurse.

Based on these findings and a growing body of research, CNOs who practice evidence-based decision making have a higher rate of patient satisfaction regarding their healthcare experience (Morton et al., 2014; Otani et al., 2009). Thus, patient satisfaction can be best understood as a function of personal care and concern for the patient as demonstrated by transformational CNO leaders.

## **Conclusion 8: New Nurses Thrive When CNOs Encourage Teamwork and Collaboration Through Shared Governance**

By promoting interprofessional decision making, CNO leaders help members of the nursing staff experience improved motivation and job satisfaction. CNOs understand that nurses who feel like they are part of a team will have a higher satisfaction with their work. The following is a summary of the key findings supporting this conclusion:

1. Ten of the 13 CNOs interviewed for this study (77%) had new nurse graduates attend team-oriented meetings.
2. Ten of the 13 CNOs interviewed for this study (77%) supported new nurses who were able to work collaboratively with other departments.
3. Ten of the 13 CNOs interviewed for this study (77%) believed new nurses benefited from shared governance.

These findings support the research indicating that shared governance “promotes collaboration, shared decision making and accountability for improving quality of care, safety, and enhancing work life” (Vanderbilt University Medical Center, 2016, para. 2). Shared governance helps nursing staff members recognize their critical importance in the healthcare setting. Improvements in nursing staff job satisfaction, in turn, help support the development of healthful practice work environments, which improve nursing staff retention (Sherman & Pross, 2010). Summarily, CNO leaders are advised to keep in mind that shared governance is one of the most important organizational elements for improving nursing staff retention.



## **Implications for Action**

The following implications are recommended to ensure CNOs continue to lead and support new nurses. Nursing staff retention is critical in ensuring quality healthcare service. As research has shown, successful nursing staff retention programs require the hiring, training, and development of new nurses. To support this objective, CNO leaders must possess a broad knowledge base and advanced skill set. In this respect, the following recommendations will help CNO leaders develop the critical skills necessary for promoting healthful practice work environments. Even in the context of healthful practice work environments, nursing staff retention remains very challenging. Yet, the objective becomes far more manageable under the influence and direction of the skilled CNO leader.

### **Implications for Action 1 and 8: Invest in Ongoing Meetings and Mentorship for CNOs to Develop Leadership Skills With Nurse Graduates, Both Formal and Informal**

Hospitals and healthcare organizations should invest in both formal and informal meetings and provide mentorship opportunities for CNOs. Research has shown that a collaborative practice culture represents a key element for supporting the development of healthful practice work environments (Sherman & Pross, 2010). Teamwork refers to the collaborative efforts of nurses and other professionals in the healthcare environment. CNOs who invest in team building create nurses who thrive.

## **Implication for Action 2: CNOs Need to Invest in Transition Into Practice That Gives New Graduates Accelerated Experience and Leadership Experience**

Transition into practice programs will decrease the time it takes for new nurses to be trained and ready for advanced practice. With the shortage of nurses with experience and the demand for nurses rising, transition programs are a good investment for institutions. Additionally, the Institute of Medicine (IOM), in its October 5th, 2010, *Future of Nursing* report, called for the implementation and evaluation of nursing residency programs. CNOs who support transition into practice programs improve patient safety records and reduce the risk of patient errors.

## **Implication for Action 3: CNOs Need to Create Change Leadership Teams Made Up of the Top Performers to Develop New Nurses and Provide Them With Resources**

CNOs should develop work teams made up of the best of the best associates to create change by encouraging buy-in and support from those who are in the trenches. They should nominate team leaders who will run the project over a specified amount of time. Furthermore, they should encourage as many change teams deemed necessary for the size of the facility. CNOs who create change leadership teams will find themselves able to navigate the unknown future of healthcare.

## **Implication for Action 4: Invest in Advanced Performance Review Software to Ensure Two-Way Communication Between CNOs and New Nurse Graduates**

Within a hyperturbulent environment such as healthcare, once-a-year performance reviews are out of date and are not effective. Frequent communication, including allowing nurses to share anonymously, will improve communication. It is important for

communication to be two-way, as this allows for much more effective and real-time feedback, encouraging the positive and making course corrections to improve performance. CNOs who give frequent feedback and ask for feedback help new nurses thrive.

#### **Implication for Action 5: CNOs Need to Provide Specialized Diversity Training for New Nurse Graduates by Contracting With Generational Diversity Experts**

As new nurses enter the nursing profession, the focus on an encouraging and safe environment is important for CNOs to encourage to nurse leaders and those working directly with new nurse graduates (Longo et al., 2011). Healthcare leaders continue to increase education and budget resources because financial costs of turnover, retention, and training of new nurses increase the risk of not having a sufficient and well-trained staff that will keep up with the demands of the nursing profession (Griffin & Clark, 2014; Lipscomb & London, 2015; Porath & Pearson, 2012). CNOs who provide specialized diversity training have an overall more satisfied nursing staff.

#### **Implication for Action 6: CNOs Need to Implement Professional Development Programs Focused on Critical Thinking and Soft Skills**

Professional development is vital to improving retention of new nurses. The CNO leader must, therefore, view professional development as vital to improving the work environment. Research has shown that encouragement of professional practice and continued growth/development represent key elements for supporting the development of healthful practice work environments (Sherman & Pross, 2010). Along these lines, research has shown that “a continued investment in nursing leadership development across all levels—executives, managers and front-line staff—is necessary in an

increasingly complex and demanding workplace” (O’Neil et al., 2008, p. 179). CNOs who commit to professional development are assured of improvements in patient satisfaction due to improved nursing staff retention.

**Implication for Action 7: CNOs Should Champion Their Hospitals to Provide Tuition Reimbursement for Advanced Degrees**

Education and training are crucial so that the future of healthcare is properly supported by the nursing community, as shared by the IOM (2010) reporting its goal that 80% of the nursing workforce achieve Bachelor of Science in Nursing (BSN) preparedness by 2020. The investment in furthering education will result in less turnover and higher employee referral rates. When associates feel their companies invest in them, they are more likely to be loyal, and retention improves. CNOs who support a better educated staff have better patient outcomes and fewer medical errors.

CNOs use transformational leadership to lead and support new nurses. As this research shows, CNOs who use transformational leadership ensure quality healthcare. As previous research has shown, successful nursing staff retention programs require the hiring, training, and development of new nurses. To support this objective, CNO leaders must possess a broad knowledge base and advanced skill set. In this respect, the conclusions and recommendations shown in Table 11 will help CNO leaders develop the critical skills necessary for promoting healthful practice work environments. Even in the context of healthful practice work environments, nursing staff retention remains very challenging. Yet, the objective becomes far more manageable under the influence and direction of the skilled CNO leader.

In recent years, nursing staff retention has become an increasingly difficult challenge for healthcare institutions. Yet, retention of nursing staff is arguably the most important managerial function for ensuring quality healthcare service. Fortunately,

Table 11

*Skills Inventory Findings, Conclusions, and Implications*

TLSi domain	Finding	Conclusion	Implication
Communication	Participating in rounds <ul style="list-style-type: none"> <li>• 13 sources</li> <li>• 14 references</li> </ul> Taking time to listen <ul style="list-style-type: none"> <li>• 13 sources</li> <li>• 24 references</li> </ul>	New nurses thrive when CNOs communicate with them by rounding and listening to them.	Invest in ongoing meetings and mentorship, both formal and informal.
Character and integrity	Creating culture of caring and compassion <ul style="list-style-type: none"> <li>• 13 sources</li> <li>• 18 references</li> </ul> Focusing on patient care <ul style="list-style-type: none"> <li>• 11 sources</li> <li>• 24 references</li> </ul>	New nurses understand their responsibility to patient outcomes when CNOs create a culture of caring and compassion and focus on patient care.	Invest in transition into practice that gives new graduates accelerated experience.
Visionary leadership	Creating sustainable change <ul style="list-style-type: none"> <li>• 11 sources</li> <li>• 26 references</li> </ul> Sharing vision with new nurses <ul style="list-style-type: none"> <li>• 8 sources</li> <li>• 13 references</li> </ul>	New nurses adapt quickly when CNOs respond and adapt rapidly to hyperturbulent environments.	Create change leadership teams made up of the top performers and provide them with resources.
Teamwork and collaboration	Meeting regularly with new nurses <ul style="list-style-type: none"> <li>• 12 sources</li> <li>• 29 references</li> </ul>	Nurses thrive when CNOs meet with them regularly.	Invest in advanced performance review software to ensure two-way communication.
Diversity	Recognizing generational differences <ul style="list-style-type: none"> <li>• 10 sources</li> <li>• 17 references</li> </ul>	New nurses will connect with other generation nurses when CNOs recognize generational differences.	Provide specialized diversity training by contracting with generational diversity experts.
Personal and interpersonal skills	Hiring for critical thinking skills <ul style="list-style-type: none"> <li>• 6 sources</li> <li>• 10 references</li> </ul> Hiring for soft skills <ul style="list-style-type: none"> <li>• 7 sources</li> <li>• 11 references</li> </ul>	New nurses have a positive impact on patient satisfaction when CNOs hire for critical thinking and soft skills.	Implement professional development programs focused on critical thinking and soft skills.

Table 11 (*continued*)

TLSi domain	Finding	Conclusion	Implication
Problem solving and decision making	Supporting evidence-based decision making <ul style="list-style-type: none"> <li>• 6 sources</li> <li>• 13 references</li> </ul>	New nurses make fewer medical errors when CNOs support evidence-based decision making.	Provide tuition reimbursement for advanced degrees.
Team building	Encouraging teamwork and collaboration through shared governance <ul style="list-style-type: none"> <li>• 10 sources</li> <li>• 13 references</li> </ul>	Nurses thrive when CNOs encourage teamwork and collaboration through shared governance.	Have quarterly off-site meetings with cross-functional teams.

research has consistently shown that healthful practice work environments significantly improve nursing staff retention. CNOs therefore, find themselves in an important position in relation to the critical issue of nursing staff retention. Specifically, CNOs can promote healthful practice work environments by developing and promoting the following skills: (a) communication, (b) critical thinking, (c) shared governance, (d) change management, (e) compassion, (f) patient satisfaction, (g) professional development, and (h) teamwork. By developing this robust skill set, CNOs can significantly improve nursing staff retention.

### **Recommendations for Further Research**

This ethnographic case study investigated how CNOs use transformational leadership to lead and support new nurses. The following recommendations for future research were identified to extend the understanding of leadership within the nursing profession:

- This study focused on CNOs leading and supporting new nurse graduates in Southern California. Therefore, a study should be conducted in other geographical areas for comparative analysis.
- This study focused on acute care hospitals with 150 to 450 beds. Therefore, a study should be conducted with other types of nursing facilities, such as subacute and convalescent care, to determine how transformational leadership skills are used by CNOs in other settings.
- Research is needed that focuses on new nurses who leave the profession within the first 2 years of graduating nursing school and the factors that influenced this decision.
- Research points to the benefits of CNOs leading and supporting new nurses; therefore, a study should be conducted using new nurses as the population to understand their perspective.
- This study focused on new nurses; therefore, a study should be conducted on nurses who have at least 5 years of experience.
- Research is needed to further correlate patient satisfaction surveys to employee satisfaction surveys.

### **Concluding Remarks and Reflections**

By developing the robust skill set identified in this study, CNOs can significantly improve new nursing staff satisfaction, patient outcomes, and new nurse retention. Within the scope of the nursing shortage, transformational leadership is the key to improving staffing levels and, in turn, improving the quality of care available to patients. According to Thyer (2003), nurses have different perspectives than they used to and frequently prefer a relationship-based leadership style that not only offers adequate



support but also rewards engagement and values input. The transformational leadership style has the ability to combat factors that lead to nurse turnover rates, resulting in greater retention. When nurses are retained, the quality of care provided is better for patients, and job satisfaction is increased because other nurses do not have heavier workloads.

Transformational leadership will improve new nurse retention and satisfaction and will improve the quality of care. CNOs can work with new nurses and those who work with them to discover the practical impact of the shortage on the practice in the facility. Together, they can make changes to policies and procedures that ensure that the needs of the patients can be appropriately met within the limitations of staffing levels. However, one of the problems with this perspective is that it cannot be enforced. Policies cannot force leaders to use transformational leadership in healthcare settings. However, through evidence of the benefits of transformational leadership in healthcare settings, leaders may be more likely to use the leadership style in order to improve operations in their own facilities.

Final reflections from this study are that leadership is leadership regardless of the industry. Transformational leadership will be in demand for many years to come, and it is important for our leaders to developing the future leaders of tomorrow.

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## APPENDICES

APPENDIX A

**Observation Log**

TRANSFORMATIONAL LEADERSHIP SKILLS

Date:	Time:	Observer:
<p>Instructions: Please read over the domains on the side and mark all of the skills that are present during the block of time you are conducting the observation. On the narrative side, please indicate, in detail, what you observe during the time you are present.</p>		
<p><b>Visionary Leadership:</b> Creating a vision of the future as an ethical agent of change, who mobilizes stakeholders to transform the organization.</p> <p><b>Communication:</b> Leadership that effectively supports an environment of open communication where the exchange of ideas, solutions, &amp; problems are discussed inside &amp; outside the organization.</p> <p><b>Problem Solving &amp; Decision Making:</b> Creates an environment that enables everyone to contribute productively through understanding and appreciation of differences and focus on the mission of the organization.</p> <p><b>Personal/Interpersonal Skills:</b> Leaders that are approachable, likeable and demonstrate high emotional intelligence in motivating others toward excellence.</p> <p><b>Character/Integrity:</b> Fostering trust in the Organization by creating an emotional intelligent organization whose members know themselves and know how to deal respectfully and understand others.</p> <p><b>Collaboration:</b> Building a culture of trusting Relationships and purposeful involvement that supports critical and creative problem solving and decision making through effective communication and conflict resolution.</p>		

<p><b>Creativity and Sustained Innovation:</b> Developing a culture of divergent thinking and responsible risk taking that harnesses the potential of available human capital to transform the organization.</p> <p><b>Diversity:</b> Integrate the strengths that individual and cultural differences contribute to create an organization that is equitable, respectful and morally accountable in a global society.</p> <hr/> <p><b>Team Building:</b> Creating an effective team By instilling a cooperative atmosphere, building collaborative interaction, and encouraging constructive conflict.</p> <p><b>Political Intelligence:</b> Generating organizational influence to ethically advocate for causes and changes that will advance the organization's vision</p>	
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## APPENDIX B

### **Interview Procedures**

1. Call CNOs to schedule appointments
2. Send email with specifications if desired by CNO
3. Explain Scope of Study
4. Inform participant of their rights:
  - Volunteer
  - Can stop at any time
  - Interview will be recorded
  - Follows IRB requirements
  - Anonymous
5. Have CNOs sign informed consent form
6. Interview for 30-45 minutes
7. Review transcript for accuracy

## APPENDIX C

### **Observational Protocol**

The Observation protocol is as follows:

- 1) Meet with hospital CNO to identify appropriate settings to observe.
- 2) If the setting is public, no informed consent is necessary.
- 3) If the setting is private, the researcher will explain the parameters of the study, including: Informed Consent, IRB approval, participation is voluntary, participants can stop or take a break at any time, etc. Upon explaining these rights to participants, the researcher will acquire informed consent from all participants of the observation.
- 4) The researcher will observe in the most natural setting possible, not to disrupt the participants in their duties.
- 5) Observations will be noted in hand written notebooks.
- 6) The researcher will thank the participants for allowing the researcher to observe their duties.

## APPENDIX D

### **Consent for Participation in Interview Research**

I volunteer to participate in a research project conducted by Susan Paillet, doctoral student, at Brandman University. I understand that the project is designed to gather information about Chief Nursing Officers and leadership of new nurse graduates. I understand I will be one of approximately 1- to 15 people being interviewed for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation.
2. I understand that most interviewees in will find the discussion interesting and thought-provoking. If, however, I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.

The interview will last approximately 30-45 minutes. Notes will be written during the interview. An audio recording of the interview and subsequent dialogue will be made. If I choose not to be recorded, I will not be able to participate in the study.

4. I understand that the researcher will not identify me by name in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.
5. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) for Studies Involving Human Subjects: Behavioral Sciences Committee at Brandman University.

6. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. 7.

I have been given a copy of this consent form.

\_\_\_\_\_ My Signature Date

\_\_\_\_\_ My Printed Name

Signature of the Investigator For further information, please contact: Susan Paillet

spaillet@mail.brandman.edu 714-658-7721 and/or Dr. Jeffrey Lee jlee@brandman.edu



## APPENDIX E

### Permission to Use TSLi Framework

From: **White, Patricia** <pwhite@brandman.edu>  
Date: Wed, Jul 6, 2016 at 2:29 AM  
Subject: TSLi  
To: Susan Paillet <spaillet@mail.brandman.edu>  
Cc: "Larick, Keith" <larick@brandman.edu>, "Lee, Jeffrey" <jlee1@brandman.edu>

July 6, 2016

Susan Paillet , Dissertation Student, Brandman University  
[spaillet@mail.brandman.edu](mailto:spaillet@mail.brandman.edu)

Dear Susan,

This email will serve to confirm my permission for you to use the Transformational Leadership Skills Inventory (TSLi), created by Dr. Keith Larick and myself, to collect data for your Dissertation. This authorization will extend from now until May 16, 2017.

Sincerely,  
Patricia Clark White

**Dr. Patricia Clark White**

Associate Dean  
School of Education

[pwhite@brandman.edu](mailto:pwhite@brandman.edu)  
[www.brandman.edu](http://www.brandman.edu)

T: [949.585.2987](tel:949.585.2987) | C: [949.842.5041](tel:949.842.5041)

**Brandman University**  
16355 Laguna Canyon Road  
Irvine, CA 92618

APPENDIX F

Permission to Reprint AONE Rubric



155 N. Wacker Drive – Suite 400  
Chicago, IL 60606

PERMISSION TO REPRINT

American Organization of Nurse Executives (AONE),  
a subsidiary of the American Hospital Association

NAME AND ADDRESS OF PERSON MAKING REQUEST:

Name: Susan Paillet  
Address: 11912 Weatherby Road  
City: Los Alamitos State: CA Zip: 90720

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Written by: Susan Paillet  
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APPLICANT

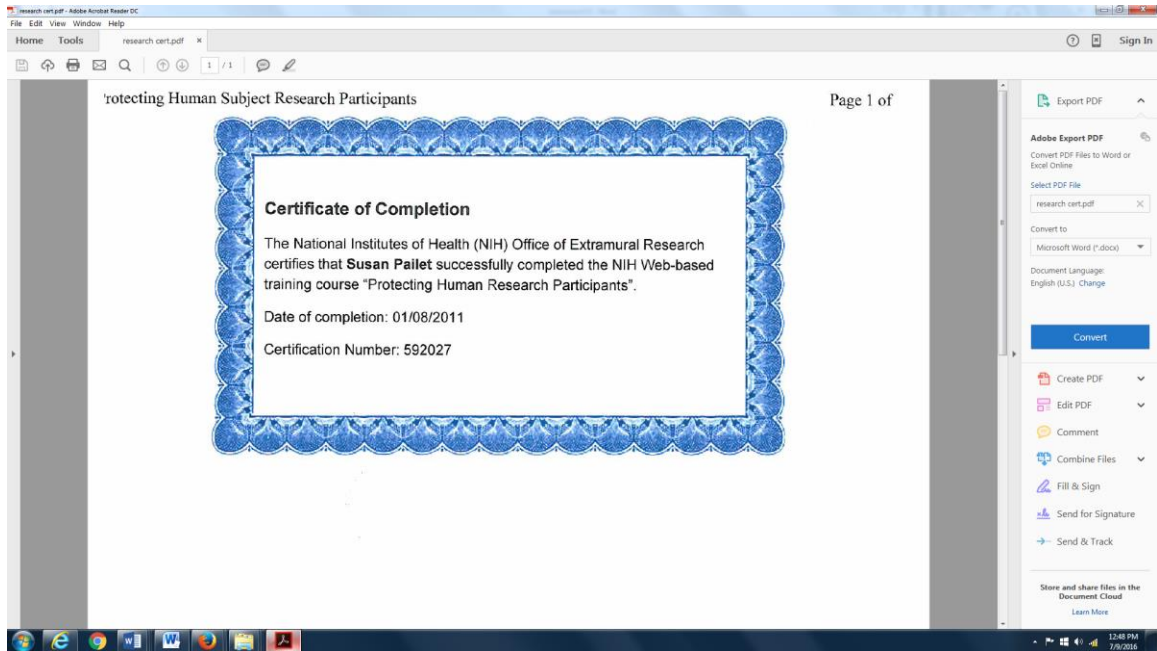
By: Susan Gluz

By: Susan Paillet

Date: 6/29/16

Date: 6/29/2016

APPENDIX G  
NIH Certificate\



APPENDIX H  
**Synthesis Matrix**

Source	Nursing Shortage	Nursing Schools	Nursing Faculty Shortage	Chief Nursing Officer	Transformational Leadership	Chief Nursing Officer & Leadership	New Nursing Skills	New Nursing Training	Education	For Profit Education
American Association of Colleges of Nursing. (2014b). <i>Building a framework for the future</i> . Retrieved from <a href="http://www.aacn.nche.edu/aacn-publications/annual-reports/AnnualReport14.pdf">http://www.aacn.nche.edu/aacn-publications/annual-reports/AnnualReport14.pdf</a>									X	X
American Association of Colleges of Nursing. (2015c). <i>2014-2015 enrollment and graduations in baccalaureate and graduate programs in nursing</i> . Retrieved from <a href="http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage">http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage</a>	X	X	X					X		
Aiken, L. H., Cheung, R. B., & Olds, D. M. (2009). Education policy initiatives to address the nurse shortage in the United States. <i>Health Affairs</i> , 28(4), w646-w656. Retrieved from <a href="http://content.healthaffairs.org/content/28/4/w646.full">http://content.healthaffairs.org/content/28/4/w646.full</a>	X	X							X	
Bailey, J. (2014). <i>The effects of hospital unit nurse leaders' perceived follower support on nursing staff performance outcomes</i> (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3580586)				X	X	X	X			
Bass, B. M., & Riggio, R. E. (2006). <i>Transformational leadership</i> (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.					X					
Carl, J. (2009). Industrialization and public education: Social cohesion and social stratification. In R. Cowen & A. M. Kazamias (Eds.), <i>International handbook of comparative education</i> (pp. 503-518). Dordrecht, The Netherlands: Springer Netherlands.									X	
Clavelle, J. T. (2012). Transformational leadership practices of nurse leaders in professional nursing associations. <i>The Journal of Nursing Administration</i> , 44(4), 201-206. <a href="http://dx.doi.org/10.1097/NNA.0000000000000058">http://dx.doi.org/10.1097/NNA.0000000000000058</a>				X	X	X		X		

Cossin, D., & Caballero, J. (2013). <i>Transformational leadership: Background literature review</i> . Retrieved from International Institute for Management Development website: <a href="https://www.imd.org/uupload/IMD.WebSite/BoardCenter/Web/213/Literature%20Review_Transformational%20Leadership.pdf">https://www.imd.org/uupload/IMD.WebSite/BoardCenter/Web/213/Literature%20Review_Transformational%20Leadership.pdf</a>					X					
Dolan, T. (2011). Has the nursing shortage come to an end? <i>Oncology Nursing Society</i> , 26(8), 8-12.	X									
Falter, E. B. (2012). Nursing leadership . . . from the board room to the bedside. <i>Nursing Administration Quarterly</i> , 36(1), 17-23. doi:10.1097/NAQ.0b013e31823a05d1				X		X	X			
Frandsen, B. (2014). <i>Nursing leadership: Management and leadership styles</i> . Retrieved from American Association of Nurse Assessment Coordination website: <a href="https://www.aanac.org/docs/white-papers/2013-nursing-leadership---management-leadership-styles.pdf?sfvrsn=4">https://www.aanac.org/docs/white-papers/2013-nursing-leadership---management-leadership-styles.pdf?sfvrsn=4</a>					X	X	X			
Hader, R. (2009). Is being a chief nursing officer in your future? <i>Imprint</i> , 56(1), 33-35. Retrieved from <a href="http://www.nсна.org/Portals/0/Skins/NSNA/pdf/Imprint_Jan09_Feat_Hader.pdf">http://www.nсна.org/Portals/0/Skins/NSNA/pdf/Imprint_Jan09_Feat_Hader.pdf</a>				X						
Hader, R. (2011). The role of the corporate chief nursing officer. <i>Nursing Management</i> , 42(6), 45-47. Retrieved from <a href="http://journals.lww.com/nursingmanagement/Fulltext/2011/06000/The_role_of_the_corporate_chief_nursing_officer.10.aspx">http://journals.lww.com/nursingmanagement/Fulltext/2011/06000/The_role_of_the_corporate_chief_nursing_officer.10.aspx</a>				X		X				
Higher Education Amendments of 1998, Pub. L. No. 105-244, §§ 401-495, 112 Stat. 1581 (1998).									X	X
History.com Staff. (2009). Dr. King is assassinated. Retrieved from <a href="http://www.history.com/this-day-in-history/dr-king-is-assassinated">http://www.history.com/this-day-in-history/dr-king-is-assassinated</a>					X					
Hughes, T. A. (2014). <i>Idealized, inspirational, and intellectual leaders in the social sector: Transformational leadership and the Kravis prize</i> (Senior thesis). Retrieved from <a href="http://scholarship.claremont.edu/cgi/viewcontent.cgi?article=1845&amp;context=cmc_theses">http://scholarship.claremont.edu/cgi/viewcontent.cgi?article=1845&amp;context=cmc_theses</a>					X					
Hughes-Rease, M. (2015). Strategic visioning: What is your “I have a dream” speech? Retrieved from American Nurses Association, Nursing Knowledge Center website: <a href="https://learn.ana-nursingknowledge.org/catalog?pagename=Strategic-Visioning">https://learn.ana-nursingknowledge.org/catalog?pagename=Strategic-Visioning</a>					X	X				
Ingram, D. (n.d.). Transformational leadership vs. transactional leadership definition. <i>Chron</i> . Retrieved from <a href="http://smallbusiness.chron.com/transformational-leadership-vs-transactional-leadership-definition-13834.html">http://smallbusiness.chron.com/transformational-leadership-vs-transactional-leadership-definition-13834.html</a>					X					







U.S. Department of Veteran Affairs. (2013). Education and training: History and timeline. Retrieved from <a href="http://www.benefits.va.gov/gibill/history.asp">http://www.benefits.va.gov/gibill/history.asp</a>										X	
U.S. Government Accountability Office. (2011). <i>Postsecondary education: Student outcomes vary at for-profit, nonprofit, and public schools</i> (Report No. GAO-12-143). Retrieved from <a href="http://www.gao.gov/assets/590/586738.pdf">http://www.gao.gov/assets/590/586738.pdf</a>										X	X
Waldron, D. J. (2015, December 15). Ten value propositions to reinvent for-profit higher education [Web log post]. Retrieved from <a href="http://www.marketdrivened.com/2015/12/ten-value-propositions-to-reinvent-for-profit-higher-education/">http://www.marketdrivened.com/2015/12/ten-value-propositions-to-reinvent-for-profit-higher-education/</a>											X
Wingfield, N. (2015, May 3). 40 busy years later, Paul Allen, a Microsoft founder, considers his creation [Web log post]. Retrieved from <a href="http://bits.blogs.nytimes.com/2015/05/03/40-busy-years-later-a-microsoft-founder-considers-his-creation/?_r=0">http://bits.blogs.nytimes.com/2015/05/03/40-busy-years-later-a-microsoft-founder-considers-his-creation/?_r=0</a>					X						