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# Adaptive Leadership: Nurse Executives Building Organizational Adaptive Capacity During Times of Crisis, Challenge, and Change

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# Adaptive Leadership: Nurse Executives Building Organizational Adaptive Capacity During Times of Crisis, Challenge, and Change

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The greatest danger in times of turbulence is not the turbulence; it is to act with yesterday's logic.

—Peter Drucker

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ABSTRACT

Adaptive Leadership: Nurse Executives Building Organizational Adaptive Capacity During Times of Crisis, Challenge, and Change

by Kristian Poitier

**Purpose:** The purpose of this exploratory phenomenological study was to identify and describe the strategies used by nurse executives in acute care hospitals to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

**Methodology:** This qualitative phenomenological study identified and described the perceived impact of adaptive leadership on building an organization's adaptive capacity as perceived by nurse executives in acute care hospitals, for-profit and not-for-profit, with the title of chief nursing officer (CNO) or chief nurse executive (CNE) in Southeast, West, and North Florida. The researcher was part of a thematic team of nine peer researchers and three faculty advisors. The thematic team collaboratively developed the semistructured interview protocol used in this study. Additionally, purposeful, convenience sampling was used to identify the 10 nurse executives who were interviewed concerning their lived experiences in building adaptive capacity within their hospital setting.

**Findings:** Analysis of the data collected from interviews and supporting artifacts resulted in 1,983 frequencies across 23 major themes and 10 key findings. Five major findings emerged from the themes and key findings.

**Conclusions:** Five conclusions were drawn based on the major findings and supporting literature. Nurse executives build adaptive capacity by (a) actively and strategically

seeking honest feedback to resolve barriers, (b) linking individual performance to organizational outcomes to establish shared accountability, (c) providing supportive autonomy and encouraging solution-oriented mindsets to encourage independent judgment, (d) setting fundamental leadership expectations and invest in on-the-job development to increase their team's leadership capacity, (e) setting dedicated time for individual and collective reflection and shared knowledge to sustain continuous learning cultures.

**Recommendations:** The researcher recommends training and development for hospital-based health care leaders on building adaptive capacity, emotional intelligence, communicating to inspire, developing purposeful meetings, and strategic transition programs for emerging leaders. Through the development and successful completion of these implications for action, health care leaders will be able to lead more strategically and effectively in hospital settings.

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# PREFACE

Following collaborative discussions regarding adaptive leadership during times of great change and opportunity, nine doctoral students, in collaboration with faculty researchers, developed a common interest in investigating how organizational leaders build an adaptive capacity. This resulted in a thematic study conducted by the research team. This exploratory phenomenological methods study focused on Heifetz et al.'s (2009), *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World*. The purpose of the study was to identify and describe the strategies used by organizational leaders to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009) as perceived by nurse executives in acute care hospitals (for-profit and not-for-profit) in Southeast, West, and North Florida.

Participants were selected by each member of the thematic research team from various organizations to examine what strategies leaders use to build an organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics. The five key characteristics are making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning. Next, I interviewed 10 nurse executives in acute care hospitals (for-profit and not-for-profit) in Southeast, West, and North Florida to determine what leadership strategies were used to build an organization's adaptive capacity. The team cocreated the purpose statement, research questions, definitions, interview questions, survey, and study procedures to ensure thematic consistency and reliability. Throughout the study, the term *peer*

*researchers* was used to refer to the other researchers who conducted this thematic study. Each researcher studied a different organization with populations in middle school public school principals, community based nonprofit leaders, public school special education directors, small school district superintendents, community emergency response team (CERT) program managers, navy command senior enlisted leaders (CSEL), public school district superintendents, nurse executives, and on-site multifamily rental property management leaders.

# CHAPTER I: INTRODUCTION

Both for-profit and not-for-profit organizations have defined leadership structures that include board, senior, middle, and supervisory level leaders to carry out designated roles and functions to meet organizational needs. Leadership is more than just a title, and an organization's approach to leadership is critical to its overall success (Lichtenstein et al., 2006). Research has indicated that the approach of an effective leader consists of the ability to motivate individuals and align activities to meet organizational goals (Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018). One unprecedented example of crisis and significant change that impacted organizations worldwide was the COVID-19 pandemic. Raderstorf et al. (2020) indicated that the coronavirus pandemic exemplified the necessity of effective organizational leadership.

Although 2023 is considered postpandemic, many organizations continue to deal with the lasting impacts, including uncertainty. One key area of uncertainty is regarding the workforce. Consequently, health care organizations and hospitals continue to deal with the effects of the pandemic on the nursing workforce (A. H. James & Bennett, 2020; Klebe et al., 2021). Raderstorf et al. (2020) described the state of the nursing workforce as challenging, increasing the nurse leaders' need for flexibility and adaptation. Notably, increased turnover related to the early retirement of baby boomers, increased resignations, burnout based on new staffing ratios, a lack of talent pipeline entering the workforce, a lack of nursing faculty and learning spaces (classrooms and clinical rotation sites) to develop the next generation have been significant challenges while the demand for care continues to increase with the aging U.S. population (Florida Politics, 2022; McGhee, 2023; Nurse.org Staff, 2023).

On a national level, there is a projected shortage of 78,610 registered nurses within the next 2 years and 63,720 by 2030 despite anticipated employment growth and an expected surplus of over 16,000 by 2035 (McGhee, 2023). The nursing workforce crisis impacted the state of Florida significantly because it is among the top employers for nurses nationwide, primarily because Florida is a popular destination for retirees (Nurse.org Staff, 2023). Florida was predicted (prepandemic) to be short 60,000 nurses by 2035 (Florida Politics, 2022). The pandemic compounded this outlook on the nursing workforce, and the Florida Hospital Association reported that 70% of hospitals encountered critical staffing shortages with ongoing resignations (Florida Politics, 2022). Thus, the current state and outlook of the nursing workforce can negatively impact patient quality of care and the ability to meet organizational goals. From an organizational perspective, times such as these call for a leadership approach that has the ability and agility to address complex change needs amid crisis (Arthurs-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004).

## Background

Leadership is an individual or group's key role or function within an organization that supports the strategy to meet the organization's goals (Kruse, 2013). Although the establishment of leadership and designated leaders is necessary for an organization's functionality, research has indicated there is not a dominant or universal style in use by all organizations (Amanchukwu et al., 2015; Avolio et al., 2009; Landis et al., 2014). Consequently, there are various leadership styles, theories, and strategies employed in various organizations.

Despite the various leadership theories and styles, research has indicated that the approach of an effective leader includes the ability to inspire, persuade, and guide individuals and activities to meet organizational goals (Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018).

## Leadership in Times of Crisis

E. H. James and Wooten (2004) explained that organizational leaders lack the preparation to lead amid crisis in such a way that causes the transformation necessary to continue to thrive. Leadership effectiveness is critical during a crisis and vital for the organization's overall success (Heifetz & Laurie, 1997; Hughes & Beatty, 2011; E. H. James & Wooten, 2004). As described previously, the approach of an effective leader is centric on the leader's capability to inspire and mobilize individuals and align activities to meet organizational goals (Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018).

## Theoretical Foundations

E. H. James and Wooten (2004) described a crisis leadership competency model that focuses on specific competencies of leadership for success that include building trust, changing mindsets, clarifying areas of vulnerability, making timely decisions, having courage, and continuing learning. Building trust is foundational to leadership in literature (Avolio et al., 2009; Hughes & Beatty, 2011). In addition to building trust, various concepts, and competencies for leadership during challenging times were described in the literature. Agility and adaptability were highlighted as key competencies (Arthurs-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004).

Adapting to ongoing change builds a form of resilience for the organization (Bagwell, 2020; Heifetz, 1994; Yukl & Mahsud, 2010). The following sections review the historical context of adaptive leadership, examine seminal studies and authors, identify key characteristics based on leading theoretical frameworks, and evaluate the application to health care organizations and nurse leaders during times of crisis, challenge, and significant change.

### *The Transactional Leadership Model*

Transactional leadership emerged during the late 1970s and focused on exchanges between leadership and employees (Nawaz & Khan, 2016). Transactional leadership can be used during challenging times to motivate and incentivize expected behaviors during the change process and to maintain a line of sight on specific goals (Amanchukwu, 2015; Nawaz & Khan, 2016). This leadership style strives to achieve goals by leveraging positive and punitive incentives (Amanchukwu, 2015).

### *The Transformational Leadership Model*

Transformational leaders differ from transactional leaders because their key drivers are based on human relations aspects (D. Anderson & Ackerman Anderson, 2010; Nawaz & Khan, 2016; Vasilescu, 2019). Nawaz and Khan (2016) highlighted that transformational leaders flourish in environments that require empathic consideration and the overall motivation of others. The transformational leadership style focuses on the positives at the individual and organizational levels to drive continual goal achievement (W. Martin, 2018; Nawaz & Khan, 2016). This model includes key leadership characteristics to inspire those they lead to ongoing goal achievement despite environmental challenges (W. Martin, 2018).

### *The Situational Leadership Model*

Situational leadership is a contingency leadership concept that considers environmental factors and ultimately fluctuates between transactional, technical, and task-oriented focus and the transformational focus of building relationships (Nawaz & Khan, 2016). There is an underlying belief that not one way of leadership is standard in all situations; thus, the style of leadership fluctuates based on existing conditions, and all variables are considered to determine the best leadership approach to maintain engagement and meet organizational goals during any crisis (Amanchukwu, 2015; W. Martin, 2018; Nawaz & Khan, 2016).

## Adaptive Leadership

Adaptive leadership is considered effective when dealing with individuals and the need for change to meet organizational goals during challenging times (Hayashi & Soo, 2012; E. H. James & Wooten, 2004). Notably, the ability of an adaptive leader to inspire, influence, and mobilize support within the organization sets this leadership style apart (Arthur-Mensah & Zimmerman, 2017; Heifetz & Linsky, 2014). Adaptive leadership is a strategic approach based on effectively anticipating and communicating evolving needs (Hughes & Beatty, 2011; Ramalingam et al., 2020). Researchers described the key to success as the principle of collaboration with all individuals in the organization by fostering a culture of communication and shared responsibility (DeRue, 2011; Hayashi & Soo, 2012).

### Seminal Studies on Crisis and Adaptive Leadership

In the late 1900s, Bennis, Gilmore, and Vaill addressed the state of leadership in a challenging environment and noted the need for flexible and adaptable leaders who learn

quickly to support decisive decisions (Krantz, 1990). Avolio et al. (2009) highlighted the work of Burns and Bass that provided a call to action to transition from traditional leadership theories and practices of transactional experiences between leadership and those in their purview to what was known in the late 1900s as more inspirational leadership styles.

The ability of an organization to adapt to volatile environments and thrive highlighted the need for transitioning from a top-down hierarchical approach to engaging individuals within the organization for collaboration (Amanchukwu et al., 2015; Krantz, 1990). Gyuroka (2010) noted the initiation of the adaptive leadership terminology and theory in 1994 from Heifetz's *Leadership Without Easy Answers*. Over the years, the literature has described adaptive leadership as the critical approach for organizations navigating challenging times (Hayashi & Soo, 2012; E. H. James & Wooten, 2004).

**The Practice of Adaptive Leadership Over the Years**

Adaptive leadership is the leaders' capacity to remain agile to changing environmental conditions and needs (Heifetz et al., 2009). During rapid change and uncertainty, this leadership style reevaluates existing strategies and current environmental needs (internal and external) to maintain organizational viability (Amis & Greenwood, 2020; Obolensky, 2017; Schoemaker et al., 2018). Hayashi and Soo (2012) described adaptive leadership as centered on agility and capitalizing on significant change needs and environmental uncertainty to drive organizational improvement. Aligning relevant, strategic, and specific behaviors to the evolution of organizational needs is a foundational principle (Heifetz et al., 2009; Hughes & Beatty, 2011; Moen, 2017). According to Yukl

and Mahsud (2010), how well leaders handle immediate crises indicates responsive and adaptable leadership.

### The Practice of Adaptive Leadership Today

Because of the foundational principles of adaptive leadership when dealing with crisis or change, this era of volatile political and environmental change has been described as a time of need for an agile and adaptive leadership style (Klebe et al., 2021). In addition, considering the current state of virtual work and overall risks of lack of effective communication has been described as an opportunity to reconsider past practices and foster cultures with organizations that support collaboration of all levels and general thinking about the totality of a situation to determine the right course of action (Arthur-Mensah & Zimmerman, 2017; Moen, 2017; Obolensky, 2017). Adaptive leadership mobilizes and sets the expectation for collaboration and shared accountability to organizational goals (Arthur-Mensah & Zimmerman, 2017; Bagwell, 2020).

## Theoretical Framework on the Practice of Adaptive Leadership

Researchers have described Heifetz's theory of adaptive leadership as an essential concept for individuals, structures, and organizations that want to thrive when navigating rapid change versus survival mode (Arthur-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Heifetz & Linsky, 2014). The mobilization of support is one of the critical leadership capabilities that drives the success of the adaptive leader in accomplishing organizational goals and maintaining a culture that aligns with the underlying mission and standards of the organization (Moen, 2017; Yukl & Mahsud, 2010). Heifetz and Linsky (2014) asserted six assumptions in adaptive leadership:

1. The response to significant change builds organizational capacity to flourish overall.
2. Change strategies build upon historical experiences and do not disregard them.
3. Experimentation is critical to ensuring true organizational transformation.
4. Diversity of thinking is foundational.
5. Adaptation can disrupt structures.
6. Actual adaptive change requires time and dedication.

## Heifetz's Five Key Characteristics of Adaptive Leadership

Considering the assumptions, Heifetz et al. introduced key characteristics of Adaptive Leadership: naming the elephants in the room, shared responsibility, expected independent judgment, leadership capacity, and institutionalizing reflection and continuous learning (Heifetz et al., 2009; Heifetz & Linsky, 2014).

### Naming Elephants in the Room

Adaptive leaders and organizations are known to call out issues and circumstances rather than avoid them in open conversations and meetings (Gyuroka, 2010; Heifetz et al., 2014). More importantly, the adaptive leader protects the employee who exhibits the courage to speak up in settings to foster behavior expectations. Subsequently, there is a culture of early identification and remediation of potential crises (Heifetz al., 2009).

### Nurturing a Shared Responsibility

Early identification and crisis avoidance for the organization's success becomes a shared responsibility with adaptive leadership (Heifetz et al., 2009; Heifetz & Linsky, 2014). In addition, communication is increasingly developing a culture of concern for

others and the organization's overall needs for success. Heifetz et al. (2009) asserted that when there is a shared responsibility, the possible negativity from self-preservation attitudes is limited. Individuals in the organization continue to understand their specific roles and expectations; however, they actively share accountability for the organization's outlook (Gyuroka, 2010; Heifetz et al., 2009; Heifetz & Linsky, 2014).

**Encouraging Independent Judgment**

Through shared accountability, individuals in the organization are encouraged to mature and use independent judgment (Gyuroka, 2010; Heifetz & Linsky, 2014). Heifetz et al., 2009 described the independent judgment as taking ownership of the organization's success off the executive leadership team alone. Therefore, everyone plays a significant role in the organization's success and is empowered to share ideas, ask questions, and make independent decisions.

**Developing Leadership Capacity**

The encouragement of independent judgment supports the following key characteristic of adaptive leadership: developing leadership capacity. Developing leader capacity endorses the establishment of leaders next in line from the perspective of proactive succession planning (Heifetz et al., 2009; Heifetz & Linsky, 2014). Heifetz et al. (2009) noted that development is not sending the leader to a formal workshop but more of an "on-the-job" approach to growing an individual's potential.

**Institutionalizing Reflection and Continuous Learning**

Several studies on adaptive leadership stated that the ability to drive continual learning is foundational to supporting organizational success when navigating change (Amis & Greenwood, 2020; Heifetz et al., 2009; Hughes et al., 2014; Schoemaker et al.,

2018). An adaptive leader deliberates on institutionalizing continuous learning throughout the organization (Cojocar, 2008; Heifetz et al., 2009; Ramalingam et al., 2020). Consequently, continuous learning is a part of the culture and expectation for all employees (Heifetz et al., 2009; A. H. James & Bennett, 2020).

As employees learn individually, the organization benefits from sharing information (Cojocar, 2008). A learning culture encourages and expects information sharing and collaboration driven by leadership (Vera & Crossan, 2004). Hughes et al. (2014) noted that organizational success is subject to the collective efforts of all. With multiple perspectives and information, there is increased visibility to effectively respond to internal and external environmental changes (Ramalingam et al., 2020).

## Literature on Adaptive Leadership in Health Care Organizations

Like other organizations, health care organizations continue to deal with the pandemic's effects on the nursing workforce, triggering significant staffing challenges with the potential to impact the quality of care provided to patients. These changes increase nurse leaders' need for flexibility, adaptation, and innovation (Raderstorf et al., 2020). How well leaders handle immediate crises indicates flexible and adaptive leadership (Yukl & Mahsud, 2010). A. H. James and Bennett (2020) discussed the importance of timely responses to evolving demands and strong communication by leadership throughout the change process to inspire and motivate others.

### The Role of Adaptive Leadership in Health Care Organizations

Adaptive leadership is a strategic leadership model that is effective in health care organizations because of the unpredictable and urgent nature of the health care business. A. H. James and Bennett (2020) highlighted change as one constant in health care. The

ability to be flexible based on current situational needs and prepared for what is to come is a continual state. Health care organizations prepare for natural disasters, active shooters, and emergent health needs (Lister, 2005; Toner, 2017). Lister (2005) described the need for constant readiness for the unknown and flexibility to adjust to meet organizational needs.

## The Role of Nurse Leaders in Health Care Organizations

The most recent crisis that heavily impacted nurse leaders was the pandemic, and the direct impact on the nursing workforce triggered significant staffing challenges that had the potential to affect the quality of patient care. There is a call to action for nurse leaders to develop flexibility, adaptation, and innovation (Raderstorf et al., 2020). A. H. James and Bennett (2020) described the need for the increased presence of leadership, enhanced communication, and intentional efforts to motivate teams by providing clear direction, adding meaning to work, and overall understanding.

## The Role of Nurse Leaders in Acute Care Hospitals

Nurse leaders are responsible for the overall direction, retention, engagement, and ultimate success of their departments and service lines. Nurse leadership hierarchies are evident as well, at the top being the chief nursing officer role. Nurse leaders support their staff by removing barriers and driving the overall strategy to ensure quality and safe care is provided by nurse professionals. During times of crisis and rapid change, nurse leaders must remain diligent and intentional in communication to assess and inspire nurses and other staff to ensure expectations are met (A. H. James & Bennett, 2020).

## Nurse Leaders Practicing Adaptive Leadership in Acute Care Hospitals

The development of nurse leaders in adaptive leadership and behavioral skills is essential in supporting their ability to lead effectively within hospitals today (Arthur-Mensah & Zimmerman, 2017; Raderstorf et al., 2020). This study investigated how nurse leaders implemented the essential characteristics within the adaptive leadership theory during crisis and significant change despite formal training.

## Statement of the Research Problem

Adaptive leadership is effective with individuals and situations requiring changes to meet organizational goals during challenging times (Hayashi & Soo, 2012; E. H. James & Wooten, 2004). How well leaders handle immediate crises indicates agile and adaptive leadership (Yukl & Mahsud, 2010). Adaptive leadership is centered on agility and capitalizing on significant change needs and environmental uncertainty to drive organizational improvement (Hayashi & Soo, 2012). An adaptive leader embodies discrete characteristics to successfully navigate an organization's specific needs while supporting the overall development of individuals (employees) during the change process (Heifetz et al., 2009; A. H. James & Bennett, 2020).

Consequently, the ability of an adaptive leader to inspire, influence, and mobilize support within the organization sets this leadership style apart (Arthur-Mensah & Zimmerman, 2017; Heifetz & Linsky, 2014). Rubino et al. (2018) described the need for intentional training on adaptive leadership skills beyond the standard health care management degree curriculum. Researchers noted that health care organizations and historical leadership structures must evolve from previous standards and methodologies to sustain organizational objectives (A. H. James & Bennett, 2020; Rubino et al., 2018).

In addition, Porter-O'Grady (2020) emphasized the necessity to shift from the traditional focus of leadership at the individual level with perceived desirable attributes to the role of a change agent navigating iterative complexities and creating opportunities to achieve and exceed goals in 21st-century health care.

Health care organizations are complex adaptive systems requiring continuous learning and innovation to achieve desired outcomes and results (Porter-O'Grady, 2020). The coronavirus pandemic significantly affected hospitals, escalating these organizations into a crisis mode because of insufficient resources, structures, and processes to handle the unprecedented conditions, thus being one notable example of a crisis driving rapid and significant change (Cho et al., 2021). As a result, the state of the nursing workforce was negatively impacted. Nurses left the bedside or their consistent places of employment to take on high-dollar travel assignments as contractors at an unexpected rate, causing ongoing staffing shortages and crises (Hansen & Tuttas, 2022; Poindexter, 2022).

A. H. James and Bennett (2020) explained that during times of crisis and rapid change, nurse leaders must remain diligent and intentional in communication to assess and inspire nurses and other staff to achieve expectations successfully. Considering the current state of nursing and ongoing workforce challenges, the development of nurse leaders in adaptive leadership and behavioral skills is essential in supporting their ability to lead effectively within hospitals today (Arthur-Mensah & Zimmerman, 2017; Raderstorf et al., 2020). Despite adaptive leadership being described as a necessary skill set for nurse leaders, there is minimal research connecting the essential characteristics within the adaptive leadership theory specifically to nurse leaders for applied and

continuous learning. This study sought to evaluate how nurse leaders implemented the critical attributes within the adaptive leadership theory during the challenging times of significant change without formal training to influence future training and development of nurse executives to lead effectively amid crises.

## Purpose Statement

The purpose of this exploratory phenomenological study was to identify and describe the strategies used by nurse executives in acute care hospitals to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

## Central Research Question

What strategies did nurse executives in acute care hospitals use to build an organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics (making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning)?

## Research Questions

1. How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?
2. How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?
3. How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?

4. How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?
5. How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?

## Significance of the Problem

One constant factor in life is change. Navigating the pace of innovation, regulatory changes, evolving business practices, and workforce challenges in health care support the ongoing need for adaptive leadership (Edmonson et al., 2016; Losty & Bailey, 2021; Porter-O'Grady, 2020). This pace of change can be considered an opportunity rather than a threat. Franklin (2014) stated, "Whilst the pace of change today feels fast, it is unlikely ever to be this slow again" (p. 6). Embracing the need for ongoing change and the determination to evolve is a pathway to success (Rigby et al., 2020; Worley & Mohrman, 2014). Leadership has a direct role in engaging stakeholders in change by communicating the vision and plan. Various experts have noted that despite extensive research and evidenced-based frameworks for leading change, there is still a significant failure rate for organizational change efforts (Ashkenas, 2013; Worley & Mohrman, 2014).

Managing change is both necessary and complex. Change is most effective when rooted in an organization's culture of continuous learning and not solely linked to new projects and initiatives (Heifetz et al., 2009; Worley & Mohrman, 2014). Leadership can influence stakeholder commitment to change and foster a shared vision for engagement and sustainability (Hechanova & Cementina-Olpoc, 2013). An organization's approach to leadership is critical to its overall success (Amanchukwu et al., 2015; Arthur-Mensah &

Zimmerman, 2017; Lichtenstein et al., 2006; W. Martin, 2018). Successful organizations recognize the need for agility and continual innovation to remain competitive and meet organizational change expectations (Rigby et al., 2020).

Sunil (2018) concluded that agility is a core quality and a must-have for organizations to survive and thrive in today's rapidly changing environment. Health care organizations have been described as complex and adaptive systems (Losty & Bailey, 2021; Porter-O'Grady, 2020). Edmonson et al. (2016) stated, "Embracing complexity is a priority for leaders today, especially in healthcare" (p. 417) and highlighted the importance of adaptive leadership, ethics, and integrity to guide leaders and their organizations through challenging times. Raderstorf et al. (2020) expanded that the coronavirus pandemic exemplified the necessity of effective organizational leadership. The pandemic ultimately created high-stress environments for organizations, the patients they serve, their families, providers, and especially the nurses providing care (Losty & Bailey, 2021).

Various studies have clarified principles and theories regarding effective leadership and the value of adaptive leadership methodology (Arthurs-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004). Evaluating the lived experiences of nurse executives who navigated times of crisis and rapid change to build adaptive capacity and the direct effect within their hospitals provided the opportunity to identify and align the five key characteristics of adaptive leadership recognized by Heifetz et al. (2009) within their strategies. This research and findings provide the opportunity to define evidence-based practices and proven tactics for developing formal training in adaptive leadership for new nurse executives, enhancing

nurse executives' ability to effectively navigate significant change, crisis environments, and uncertainty while remaining focused on mobilizing individuals within the organization to achieve and exceed organizational goals.

## Definitions

### Theoretical Definitions

This study's theoretical definitions align specific terms with the relevant adaptive leadership principles (Heifetz et al., 2009).

**Adaptive capacity.** The ability to adapt to changing environmental circumstances and challenges to ensure the organization thrives in its mission and so forth despite the present crisis, challenge, or volume of change necessary (Heifetz et al., 2009; Jakku & Lynam, 2010).

**Adaptive leadership.** According to Heifetz et al. (2009), "Adaptive leadership is the practice of mobilizing people to tackle tough challenges and thrive" (p. 14).

**Developing leadership capacity.** The systemic focus on expanding competencies and resources and intentionally motivating groups or individuals to increase leadership potential proactively (Eade, 1997, 2007; Elmore, 2003; Eyben et al., 2006; Harris, 2011; Heifetz et al., 2009; Sharratt & Fullan, 2009).

**Encouraging independent judgment.** A leader's capacity to provide an opportunity for team members to make choices based on personal and professional experience regardless of the position held within the organization (Casavant et al., 1995; Heifetz et al., 2009; Shanbhag, 2002).

**Institutionalizing reflection and continuous learning.** Providing a culture conducive to the safe exploration of new ideas and sharing of lessons learned both from

an individual and organizational perspective and creating a sustainable learning culture driven by a willingness to overcome engrained mental models across all levels of the organization (Cojocar, 2008; Pearson & Smith, 1986; Ramalingam et al., 2020; Senge et al., 2015; Veldsman et al., 2016; Vera & Crossan, 2004).

**Making naming elephants in the room the norm.** The act of openly addressing sensitive underlying issues, or undiscussables, to resolve potential barriers that interfere with an organization realizing its full potential (Baker, 2004; Heifetz et al., 2009; Toegel & Barsoux, 2019).

**Nurturing a shared responsibility for the organization.** The collective ownership across team member roles for the decision making of operational goals and outcomes of the organization's future (Harris & Spillane, 2008; Heifetz et al., 2009; Heifetz & Linsky, 2002; Northouse, 2016; Tremblay et al., 2016).

## Operational Definitions

The operational definitions provide meaning to the specific terms of the additional variables pertinent to this study. Similar to theoretical definitions, these terms and meanings are specific usage within this research study.

**Acute care hospitals.** Hospitals that provide inpatient level of medical care and other related services for short-term episodes of illness or conditions, such as surgery, injuries, or disease-related conditions (U.S. Centers for Medicare & Medicaid Services, n.d.).

**Constructive conflict.** The deliberate engagement of understanding differing viewpoints, attitudes, or beliefs to creatively work toward a solution or resolution through dialogue, curiosity, and collaboration (Schlaerth et al., 2013).

**Nurse executive.** The organization's most senior leadership role for a nurse with the job title of chief nursing officer (CNO) or chief nurse executive (CNE). The position serves on the hospital's executive team, driving the mission to deliver high-quality, safe, and compassionate care through multistakeholder teams and partnerships while leveraging facility resources effectively (NurseJournal Staff, 2023).

## Delimitations

This study was delimited to 10 nurse executives in acute care hospitals (for-profit and not-for-profit) in Southeast, West, or North Florida who met four of the six following criteria:

1. evidence of successful relationships with stakeholders.
2. evidence of breaking through conflict to achieve organizational success.
3. five or more years of experience in that profession or field.
4. evidence of having written, published, or presented at conferences or association meetings.
5. recognition by their peers.
6. membership in associations of groups focused on their field.

## Organization of the Study

This research study is arranged into specific chapters with companion references and appendices. Chapter I presented the adaptive leadership theory and key characteristics of adaptive leaders as the foundation for review. Additionally, Chapter I included the problem statement, purpose statement, research questions, definitions, and delimitations for this study. Chapter II reviews the literature on adaptive leadership and its implication to nurse executive leadership practices to support organizational viability

amid crisis and rapid change. Chapter III specifies the study methodology, design, and data collection. Chapter IV describes the data collected and a synopsis of significant findings. Chapter V addresses the collective findings, conclusions, and recommendations.

# CHAPTER II: REVIEW OF THE LITERATURE

Chapter II presents a comprehensive assessment of the literature on adaptive leadership and the strategies employed by nurse executives in acute care hospitals to build an adaptive capacity that supports organizational viability amid crisis and rapid change based on Heifetz et al.'s (2009) five key characteristics of adaptive leadership. The literature review is essential to a research study (Patten & Newhart, 2018). The review process includes aggregating significant and relevant information from existing research and concepts that align with study variables to identify connections and contrasts and the need for additional research (Roberts & Hyatt, 2019).

The review is organized into seven sections, and the first establishes the current environment and leadership challenges. The second section defines leadership and the role of a leader within an organization. Leadership models advised for times of crisis and rapid change are described in the third section. The fourth section reviews the theoretical foundations of transactional, transformational, and situational leadership models and their specific contributions to leadership advancement. Section 5 discusses seminal studies on crisis leadership and literature precedence for adaptive leadership. Section 6 addresses the theoretical framework and practice of adaptive leadership while defining Heifetz's five key characteristics that support building an organization's adaptive capacity. The seventh section focuses on adaptive leadership within health care and the nurse executive leader's role in practicing adaptive leadership. A description of the synthesis matrix (Appendix A) developed to support relevant literature aggregation and synthesis is included. The synthesis matrix was instrumental in identifying and analyzing themes and commonalities in the references, ultimately supporting alignment with the guiding theoretical

framework. The final section summarizes the research findings and validates the need for this study.

## A Time for Crisis Leadership

Despite decades of crises impacting individuals and organizations, the study of crisis leadership is limited (Wu et al., 2021). According to A. H. James and Bennett (2020), the term "crisis" is commonly used to describe a significant challenge in time that causes disruption and a form of struggle for those involved. Crisis is no stranger to organizations, regardless of size or structure (nonprofit, not-for-profit, or for-profit). Because of the scale of crises organizations are susceptible to, E. H. James and Wooten (2004) described the importance of differentiating a problem from an actual crisis. In an organization or business context, crises can suddenly obstruct processes and procedures, causing uncertainty and often adverse emotions from stakeholders because of the immediate need for agility and strategic decision making (Bundy & Pfarrer, 2015; Pillai, 1996).

Conversely, a particular crisis may evolve from a perceived insignificant internal issue to a public disaster when not managed effectively by leadership (E. H. James & Wooten, 2004; Klebe et al., 2021). No matter the evolution, crises can be catastrophic. Crises disrupt the organization's overall performance because of the immediate shift to an environment of uncertainty and instability (Klebe et al., 2021; Kok & Van Den Heuvel, 2019).

Kok and Van Den Heuvel (2019) described this challenging environment as VUCA, a term birthed from the U.S. Army War College, which stands for volatile, uncertain, complex, and ambiguous. Each word culminates in representing an

environment with large-scale change at a high momentum that is random, impulsive, chaotic, and lacking an immediate resolution (Horney et al., 2010). One VUCA example to consider is the COVID-19 pandemic in 2020, which caused significant disruption to many organizations globally (Amis & Greenwood, 2020; Donthu & Gustafsson, 2020). Amis and Greenwood (2020) and Donthu and Gustafsson (2020) described various disruptions to include lockdowns based on federal mandates, iterative vaccine and mask requirements, business closures impacting job and financial security, immediate transitions to remote work, and lack of available resources impacting activities of daily living (e.g., food, gasoline, paper, and cleaning products). Joly (2020) highlighted the collective disruption as evoking a substantial shift from normalcy to an immediate crisis filled with various challenges. The financial impact of the pandemic cannot be overlooked because for-profit and nonprofit individuals and organizations experienced significant economic implications (Donthu & Gustafsson, 2020). Notably, some entities did not survive the pandemic and its aftermath.

Health care organizations, specifically hospitals, remain in crisis (A. H. James & Bennett, 2020; Poindexter, 2022; Raderstorf et al., 2020). Raderstorf et al. (2020) described the health care climate as a constantly changing, complex, and turbulent health care delivery system. Nursing shortages further impacted the climate with increased patient acuity and concern for quality of care with the significant reduction in staff (A. H. James & Bennett, 2020). To counteract, health care organizations began focusing on hiring novice nurses to fill bedside positions while also learning of faculty shortage challenges that limit the ability of nurses entering the profession to fill the projected gaps (Florida Politics, 2022; McGhee, 2023; Poindexter, 2022; Nurse.org Staff, 2023).

## Background on the Role of Leadership in Organizations

Leadership literature evolved to adjust to environmental needs in a changing world (Lichtenstein et al., 2006). Yukl and Mahsud (2010) described leadership as effectively engaging individuals to comprehend, agree, and support efforts that drive the attainment and sustainability of individual and collective objectives. Thus, leadership is a dynamic process that goes beyond the personality and style of the person with the designated role and title within an organization. Although leadership is a critical area of research, universal interpretation and agreement remain an opportunity (Northouse, 2013).

Leadership structures and styles directly contribute to an organization's ability to successfully meet set goals and objectives (Amanchukwu et al., 2015; Kruse, 2013; Lichtenstein et al., 2006). Research has indicated that the approach of an effective leader includes the successful motivation of individuals and the alignment of business activities to meet organizational goals while supporting group and individual goals (Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018). Amanchukwu et al. (2015) noted that effective leaders drive stakeholder motivation and fulfillment while working toward common goals aligned with the organizational vision.

Leadership is essential to the functionality of an organization and thus most critical amid crises and times of rapid change (D. Anderson & Ackerman Anderson, 2010; Doz & Kosonen, 2008). Peter Drucker (n.d.) stated, "The greatest danger in times of turbulence is not the turbulence; it is to act with yesterday's logic" (para. 1). Leadership must, therefore, respond effectively to crisis (Heifetz & Laurie, 1997; Hughes & Beatty, 2011; E. H. James & Wooten, 2004). Some research has suggested that the

solution to organizational turbulence is adaptive leadership with the agility to respond timely and effectively to changing environments (Arthurs-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; Kok & Van Den Heuvel, 2019).

## Leadership in Times of Crisis

Crises have significant implications for organizations requiring effective leadership strategies to address evolving and sometimes immediate stakeholder demands and expectations (Heifetz et al., 2009). Brian Tracy, a motivational speaker and self-development author, pointed out that leadership's true test is based on functionality in a crisis (Wu et al., 2021). Thus, effective leaders ensure the achievement of organizational goals by successfully motivating and mobilizing followers amid challenging circumstances (Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018). The literature suggests several essential leadership strategies, traits, and competencies to accomplish effective leadership in times of crisis.

One of the critical leadership strategies leveraged is building trust (E. H. James & Wooten, 2004). Establishing trust is foundational to leadership in literature (Hughes & Beatty, 2011; Avolio et al., 2009). In addition to building trust, additional traits and competencies for leadership during challenging times are noted in the literature. Notably, agility and adaptability are critical competencies (Arthurs-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004). Leadership is not exclusive to an individual; it is based on specific dynamics within the leader and follower relationship that drive perceptions, understanding, and outcomes (Kouzes & Posner, 2017; Lichtenstein et al., 2006).

Kouzes and Posner (2017) further asserted, “It’s about the practices leaders use to transform values into actions, visions into realities, obstacles into innovations, separateness into solidarity, and risks into rewards” (p. xi). In addition to the ability to operationalize an effective response and decision making amid crises and challenging times, employees have been known to expect leadership to provide direction and guidance (Boin et al., 2013). Teo et al. (2017) highlighted the need for resilience from the perspective of leadership and employees to survive organizational crises. Resilience is the ability to overcome adverse conditions to develop a capacity to address future challenges successfully (Wildavsky, 1988). The ability of an organization to survive internal and or external environmental crises is centered on the power to enact resilience despite the present challenge (Holling, 1973; Wildavsky, 1988). Because of the complex nature of challenges, the review and analysis of crisis leadership is paramount for leaders to study to optimize a leader’s ability to manage crises and overall effectiveness (Wu et al., 2021).

Bennis (2009) described successful leaders embodying four essential competencies based on principles of character and authenticity in *On Becoming a Leader*. The core competencies include empathy, emotional intelligence, integrity, and adaptive capacity. Each competency supports the leader’s capability to connect with and support followers to gain the buy-in, trust, and support needed to meet organizational needs.

Throughout literature, leadership is not a title. It is, instead, a compilation of relevant behaviors, traits, and strategies that center on connecting with others in a productive way that enhances individual and organizational performance. Ultimately, leadership effectiveness requires understanding foundational leadership principles and applying the appropriate concepts to benefit people and organizations positively

(Amanchukwu et al., 2015; Arthur-Mensah & Zimmerman, 2017; W. Martin, 2018; Northouse, 2013).

## Theoretical Foundations

Although the formal study of leadership was initiated in the 1930s, literature has described various leadership theories relevant to navigating challenging times and crises (Allio, 2013; Bennis, 2009). Warren Bennis, one of the 20th-century pioneers of leadership research, described a method by which leaders shift from tradition to trait-focused approaches that gain control through inspiration and motivation, inducing core competencies of vision casting, integrity, passion, and building trust (Bennis, 2009). Kouzes and Posner (2017) highlighted successful leadership models: developing teams, recognizing individual contributions of followers, and celebrating individual and group successes. Transactional, transformational, and situational leadership models were reviewed and identified as theoretical foundations for this study.

### The Transactional Leadership Model

Burns (1978) described transactional leadership as a connection dependent upon exchanges and arrangements. Bass and Avolio (1999) noted that the transactional relationship includes specific positive rewards and negative consequences based on the job performance of the nonleader. Although the leader's influence is heavily focused on the nonleader, this theory illuminates the impact the nonleader has on the leader as to the type of response (Nawaz & Khan, 2016). Transactional leadership reinforces performance expectations through contingent rewards (Humphrey, 2013; Nawaz & Khan, 2016; Northouse, 2013).

Nawaz and Khan (2016) highlighted the possible reward and punishment transactions from the perspective of active and passive approaches. Active approaches were described as acts of gratitude, such as bonuses, merit increases, promotions, and overall positive exchanges. On the other hand, leaders can focus on the negative performance and attach specific actions to address, such as delayed responses and avoiding behaviors passively as well as direct confrontation, to ensure desirable areas of improvement are acknowledged (Meyer, 2013; Nawaz & Khan, 2016; Northouse, 2013). Northouse (2013) shared similar reward-based exchanges for optimal and suboptimal performance.

Avolio et al. (1999) elaborated on the importance of leader cadence for engagement in reward and punishment transactions. Deploying consistent performance monitoring tactics to ensure timely interactions and being able to initiate any changes needed in close to real-time to avoid adverse outcomes and subsequent consequences further describes the optimal approach. Thus, the focus is on daily organizational operations with structured performance expectations regarding tasks and goals (Lord et al., 2017). Sadeghi and Pihie (2012) noted transactional leaders are risk-averse and align best with the status quo, focusing on motivating followers with predetermined rewards. Other theories associated with transactional leadership include behavioral, contingency, and trait theories. Humphrey (2013) suggested that the most favorable outcomes for leaders and followers occur in stable, more predictable organizations. Although organizations are subject to more unpredictable events, transformational leaders elicit more of a positive relationship with followers.

## The Transformational Leadership Model

Transformational leadership is not focused on rewards and punishments but instead on empathetic considerations that drive behavioral changes in the leader to connect with and motivate followers in such a way that ultimately enhances performance outcomes (Nawaz & Khan, 2016; Northouse, 2013; Vasilescu, 2019). According to Dionne et al. (2014), transformational leadership has been the most studied and likely the most adopted model within the last 4 decades. This model sets itself apart from other leadership models and theories, focusing on the individual and organization to drive continual goal achievement despite environmental challenges (W. Martin, 2018; Nawaz & Khan, 2016).

Important structures in transformational leadership include idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration, which are all driven by the leader engaging in supportive behaviors to elicit each of the four components with followers (Bass & Riggio, 2006; W. Martin, 2018; Nawaz & Khan, 2016). Burns (1978) introduced transformational leadership, highlighting the transformational leader's focus on transforming the follower into a leadership capacity to focus on shared goals. At the same time, the transformational leader elevates morally based on their role in elevating the follower. The reciprocal elevation transforms individuals from solely personal interests (Burns, 1978; Geijsel et al., 2003; Warrick, 2011).

Bass (1985) focused his research on the ability of the leader to achieve transformational change by vision casting. Ensuring vision buy-in and through motivating factors, followers' behavior aligns with the vision and develops shared values

and a culture of collaboration supporting the change needs and success. Bass championed transformational leadership, describing it as a superior leadership model because of the leader's role in inspiring change and innovation while reducing self-interest (Bass, 1990; Bass et al., 2003).

By 1986, Ackerman expanded the view of this leadership model by concentrating on the transformational change method and outcomes. D. Anderson and Ackerman Anderson (2010) professed, "At the risk of oversimplification, the generic transformational process begins with ever-increasing disruption to the system, moves to the point of death of the old way of being, and then, as with the phoenix, proceeds toward an inspired rebirth" (p. 61). This statement aligns with the change process by which new and sustainable concepts and experiences are produced amid the cultural, behavioral, and belief shift connecting with the new normal (Gass, 2010; Hamstra et al., 2014; Warrick, 2011). Twenty-first-century studies defined transformational leadership as complex and unpredictable, impacting individuals at multiple levels, collective groups, atmospheres, environments, and psychosocially as the evolution of change is achieved; thus, adaptability and agility are essential traits of the transformation process supporting the iteration needed for success and sustainability (D. Anderson & Ackerman Anderson, 2010; Arthur-Mensah & Zimmerman, 2017).

**The Situational Leadership Model**

Situational leadership is a contingency-based theory developed in the 1960s and centered on the need to adjust leadership responses and approaches to differing situations and the level of the follower's development (Blanchard & Hersey, 1996). Graeff (1983) described situational leadership's limited influence in leadership literature while

recognizing the valuable components of behavioral flexibility and ongoing recognition of followers as the critical situational determinants of desirable leadership behaviors, thus elevating the follower as the primary focus. Northouse (2013) expanded on the model, suggesting leaders match their decision-making style to followers' maturity level. The decision-making styles described include delegation, participation, and dictation. Stogdill's trait-based leadership was a precursor to situational leadership because he later determined traits did not determine leaders' effectiveness but the ability to adapt leadership styles and approaches to achieve optimal results in a particular situation.

In consideration of the impact of environmental factors, situational leadership incorporates various peer-reviewed models that support relationship building as needed, including transactional and transformational, as described in this chapter (Nawaz & Khan, 2016). Adaptability to iterative conditions and environments is foundational to situational leaders as they actively consider the best approaches to support ongoing individual engagement and achievement of organizational goals amid challenges (Amanchukwu et al., 2015; W. Martin, 2018; Nawaz & Khan, 2016).

## Adaptive Leadership

Adaptive leadership is considered a highly effective leadership and change model to enact during challenging times of uncertainty and complex organizational change (Arthur-Mensah & Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004). Arthur-Mensah and Zimmerman (2017) stated that traditional change models are prescriptive. In contrast, the adaptive leadership model's agile approach optimizes an organization's response throughout the unpredictable nature of change and crises because

of the continual focus on the people involved in the shift process (Arthur-Mensah & Zimmerman, 2017).

An adaptive leader understands the importance of addressing the human aspects of change, tackling the social and emotional facets throughout the organizational change process by anticipating and communicating evolving needs to engage, inspire, and motivate all stakeholders toward desired change outcomes and acceptance of the new normal (Arthur-Mensah & Zimmerman, 2017; Heifetz & Linsky, 2014; Ramalingam et al., 2020). Thus, this leadership model drives a culture of shared responsibility for organizational success and effective communication at all levels (DeRue, 2011; Hayashi & Soo, 2012; Heifetz & Laurie, 1997). At the same time, failed organizational change can be linked to a lack of human engagement and actively addressing emotions and reactions throughout the change process (Palmer, 2004). Before the formal development of the adaptive leadership framework and concept, flexible and situational leadership supported the need to engage individuals and not leave the decision making to one person or group based on titles (DeRue, 2011; Lichtenstein et al., 2006).

**Seminal Studies on Crisis and Adaptive Leadership**

Krantz (1990) discussed the advancement in research focusing on the importance of flexibility and adaptability as essential leadership characteristics for challenging environments in the late 1900s. In addition, Burns and Bass studied the importance of leaders who drive collaboration and maintain positive relationships with followers amid environmental unpredictability through the transformational leadership model (Avolio et al., 2009; Bass, 1990; Burns, 1978; Krantz, 1990). Their seminal studies set the stage for the focus on successfully engaging and inspiring others, leveraging change processes to

develop followers to lead in their own spaces in alignment with what would be later defined as adaptive leadership (Avolio et al., 2009). In 1994, Heifetz presented the concept of adaptive leadership in his seminal study *Leadership Without Easy Answers* (Gyuroka, 2010).

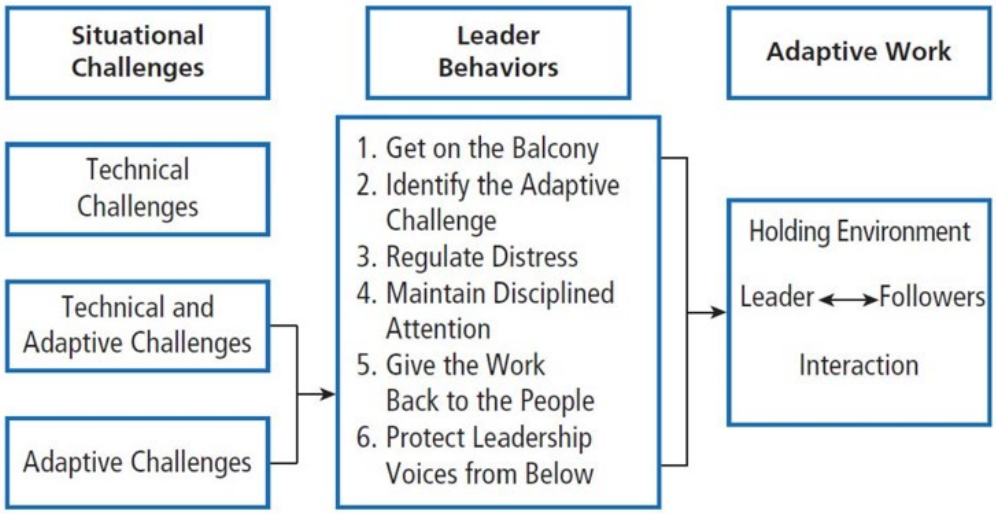
Further studies over the years have supported the practice of adaptive leadership as an essential leadership approach in the context of an organization's ability to successfully navigate challenging times and thrive (Gyuroka, 2010; Hayashi & Soo, 2012). Adaptive leaders recognize their role and the difference between authentic leadership and the posture of authority alone and effectively differentiate between technical and adaptive challenges (Gyuroka, 2010; Northouse, 2016). A leader must be able to identify adaptive challenges to enact the appropriate leadership behaviors that support the need to develop appropriate solution strategies to navigate the organization's existing and evolving change needs (Gyuroka, 2010; Heifetz & Laurie, 1997; Northouse, 2016).

Adaptive challenges often require a learning environment that provides a safe space to evolve habits, attitudes, values, roles, norms, and procedures (Gyuroka, 2010). One of the defining features is the leader's ability to recognize when a challenge is technical in which there is an existing solution despite the complexity and immediacy of the situation. In a review of the adaptive leadership model (Figure 1), the model illustrates the process for assessing the situational challenge, change needs, and necessary behaviors to navigate the specific need for change with each of the key stakeholders. The environment in which adaptive work occurs is a safe space for uncovering historical

beliefs and values, learning, processing, and developing sustainable solutions (Northouse, 2016).

**Figure 1**

*Model of Adaptive Leadership*




*Note*. From *Leadership: Theory and Practice* (7th ed.), by P. Northouse, 2016, p. 261, SAGE Publications.

The seminal studies and research consistently exhibited the value of adaptive leadership amid challenges and crises because of its ability to engage and mobilize all key stakeholders to develop strategies to ensure organizational success collaboratively (Arthur-Mensah & Zimmerman, 2017; Heifetz & Linsky, 2014; Krantz, 1990). Adaptive leaders remain flexible amid VUCA conditions and reevaluate existing strategies and current environmental needs (internal and external) to maintain organizational viability (Heifetz et al., 2009; Obolensky, 2017). Ultimately, followers become critical participants in developing and enacting solutions to meet advancing environmental needs with the support of leadership.

## The Practice of Adaptive Leadership Over the Years

Over the years, environmental landscapes have changed to include globalization and significant technological advancements. Thus, there is the need for a flexible, adaptive, methodical, and inspirational leadership style complementary to driving complex change needs while engaging key organizational stakeholders (Arthurs-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Hayashi & Soo, 2012; E. H. James & Wooten, 2004). An adaptive leader remains aware of the current environment in the context of existing organizational goals and then inspires, influences, and mobilizes support throughout the organization to ensure critical goals, tactics, and performance align (Arthur-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Heifetz & Linsky, 2002).

The emphasis on mobilization and collaboration continues to set the model apart from other crisis leadership models while also providing organizations with the ability to thrive amid crises (Amis & Greenwood, 2020; Arthur-Mensah & Zimmerman, 2017; Heifetz,1994; Heifetz & Laurie, 1997). Heifetz et al. (2009) continued to examine the adaptive leadership model, identifying an opportunity to optimize followers' problem-solving abilities by encouraging leader involvement in counteracting any bias based on historical experiences, beliefs, and values. Aligning relevant, strategic, and specific behaviors to the evolution of organizational needs is a foundational principle of building the adaptive capacity of involved stakeholders (Heifetz et al., 2009; Hughes & Beatty, 2011; Moen, 2017; Yukl & Mahsud, 2010).

## The Practice of Adaptive Leadership Today

Considering the current state of the United States of America, political unrest, international relations, technology, and artificial intelligence, heavy reliance on social

media, and the general postpandemic era with lingering organizational challenges driven by the shift in the workforce, the practice of adaptive leadership continues to be noted as a superior model amid these challenging times (Klebe et al., 2021). Adaptive leaders' ability and dedication to mobilizing teams, setting and defining expectations for ongoing and strategic collaboration, and shared accountability to meet new organizational goals are relevant today (Arthur-Mensah & Zimmerman, 2017; Bagwell, 2020). As expressed earlier in this study, many organizations remain impacted by the shift in remote work strategies, which has become the new standard (Amis & Greenwood, 2020; Donthu & Gustafsson, 2020).

## Theoretical Framework on the Practice of Adaptive Leadership

Theoretical frameworks connect key variables to the research problem grounded on established theory (Roberts & Hyatt, 2019). This study examined approaches leaders used to build an adaptive capacity and culture based on the five essential characteristics described by Heifetz et al. (2009). The critical foundational notion in adaptive leadership is that leaders recognize their role and the active nature of leading (beyond a title of authority) and effectively differentiate between technical and adaptive challenges (Gyuroka, 2010; Northouse, 2016).

### Heifetz's Five Key Characteristics of Adaptive Leadership

From the perspective of an ability to thrive, Heifetz's theory of adaptive leadership is an essential concept for individuals, structures, and organizations amid rapid change and organization-wide uncertainty (Arthur-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Heifetz & Linsky, 2014). The adaptive leader approach during times of significant change is to mobilize an internal team to assist in developing solution

strategies and is one of the essential leadership capabilities that drive the success of the adaptive leader to accomplish organizational goals and maintain a culture that supports the underlying mission and values of the organization (Heifetz & Linksy, 2002; Moen, 2017; Yukl & Mahsud, 2010). Within each of the five characteristics, specific techniques are suggested as effective practices to support building adaptive capacity in an organization through people. Aligning the methods described in the framework offers a standardized structure to explore connections to adaptive leadership in health care organizations.

### *Naming Elephants in the Room*

Heifetz et al. (2009) defined naming elephants as actively addressing issues and concerns in public settings rather than avoiding them. Heifetz et al. set the stage by describing the four concurrent meetings within the organization, separated into formal and informal categories. The formal meeting is scheduled and held in a public setting, whether in person or virtually. The other three meetings are informal, one being before or on the way to the meeting with a select group of people, and the second is the internal meeting in which thoughts of the agenda and active discussions are occurring during the same time as the meeting in each individual's head (the voice heard privately only). The last meeting is after the meeting when individuals come together to debrief outside of the larger group, whether in small huddles or by way of emails, which without all parties are often assumptions or final interpretations (Heifetz et al., 2009).

The opportunity to name elephants is in the public meeting. Organizations that normalize and expect individuals within the organization, no matter their title and existing influence, to publicly call out elephants in the room create a safe environment

that dispels fear and avoidance and welcomes additional perspectives, thoughts, concerns, and solution ideas (Heifetz et al., 2009). Organizational cultures with adaptive capacity encourage individuals at all levels to speak up by normalizing perceived undiscussable as more of a job expectation or requirement than an option (Baker, 2004; Heifetz et al., 2009; Toegel & Barsoux, 2019). Most importantly, the adaptive leader protects the individual who chooses to speak up in the same setting to show support and foster behavior expectations across the organization (Heifetz et al., 2009).

Subsequently, there is a culture shift to early identification and remediation of potential crises (Heifetz et al., 2009). Thus, when an individual thinks of something that is a current issue or has the potential to become a future issue if not addressed, the expectation is to speak up because it supports the greater good and builds organizational capacity. In contrast, publicly avoiding issues is often driven by an individual feeling unsafe speaking up when the concern is related to someone in an authoritative role whom the individual feels may become upset or by fear of speaking up and being wrong (Baker, 2004; Gyuroka, 2010; Heifetz & Linksy, 2014). Naming elephants in a room openly addresses sensitive underlying issues or the perceived undiscussable, eliminating any barriers to an organization's ultimate success (Baker, 2004; Heifetz et al., 2009; Toegel & Barsoux, 2019).

Another way to describe the process mentioned is openness to constructive conflict. Schlaerth et al. (2013) described constructive conflict as a solution-driven approach to collaboratively discussing and evaluating opposing views, attitudes, or beliefs.

### *Nurturing a Shared Responsibility*

Organizations further build adaptive capacity by cultivating a collective accountability for the organization, according to Heifetz et al. (2009). Regardless of the existing structures, hierarchies, titles, job descriptions, and specific duties each individual is assigned, Heifetz et al. noted the importance of thinking outside of oneself and personal interests, which in many cases can be department-centered, to the organization's success and future as whole. Developing shared responsibility is evidence of the adaptive leaders' foundational ability to mobilize individuals to best adapt to change for the organization's greater good. In addition, enhanced communication at broad stakeholder meetings supports more significant insights and vantage points to proactively identify or avoid crises, increasingly developing a culture of concern for others and the organization's overall needs for success (Heifetz et al., 2009; Heifetz & Linsky, 2014).

Heifetz et al. (2009) asserted that when there is a shared responsibility, the possible negativity from self-preservation attitudes is limited. Individuals in the organization continue to understand their specific roles and expectations while accepting the need for active collaboration for organizational success (Gyuroka, 2010; Heifetz et al., 2009; Heifetz & Linsky, 2014). The shared leadership and accountability for defining priorities increases the landscape of success for the organization's future (Harris & Spillane, 2008; Heifetz et al., 2009; Heifetz & Linsky, 2002; Tremblay et al., 2016). Shared leadership requires team members to recognize their role in supporting the organization's success by consistently bringing their authentic selves, thoughts, opinions, and ideas to the table. In conjunction, the adaptive leader endorses the level of engagement and feedback collectively, again role-modeling expected behaviors and

responses to maintain the culture of collaboration, collective sharing, and effective communication (Heifetz et al., 2009; Northouse, 2016; Tremblay et al., 2016).

### *Encouraging Independent Judgement*

Through the process and adaptation of publicly naming elephants in the room without fear of retribution and developing a strong sense of shared accountability, individuals in the organization are encouraged to use and mature in independent judgment (Gyuroka, 2010; Heifetz & Linsky, 2014; Kouzes & Posner, 2017). Heifetz et al. (2009) described the concept of independent judgment as taking responsibility for the organization's success by understanding that executives do not have all the answers and instead depend on the power of individual voices who have the same desire for the organization's success to speak up when needed, question strategies, and look for ongoing opportunities for improvement through lessons learned.

Therefore, everyone owns their role in the organization's success and is empowered to share ideas, ask questions, and make independent decisions. To foster independent judgment, leaders may incorporate time into existing meeting agendas for feedback, delegate specific tasks, and formally celebrate good catches and positive outcomes from proposed concepts for addressing challenges (Northouse, 2016; Senge et al., 2015). Independent judgment is similar to the idea of a learning culture and a safe space for discussing what has worked well, what has not, and specific areas of opportunity to improve as an organization or department (Edmonson et al., 2016).

### *Developing Leadership Capacity*

Adaptive learning cultures that encourage independent judgment directly support the characteristic of adaptive leadership: developing leadership capacity (Heifetz et al.,

2009). Developing leader capacity endorses the establishment of leaders next in line from the perspective of gaining subject matter expertise (personal and professional experiences) from those closest to the point of the customer as well as proactive succession planning (Heifetz et al., 2009; Heifetz & Linsky, 2014). This process proactively increases leadership potential by intentionally expanding shared responsibility and independent judgment through motivation and strategically increasing individualized competencies (Eade, 1997, 2007; Elmore, 2003; Eyben et al., 2006; Harris, 2011; Harris & Spillane, 2008). Heifetz et al. (2009) noted that capacity development does not send the employee away to dedicated workshops on leadership development; instead, it focuses efforts on an on-the-job approach to growing an individual's potential.

Weiss et al. (2010) stressed the importance of bridging the leadership capacity gap to ensure the organization can sustain and thrive. Furthermore, while leading in their dedicated spaces, leaders with titles and those without collectively support the achievement of key deliverables and overall organizational performance. Thus, organizations must value, actively attract, and foster the identification of talented employees and support their development. Building internal pipelines includes succession planning through mentorship and intentional development strategies (Heifetz et al., 2009; Weiss et al., 2010). Thus, those considered successors are aware that they are and welcome the opportunity for growth and development; the goal is for those individuals to practice similar succession tactics from their experiences.

### *Institutionalizing Reflection and Continuous Learning*

According to Heifetz et al. (2009), institutionalizing reflection and continuous learning are the concluding characteristics conducive to building individual and organizational adaptive capacities. An adaptive leader deliberately institutionalizes continuous organizational learning at all levels of leadership (Cojocar, 2008; Heifetz et al., 2009; Ramalingam et al., 2020). Heifetz et al. (2009) described the potential for senior leaders to sponsor development and learning opportunities for their direct reports and not themselves; however, "people at all levels in the organization must be able to acknowledge what they do not know and need to discover" (p. 105). Furthermore, participation in learning courses and development conferences alone cannot solve adaptive challenges; experimentation and discussing historical perspectives should be normalized. Heifetz et al. went on to define what a continuous learning mindset looks like from an organizational perspective as follows:

- Avoid marginalization of individuals who will share lessons learned from mistakes or errors. Instead, regard them as valid teachers of information.
- Incorporate frontline perspectives in developing strategy because most helpful information comes from differing day-to-day operations subject matter experts.
- Include all levels across the organization for retreats and off-site sessions. The goal is to ensure not one-way lectures but instead collaborative conversations.
- If something untoward happens, it is acknowledged, and a debriefing occurs for lessons learned.
- Encourage time away from the office for new insights and perspectives.

- Encourage both formal and informal communication and interaction practices across the organization. Bring together team members who do not interact regularly.
- Encourage candid reflection and formal agenda-based discussion forums as an opportunity to hear varying perspectives and experiences of the same phenomenon.
- Activate organization support for senior leader coaching.
- Remember, the strategic plan is not written in stone but rather a guide that can and should be refined over time as new information is introduced.

Driving continuous learning is foundational to support organizational success when navigating change; thus, an expectation is recommended to be embedded in an organization's culture (Hughes et al., 2014; Schoemaker et al., 2018). As employees learn individually, the organization benefits from sharing information (Cojocar, 2008). Vera and Crossan (2004) described how effective learning cultures exhibit leadership-driven information sharing and collaboration (see also Hughes et al., 2014). With multiple perspectives and information, there is increased visibility to effectively respond to internal and external environmental changes (Hughes et al., 2014; Ramalingam et al., 2020; Vera & Crossan, 2004). Ultimately, this creates and sustains a learning culture across the organization that is not limited to historical mental models (Pearson & Smith, 1986; Ramalingam et al., 2020; Senge et al., 2015).

**Summary of the Adaptive Leadership Model as a Theoretical Framework**

Heifetz and Laurie (1997) introduced an agile leadership model conducive to volatile environments requiring complex sustainable change (see also Arthur-Mensah &

Zimmerman, 2017; Hayashi & Soo, 2012; E. H. James & Wooten, 2004). In contrast to traditional leadership models, an adaptive leader aligns current state environments and organizational goals and then inspires, influences, and mobilizes support throughout the organization to ensure goals are achieved (Arthur-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Heifetz & Linsky, 2014). Leveraging the five key characteristics of an adaptive organization and differentiating types of challenges organizations may encounter, seminal and subsequent studies confirm the significance of adaptive leadership in building organizational performance and outcomes amid change (Heifetz et al., 2009; Moen, 2017; Yukl & Mahsud, 2010).

## Literature on Adaptive Leadership in Health Care Organizations

In reviewing the literature on adaptive leadership in health care organizations, I found that most focused on applying the foundational concepts of the leadership model to the clinical encounter to enhance the patient relationship and mobilization to adaptive change (Bailey et al., 2012). Bailey et al. (2012) aligned the change process expectations to the stakeholder because the provider drives technical challenges and solutions. On the other hand, adaptive challenges require patients and family members to develop knowledge and transform attitudes and supportive behaviors during the change process, enhancing the patient and their family's capacity to improve personal health outcomes.

R. A. Anderson et al. (2015) and C. Martin and Sturmberg (2009) identified complex chronic care as an adaptive challenge in which the change process and landscape for development is the patient's growth mindset in activities to improve health and well-being requiring each stakeholder in the care model (providers, patients, and care teams) to function as the adaptive leader who inspires action. Advancing person-centered

care at the clinical and organizational levels creates cultures without fear of failure during the change processes, reiterating that adaptive leaders in this context are the organizational leaders with the inclusion of patients, caregivers, and care providers (R. A. Anderson et al., 2015; Kuluski et al., 2020; C. Martin & Sturmberg, 2009). Figure 2 illustrates Kuluski et al.'s (2020) leadership and person-centered care approach.

**Figure 2**

*How Adaptive Leadership Concepts Translate to Person-Centered Care*

| Adaptive Leadership Concept | Definition | How it Translates to Person-Centred Care |
|---|---|---|
| Adaptive Conversation | Inspiring leadership in others by helping them to reflect on challenges, think ahead, and plan for the future. | Reviewing goals of care and priorities including how to prepare for the future and what to expect in the disease trajectory; patients, caregivers and care providers manage expectations of each other. |
| Alignment Conversation | Identifying and discussing the underlying reasons for people's resistance to change and providing a safe space to talk about concerns. | Explicitly asking about fears and concerns, demonstrating compassion and empathy when communicating. |
| Courageous Conversation | Correcting unacceptable behaviours or respectfully calling out a discrepancy in others' behaviours. | Care providers being honest about the likelihood of a poor outcome due to a patient's behaviours. At the same time, patients and caregivers verbalizing their discomfort when they feel their preferences are not being considered. Patients and caregivers need to feel safe in speaking out without fear of reprisal. |
| Observing | Heifetz and Linsky[39] use the analogy of 'getting off the dance floor and onto the balcony'. From the balcony, you can see the broader context or the 'big picture' which can inform a greater understanding of issues and actions. | For care providers, it is about understanding the social context of patients and caregivers to identify factors that will influence their ability or willingness to manage their conditions. For patients and caregivers, it is about recognizing care providers' constraints in their ability to support them (such as a lack of time or resources, high patient demand, lack of evidence base of suitable treatments). Like any relationship, acknowledging the constraints of the other party is critical in creating a sustainable, respectful relationship and preventing burn-out. |
| Interpreting | Reading between the lines and not taking everything at face value. Heifetz et al[39] describes *interpreting* metaphorically as *'listening for the song beneath the words'*. | Paying attention to body language, facial expressions and what is not being said. Such intentional listening requires patience, time, trust, probing and comfortable silence. Continuity of care between the care providers, patient and caregiver is required. |
| Intervening | Reflecting on the hypothesis of the problem. Any proposed 'intervention/solution' should be considered a 'trial' which may need to be adapted over time. The 'intervention' should be clearly connected to a shared purpose and take into account the resources available. | Trying a new treatment or care plan that reflects the shared goals of the provider(s), patient and caregivers with the caveat that things may need to be tweaked and changed over time (continually testing what works and what does not work). The new treatment/care plan needs to leverage available resources of the patient/caregiver (including their access to financial resources and caregiver capacity). It is important here that a balance be struck between giving a treatment or plan enough time to succeed versus pivoting to a new strategy too quickly.[40] |

*Note*. From "Applying the Principles of Adaptive Leadership to Person-Centered Care for People With Complex Care Needs: Considerations for Care Providers, Patients, Caregivers, and Organizations," by K. Kuluski, R. J. Reid, & G. R. Baker, 2020, *Health Expectations*, *24*(2), p. 179.

Kuluski et al. (2020) aligned the defining nature of adaptive leadership in separating technical solutions based on applying standing knowledge and practices from adaptive solutions requiring changes in what teams do and how teams work together. Furthermore, addressing adaptive challenges involves recognizing any assumptions that are potential barriers to change and drive undesirable behaviors and lack of overall motivation and mobilization in the direction the change needs.

**The Role of Adaptive Leadership in Health Care Organizations**

Health care organizations are "purposefully designed, structured social systems developed for delivering health care services by specialized workforces to defined communities, populations, or markets" (eCQI Resource Center, 2023, para. 1). As such, health care is complex, spanning various models such as community health centers, primary care practices, urgent care facilities, hospitals (acute care, surgical, extended stay, etc.), and long-term care facilities (Olden, 2019). Acute care hospitals provide inpatient-level medical care and other related services for short-term episodes of illness or conditions such as surgery, injuries, or disease-related conditions (U.S. Centers for Medicare & Medicaid Services, n.d.).

Because of health care organizations' complexity and change-driven nature, organizational leaders play a critical role in adopting a highly effective leadership model to drive the ongoing needs for change and the ability to navigate (A. H. James & Bennett, 2020). Adaptive leadership is a strategic leadership style that supports these needs by intentionally and thoughtfully addressing the current culture, focusing on producing supportive change behaviors through intentional engagement practices of individual stakeholders (Gyuroka, 2010; Heifetz & Linsky, 2014). The ability to be flexible based

on current situational and organizational needs while proactively preparing for the future is a continual state in health care because of specialized purposes that present risks, such as natural disasters, active shooters, and emergent health needs, that can impact business models (Allen, 1991; Lister, 2005; Toner, 2017).

Heifetz et al.'s (2009) five key characteristics of building adaptive capacity align with foundational principles in health care-specific change management (Campbell, 2008). In health care organizations, keeping patients safe and providing quality care requires teamwork and effective communication among stakeholders, including patients and families (King et al., 2008; Stead et al., 2009). Foundational principles of speaking up for safety require anyone with a question or concern, no matter their role or title, to say something (Okuyama et al., 2014). More importantly, it is crucial to speak up promptly to prevent patient harm during episodes of care (Alingh et al., 2018; Herbst, 2022; Okuyama et al., 2014). Speaking up and naming elephants in the room require a supportive culture for psychological safety (Alingh et al., 2018; O'Donovan & McAuliffe, 2020). From the perspective of health care change management, shared responsibility, independent judgment, reflection, and continuous learning are strategies used across multiple shifts daily to ensure adequate patient-centered care (Campbell, 2008; King et al., 2008; Stead et al., 2009).

**The Role of Nurse Leaders in Health Care Organizations**

Studies over the years have described burnout, safety issues, staffing, and nurse-patient ratio concerns compounded by the aging workforce (B. Martin et al., 2023). The pandemic intensified these longstanding concerns, specifically exacerbating staffing challenges as nurses left the bedside while patient volumes continued to surge (B. Martin

et al., 2023). There has been a call to action for nurse leaders to assist in closing the gap by intentionally developing capacity in resilience, flexibility, adaptation, and innovation practices to support change needs (Edmondson et al., 2016; Joniaková et al., 2021; Raderstorf et al., 2020). A. H. James and Bennett (2020) highlighted the importance of nurse leader visibility and engagement as motivational factors; this includes frequent rounding, timely responses to concerns, and active role modeling. Active crisis management strategies can indicate flexible and adaptive leadership (Yukl & Mahsud, 2010).

Nurse leaders must continue to deal with the pandemic's effects on the nursing workforce, which triggered significant staffing challenges with the potential to impact the quality of care provided to patients (Poindexter, 2022). These changes increase nurse leaders' need for flexibility, adaptation, and innovation (Raderstorf et al., 2020). Effective communication practices are critical for staff members pre- and postpandemic to alleviate the stress of perceived unknowns. Amid evolving demands in the health care setting, assertive communication by leadership can effectively inspire and motivate direct reports throughout the change process (Fedoruk & Pincombe, 2000).

**The Role of Nurse Leaders in Acute Care Hospitals**

Nurse leaders support clinical staff across hospital departments by driving the overall strategy to ensure quality and safe care in alignment with the values of the organization through effective communication, open-door policies, and removing any impeding barriers (Losty & Bailey, 2021). Therefore, during times of crisis and rapid change, nurse leaders must remain diligent and intentional in daily practices as the challenges heighten the sense of vulnerability within the organization (Edmonson et al.,

2016; Raderstorf et al., 2020). Increased communication to assess and inspire nurses and other clinical team members is crucial to sustain goals and practices (A. H. James & Bennett, 2020).

Within hospital settings are executive teams, a collection of the most senior leaders with chief titles and roles in their areas of responsibility (University of Southern California, 2023). The University of Southern California (2023) described the various executive positions, some of which include chief executive officer (CEO), chief medical officer (CMO), and chief operating officer (COO). The nurse executive in the hospital setting is the chief nursing officer (CNO), the nurse leader at the top of the hierarchy (Englebright & Perlin, 2008; NurseJournal Staff, 2023). The CNO usually reports to the hospital's president or CEO (Englebright & Perlin, 2008). NurseJournal Staff (2023) further described nurse executives as responsible for their hospital's clinical staff and outcomes. They lead through their department heads to ensure the nursing strategy aligns across the hospital and the various departments (Englebright & Perlin, 2008; Lúanaigh & Hughes, 2016). The overall direction, retention, engagement, and ultimate success of their departments and service lines are within their purview (Cameron & Masterson, 2000; Englebright & Perlin, 2008).

**Nurse Leaders Practicing Adaptive Leadership in Acute Care Hospitals**

The literature review specific to nurse leaders practicing adaptive leadership and using the essential characteristics and concepts in their everyday settings identified an opportunity for additional study (A. H. James & Bennett, 2020; Raderstorf et al., 2020). Existing studies discussed adaptive leadership from the aspect of health care leaders and the need for adaptive skills and from the provider-patient perspective to show the benefit

of behavioral changes in patients as the intentional focus on building adaptive capacity (R. A. Anderson et al., 2015; Kuluski et al., 2020; C. Martin & Sturmberg, 2009). Despite the lack of empirical studies in the literature specific to nurse leaders building adaptive capacity from an organizational perspective, health care systems require leadership styles with the ability and agility to address complex change needs and build on the continuous learning culture to support and ensure ongoing engagement and motivation of staff at all levels to support organizational goals (Cameron & Masterson, 2000; Kuluski et al., 2020).

## Synthesis Matrix

This study's synthesis matrix (Appendix A) was established to aggregate the identified relevant literature, organize the acknowledged themes, and align each defined theme to the study variables (Patten & Newhart, 2018; Roberts & Hyatt, 2019). This process allowed for a simplified visual representation of the volume of information reviewed to support the need for this study and its findings (Roberts & Hyatt, 2019).

## Summary

Leaders drive results through others (Amanchukwu et al., 2015; Krantz, 1990; Kruse, 2013; W. Martin, 2018). The literature review provided background on leadership and models during crises, theoretical foundations and framework for adaptive leadership, and Heifetz's five key characteristics.

Based on the literature about leadership models leveraged during challenging times and crises, models that support agility and adaptability while prioritizing the need for human engagement and mobilization were identified as the most effective (D. Anderson & Ackerman Anderson, 2010; Doz & Kosonen, 2008; E. H. James & Wooten,

2004; Yukl & Mahsud, 2010). Adaptive leadership supports all identified critical aspects based on the theoretical foundations and framework as evaluated in the review, and thus, adaptive leadership is recommended to adopt for significant organizational change needs (Heifetz & Laurie, 1997; Lichtenstein et al., 2006). However, specific limitations in adaptive leadership include the need for more research on particular skills and traits amid situational variables, the retrospective nature of shared experiences amid studies, and the potential for bias (Yukl & Mahsud, 2010).

In alignment with the purpose of this study and the identified population, I assessed the context of adaptive leadership in health care organizations and existing literature on nurse leader practices to build an adaptive capacity grounded on the theoretical framework. Despite the lack of literature on adaptive leadership in the context of nurse executives, the flexibility and strategies of adaptive leadership that define and adjust for situational changes and challenges were identified as foundational and optimal in the health care setting, demonstrating a need for additional empirical research (Arthur-Mensah & Zimmerman, 2017; A. H. James & Bennett, 2020; Raderstorf et al., 2020; Rubino et al., 2018).

# CHAPTER III: METHODOLOGY

Patten and Newhart (2018) noted that the appropriate approach, design, and method must be determined to achieve the overall goal of a research study. A critical step in selecting a suitable research method begins with the research question. Other considerations include planned instrumentation, the information and data required for analysis, and the capacity for flexibility as the study evolves (Mack et al., 2005).

The methodology for this study was a thematic-based, qualitative, phenomenological approach to recognize and examine lived experiences and the strategies organizational leaders employ to build adaptive capacity based on Heifetz et al.'s (2009) five key characteristics of adaptive leadership founded on the interests of three faculty members. As a part of a team of nine peer researchers and three faculty members who expressed interest in exploring adaptive leadership applications across multiple professional roles, I explored nurse executives' applicable strategies in acute care hospitals. Chapter III includes the purpose statement, central research question, and subquestions and describes the population, sample, instrumentation, data collection used, and steps taken to ensure the validity and reliability of the study.

## Purpose Statement

The purpose of this exploratory phenomenological study was to identify and describe the strategies used by nurse executives in acute care hospitals to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

## Research Questions

### Central Research Question

What strategies did nurse executives in acute care hospitals use to build an organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics (making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning)?

### Research Subquestions

1. How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?
2. How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?
3. How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?
4. How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?
5. How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?

## Research Design

Multiple qualitative methods were evaluated to meet the needs of the study and research question. The methodology of choice was phenomenological based on the intent to understand the lived experiences of nurse executives in acute care hospitals within the phenomena of building their organization's adaptive capacity based on Heifetz et al.'s

(2009) five key characteristics during a crisis and significant change. Although each leader may have had a different level of experience, training, and style for leading during a crisis and building an organization's adaptive capacity, the goal was to evaluate the described experiences and strategies employed by each participant to understand better the essence of the phenomenon from a group perspective while identifying specific themes (Patton, 2015).

Qualitative research methods are used when a researcher wants to evaluate a phenomenon's meaning, such as experiences, issues, and cultures. Qualitative research is exploratory and focuses on words, usually narrative (Patten & Newhart, 2018). The words obtained in this study were organized into themes based on analysis by the researcher. The researcher, versus a specific tool (e.g., a survey), was the instrument of this study.

All information obtained by interviewing and observing study participants was captured into written notes, organized, and analyzed to develop categories and themes within the findings. Inductive data were then formed without the basis of theory or preconceived views and provided the ability to iterate (i.e., flexibility to evolve throughout the study; A&S, 2016). Artifacts from the participants were encouraged as supportive documentation. Although this method can be considered time consuming because of the volume of data (e.g., quotes) to be reviewed and coded, the aim was to provide insights based on the assessment of information obtained.

## Method Rationale

According to McMillan and Schumacher (2010), a phenomenological approach focuses on participant perspectives, examining everyone's recollection of events

(phenomenon) and their expressed meanings of specific experiences within the event to understand the relationship better. Hence, a qualitative phenomenological methodology was employed in alignment with the aim of this study to identify and describe the lived experiences of nurse executives and their perceived strategies that supported building an organization's adaptive capacity. Each participant's voice was foundational to aligning experiences, meaning, and the perceived impact of Heifetz et al.'s (2009) five key characteristics during significant events (phenomenon) deemed a crisis requiring substantial change.

## Population

McMillan and Schumacher (2010) described a population as a group that exhibits particular criteria that meet the need for generalization. The study population was nurse executives in acute care hospitals, including for-profit and not-for-profit, with the title of chief nursing officer (CNO) or chief nurse executive (CNE) in the United States. The nurse executive in the hospital setting is considered the most senior leadership role for a nurse. More specifically, the nurse executive role serves on the hospital's executive team with the responsibility of driving the mission of delivering high-quality, safe, and compassionate care through multistakeholder teams and partnerships while leveraging facility resources, including staff effectively (NurseJournal Staff, 2023).

Zippia (2022) leveraged a database of 30 million profiles and estimated there are 41,447 nurse executives employed in the United States. Estimates were then validated against the U.S. Bureau of Labor Statistics, census data, and existing openings for the role to ensure accuracy. Based on these findings, I determined that the ability to study all nurse executives across 50 states was not a viable option. Therefore, a sampling frame

was developed to assist in the process of identifying a manageable population for interviews.

## Sampling Frame

When considering a sampling frame, McMillan and Schumacher (2010) described this group as the desired persons who meet specific conditions for the study's intent. In evaluating this group, generalizations and conclusions can be made about the entire population while supporting feasibility. This study's sampling frame included nurse executives in Florida with the title CNO or CNE.

I narrowed the population to the state of Florida. This sampling frame assisted in achieving a more manageable number, while Florida was further selected because of the historically robust nature of the nursing workforce being among the top employers for nurses nationwide and current challenges compounded by nursing shortages (Nurse.org Staff, 2023; Staff Reports, 2022). In 2022, it was estimated that 2,634 nurse executives were employed across Florida, with an additional 568 jobs posted during that same timeframe (Zippia, 2022). Based on these findings, I determined the need to further reduce the number of nurse executive participants in the study to a suitable sample size.

## Sample

McMillan and Schumacher (2010) described the sample as a subset of the target population included in obtaining the specific data for the study. In qualitative studies, sample sizes can range from single to double digits, depending on the study's purpose, focus, primary data collection approach, and accessibility of information-rich informants (McMillan & Schumacher, 2010; Roberts & Hyatt, 2019) because the quality and richness of the information collected is a priority over the number of participants

(McMillan & Schumacher, 2010; Patton, 2015; Roberts & Hyatt, 2019). This study's sample population and size were narrowed to encompass 10 nurse executives in acute care hospitals across Southeast, West, and North Florida who met the study's criteria. As the researcher, I broadened for generalization by ensuring the variety of working for-profit and not-for-profit hospitals (organizations) leveraging referrals from a panel of experts, further described in the sample selection section of this study.

The other eight peer researchers used the same population size of 10, which was validated as sufficient to meet the aim and data needed for this phenomenological study of the lived experiences of leaders in today's turbulent and uncertain world within the context of adaptive leadership. All study participants were required to meet four of the following six criteria:

1. evidence of successful relationships with stakeholders
2. evidence of breaking through conflict to achieve organizational success
3. five or more years of experience in that profession or field
4. evidence of having written, published, or presented at conferences or association meetings
5. evidence of being recognized by their peers
6. membership in associations of groups focused on their field

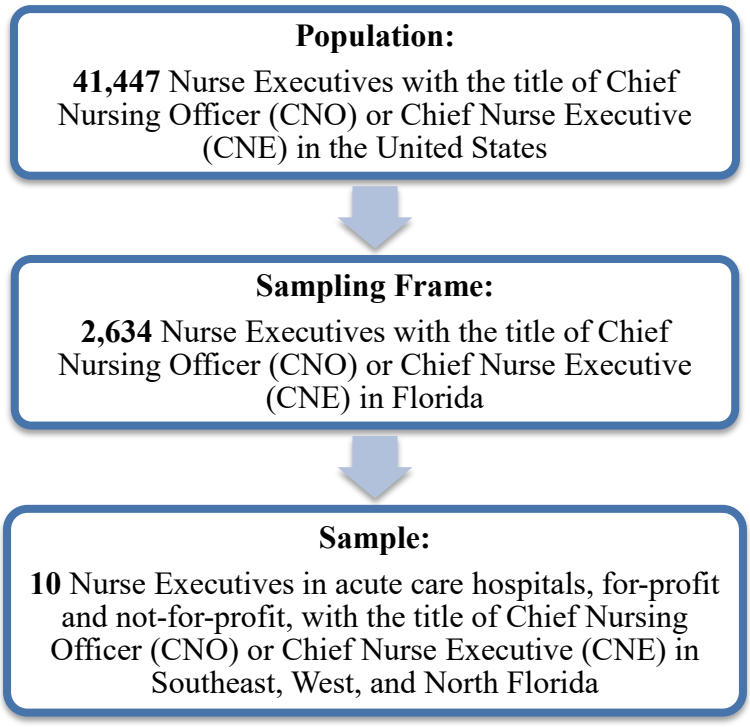
## Sample Selection

Upon approval of the Institutional Review Board (IRB), the selection process was initiated and was purposeful based on the information and rich detail needed to address the research questions (Mack et al., 2005; McMillan & Schumacher, 2010). The approach included convenience and an expert panel. A panel of six experts in the field of nursing

and health care administration were used to nominate study participants across the state of Florida to address all regions described in the study. More specifically, the experts provided three nurse executive nominees as representatives of West and North Florida and four nominees as representatives of Southeast Florida from a variety of different hospital configurations (for example rural versus urban). This supported broader perspectives in case those who agreed to participate were in the same corporate health system structure. Figure 3 illustrates the progression used to identify the sample of nurse executives for this study.

**Figure 3**

*Population, Sampling Frame, and the Sample of Nurse Executives*




Leveraging experts within the field who are knowledgeable and connected supported the participant selection process (Patton, 2015). Each identified participant

matched the generalized population and met the minimum delimitation criteria to reinforce the credibility of this study (McMillan & Schumacher, 2010). Patton (2015) noted that a criterion-based approach within purposeful sampling is effective in ensuring key informants are selected and included in the investigative process to support the detailed analysis needed for a study's purpose. I also leveraged participant referrals to identify potential additional participants across the state of Florida who met the study's criteria and parameters, which is an evidence-based approach for locating information-rich key informants willing to share their expertise (Patten & Newhart, 2018; Patton, 2015).

The final 10 participants were confirmed based on ensuring a minimum of three participants from each of the three regions (Southeast, West, and North). Within each region, participants were recommended and identified by the expert panel to include virtual introductions. Collectively, the first 10 nurse executives who met the sample criteria and confirmed their willingness to participate were chosen.

## Instrumentation

Data collection included one-on-one focused virtual interviews via Zoom or Webex with each participant to understand the nature of their experiences and perceptions of strategies used to build their organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics of adaptive leadership (McMillan & Schumacher, 2010; Patton, 2015). Time was allocated for 60 min per interview to provide enough time for a thorough discussion aligned with this study's purpose and the research questions. The interview questions were standardized with predetermined open-ended questions while maintaining flexibility for the flow of each conversation.

The nine peer researchers collaborated with the three faculty advisors to develop, field-test, and finalize the interview protocol and standardized questions used for each interview. An alignment table confirmed that each interview question connected with the purpose of this study and research questions (Appendix B). In addition, probes and prompts were developed to support the need for additional clarification and elaboration during the interview process to enhance the quality of the information received during the interview process (McMillan & Schumacher, 2010). An interview protocol, which included a script that outlined the purpose of the study, was codeveloped by the peer researchers and included the verbal acknowledgment of informed consent.

**Researcher as the Instrument of the Study**

In a qualitative study, the researcher is the essential instrument because the researcher is the facilitator of interviews, the designer of the interview questions, and the collector and analyzer of the data (Patton, 2015). I was the main instrument for gathering information supporting this study's purpose statement and research questions. While conducting this study, my role included serving on a division-level nurse executive leadership team as the assistant vice president of academic engagement and strategies in Southeast Florida as well as an adjunct faculty member at a local school of nursing.

Although connected with the importance of the study as a nurse leader; my focus remained on maintaining objectivity and aiming to ensure accurate data collection and analysis, beginning with systematic field-testing of the interview questions and the collaboration with the three faculty advisors and nine peer researchers to eliminate risks of bias (Mehra, 2002). I focused on the study's credibility throughout each step,

incorporated triangulation in capturing artifacts, and ensured that findings were demonstrable without preconceptions and predispositions (Patton, 2015).

### Field-Testing

Because of the nature of developing an interview instrument, field-testing was a critical step in ensuring the effectiveness of the determined questions and any need to adjust the content to ensure the intent of the phenomenological study and the richness of data collected (Roberts & Hyatt, 2019). All nine peer researchers conducted field tests of the finalized interview questions (Appendix C) and protocol (Appendix D), ensuring an experienced observer was present. Participants were selected in alignment with each peer researcher's intended sample for the study, including the delimitation criteria. Each peer researcher used the standardized reporting forms (Appendices E, F, and G) and reported participant and observer feedback to the thematic team and three faculty advisors. The feedback was aggregated, and the instrument was revised based on the collective findings.

For this study, the interview questions, protocol, and informed consent were provided to the participants to review 5 business days before the field test. The observer was a doctorate-prepared nurse with experience in qualitative research, interviewing, and data collection. The interview was held on Zoom or Webex, virtual conference platforms.

## Validity and Reliability

Roberts and Hyatt (2019) described the importance of establishing the validity and reliability of instruments within a study because each plays a significant role in determining the credibility and dependability of the results in connection with the purpose and research questions.

## Validity

McMillan and Schumacher (2010) described validity as "the degree of congruence between the explanation of the phenomena and the realities of the world" in qualitative research (p. 330). Therefore, it is critical to ensure that the interview tool (instrument) is developed to accurately measure what is intended based on the purpose of the study (Patten & Newhart, 2018). To ensure the highest degree of validity in this study, receiving input from the nine peer researchers and three faculty advisors in developing the interview questions and field-testing was an essential step. The aggregated feedback from participants and expert observers during field-testing contributed to the decision making and finalization of the instrument. Ultimately, the collective process and team approach confirmed the study's ability to be replicated as intended, supporting the validity (McMillan & Schumacher, 2010).

## Reliability

Establishing reliability focuses on evaluating the consistency of results when replicating a study with the same instrumentation (McMillan & Schumacher, 2010; Patten & Newhart, 2018). Reliability is accomplished with consistent processes and outcomes of data collection and analysis (Patton, 2015). Reliability supports the dependability of a study (Roberts & Hyatt, 2019). Each of the nine peer researchers participated in instrument and interview protocol development with delimitations, aligning the interview questions to the purpose of the study and intended variables while considering the varying populations, sampling frames, and samples for each individual study. The interview questions were used as scripted with each participant. Each interview was recorded and transcribed for participant review and confirmation to ensure

the accuracy of information collected for analysis and to increase the reliability of the study. According to McMillan and Schumacher (2010), this is labeled member checking and ensures an accurate representation of the lived experience. Delve software was the source for the coding of themes and patterns.

## Data Collection

In qualitative studies, "the researcher collects data directly from the source," typically narrative (McMillan & Schumacher, 2010, p. 321). Prior to the data collection processes, the Collaborative Institutional Training Initiative (CITI) Program was completed (Appendix H) to confirm integrity in the data collection process throughout the study. In addition, UMass Global Institutional Review Board (UIRB) approval was obtained, validating ethical and regulatory criteria were met, such as informed consent, confidentiality, and overall protection from harm based on the involvement of human subjects in a study (McMillan & Schumacher, 2010; Roberts & Hyatt, 2019). The study adhered to all guidelines to ensure participant confidentiality by de-identifying data collected throughout the study and keeping all information secure, including electronic and paper documents involving participants. Participant data were reported using nonidentifying pseudonyms such as Participant 1, Participant 2, … Participant 10 to ensure confidentiality. Recordings of interviews were deleted upon successful completion and confirmation of transcript accuracy. Any field notes or paper-driven information collected were locked in my home. All digital and written records are destroyed 3 years after the completion of the study.

## Interviews

The interview method solicited a description of a previous occurrence and events, building adaptive capacity based on their application as nurse executives. This is consistent with the nature of a phenomenological study, being retrospective and reflective (Patton, 2015). One-on-one interviews of 10 nurse executives in acute care hospitals, for-profit, and not-for-profit, with the title of CNO or CNE in Southeast, West, and North Florida. Nurse executives who confirmed participation in this study were emailed a formal invitation to take part in the process (Appendix I). A phone contact was shared for any clarification or additional information needs.

Upon agreement to participate in communication, a virtual interview was scheduled through Zoom or Webex with a time block of 1 hr. In addition to the invite for the virtual interview, the interview questions with definitions, informed consent (Appendix J), and Research Participant's Bill of Rights (Appendix K) were provided a minimum of 5 business days before the scheduled interview for adequate preparation. A team of nine peer researchers in consultation with three faculty developed the interview protocol. Video and audio transcripts were recorded and downloaded for documentation purposes. The interview protocol was used at the time of each interview noting the rationale for recording the interview, while verbal acknowledgment was recorded and confirmed at the beginning of the interview. Physical notes were also obtained to review and validate the accuracy of all data received. Transcripts were provided to each participant with the request to review and validate for accuracy before coding.

### Artifacts

Artifacts were requested and used for triangulation to increase credibility in the study findings to include any actual work product provided as evidence of the key characteristics of building an organization's adaptive capacity during times of crisis, challenge, and change (McMillan & Schumacher, 2010). Applicable artifacts for this study included meeting minutes, memos, presentations, emails, and infographics provided by the study participant to the researcher based on their perception of the artifact's alignment with each applicable study variable. Because of the nature and business of health care, it is expected that the receipt of described artifacts would be limited because they often include metrics with patient-sensitive indicators or outcomes that hospitals may not be able to disclose because of possible Health Insurance Portability and Accountability Act (HIPAA) constraints or hospital specific protections.

## Data Analysis

Analyzing qualitative data requires transitioning the large volume of words and narrative findings into organized themes and patterns (Patton, 2015; Roberts & Hyatt, 2019). Credibility and validity of study results and conclusions are generated by properly analyzing participant answers to the interview questions that align with the study's specific research questions (McMillan & Schumacher, 2010). The analysis process began with the interviews, including active listening and observation of participant responses, note-taking, and artifact reviews. The incorporation and examination of artifacts supported triangulation as implementing multiple ways of collecting data to understand the nature of each participant's experiences and perceptions (McMillan & Schumacher, 2010; Patton, 2015). For the purpose of this study, artifacts were to be focused on the

strategies used to build their organization's adaptive capacity within the construct of Heifetz et al.'s (2009) five key characteristics on adaptive leadership. Triangulation strengthens the study and reduces researcher bias (Patton, 2015).

After each interview, the transcripts were reviewed and provided to each participant for their review and confirmation of recorded responses. Once confirmed by the participant, the transcript was uploaded into Delve, my preferred qualitative software, to analyze and code the data collected. Qualitative software supports the researcher's ability to be creative and focus on synthesizing and analyzing information and organizing and coding data (Patton, 2015). Leveraging the functionality and capability of Delve, frequency tables were created for each research question that specified identified themes, frequencies, and percentages. Roberts and Hyatt (2019) shared a variety of approaches to code data; however, they recommended Creswell's five-step process:

1. Initially, read through the text data
2. Divide the text into segments of information
3. Label the segments of information with codes
4. Reduce the overlap and redundancy of codes
5. Collapse codes into themes. (Creswell, 2004, p. 238)

## Intercoder Reliability

To prevent research bias and support the reliability and dependability of the study, an independent third-party evaluator (evaluator) completed an analysis of 10% of the data collected to confirm a minimum of 80% agreement with what was heard and rated by the researcher (McMillan & Schumacher, 2010). The evaluator was experienced in using Delve software for qualitative data collection and analysis and had previously achieved a

doctoral-level degree. A meeting occurred with the evaluator virtually on Zoom or Webex to review transcribed interview data and coding to discuss the findings for correlation and alignment. To ensure the desired degree of reliability in coding, preparation was made to adjust as necessary to previous codes (Patton, 2015).

## Limitations

Research study limitations are often outside the researcher's control, yet conditions affect the study's interpretations and results (Patten & Newhart, 2018; Roberts & Hyatt, 2019). The researcher must disclose known limitations of the study for the reader to understand the scope of each and the potential impact on the study's findings (Roberts & Hyatt, 2019). Limitations for this study are detailed in the following sections.

### Geography

The participants in this study were nurse executives in acute care hospitals, for-profit and not-for-profit, with the title of CNO or CNE in Southeast, West, and North Florida. Despite the various regions within Florida incorporated, there are presumed cultural and demographic differences, so there are limitations to the ability to generalize findings across the state or the United States.

### Time and Process Constraints

Participants in the study and interview process were hospital-based nurse executives. As such, they likely had limited availability within their schedules, which may have impacted their ability to prepare and review provided information before the interview and the extensiveness of responses to each interview question. The time designated for the interview process was 1 hr. Another possible limitation is the dependency on complete disclosure and accurate participant recollection. In addition, the

interview process was virtual instead of in person, which can be a barrier to the effectiveness of an interview. Ultimately, each of these constraints could affect the quality of information shared and received, hence affecting the identification of themes and results.

**Sample Size**

The sample size of 10 nurse executives in acute care hospitals, for-profit and not-for-profit, with the title of CNO or CNE in Southeast, West, and North Florida is limited. Organizations may vary in culture and maturity related to acceptance of change and colleague engagement; thus, the lived experiences of nurse executives in building adaptive capacity amid crises and challenges could be specific to each organization. It would be less feasible to generalize the lived experiences of these participants and themes to others in the same role in hospitals across the same region and state. Therefore, limitations to this study's conclusions and the ability to generalize to nurse executives with the title of CNO or CNE in the United States were noted. According to Patton (2015), there is the ability to establish credible conclusions from information-rich participants, and the researchers' analytical ability, although not dependent on sample size as the quality and richness of the information collected, is a priority over the number of participants (McMillan & Schumacher, 2010; Patton, 2015; Roberts & Hyatt, 2019).

**Researcher as the Instrument of the Study**

In qualitative studies, the instrument of the study is the researcher versus a specific tool (e.g., survey) that synthesizes the information (i.e., words) obtained from interviews and observations of study participants (McMillan & Schumacher, 2010). Limitations exist because of risks of personal bias and identifying any implicit thoughts

or feelings that could affect the analysis of information (Patton, 2015). A possibility for bias exists when an inability to remain neutral causes a preference and an aversion to something or someone. The lack of awareness of existing attitudes toward people, issues, or things can significantly impact a study's process, validity, and credibility. For example, if the researcher were in the health care industry and was a nurse executive (as defined in this study) in the past, there may have been preconceived thoughts from personal experiences and views, thus developing the study to prove an ulterior motive or point during the coding and analysis process. I remained aware of possible bias and its ability to influence the study, and this possibility may contribute to the study's ability to be generalized.

## Summary

Chapter III detailed the methodology used in this qualitative, phenomenological study, identifying and describing the strategies used by nurse executives in acute care hospitals to build an adaptive capacity during challenging times of crisis and significant change based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). The chapter began with descriptions of the purpose statement, central research questions, and research questions. The chapter then focused on the methodology, design, structure, data collection, and analysis and identified limitations for transparency.

In addition, Chapter III described the validity and reliability processes to support the replicability and credibility of the study. In Chapter IV, data are analyzed and presented in alignment with the research questions and aim of the study. Finally, Chapter V summarizes the findings, presents conclusions, and describes the next steps, including implications for action and future research recommendations.

# CHAPTER IV: RESEARCH, DATA COLLECTION, AND FINDINGS

## Overview

This thematic-based qualitative phenomenological study identified and described the strategies used by nurse executives to build adaptive capacity within their respective organizations based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). The purpose statement, research questions, theoretical definitions, interview questions, and protocol were developed within the thematic structure with the nine peer researchers and three faculty members to ensure consistency across each study.

Chapter IV begins with the purpose statement, research questions, methods, and data collection procedures. It also reintroduces the study population and overall demographic data. Afterward, data and findings are presented in alignment with each research question. Chapter IV concludes with a focused summary of all key findings.

## Purpose Statement

The purpose of this exploratory phenomenological study was to identify and describe the strategies used by nurse executives in acute care hospitals to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

## Research Questions

### Central Research Question

What strategies did nurse executives in acute care hospitals use to build an organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics (making naming elephants in the room the norm, nurturing a shared responsibility for the

organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning)?

**Research Subquestions**

1. How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?
2. How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?
3. How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?
4. How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?
5. How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?

## Research Methods and Data Collection Procedures

The selection of a phenomenological methodology and a qualitative research design aligned with the purpose of the study and supported the ability to identify and describe the strategies used by nurse executives to build an organization's adaptive capacity by evaluating their lived experiences. The exploratory nature of qualitative research provides data in words and recurring themes to understand better the phenomenon's essence (McMillan & Schumacher, 2010; Patten & Newhart, 2018; Patton, 2015). Therefore, the data obtained are often gathered by interviewing participants to analyze their lived experiences (Patton, 2015).

Data for this study were collected through virtual one-on-one interviews using standardized open-ended questions. The nine peer researchers and three faculty advisors developed the interview protocol (Appendix D) containing 10 open-ended interview questions, nine specific prompts, and optional probing questions after an extensive review of evidence-based literature on the subject matter of the key characteristics of adaptive leadership. To obtain the data needed for the study's purpose, each of the interview questions and companion prompts was developed in collaboration with the peer researchers by aligning Heifetz et al.'s (2009) five key characteristics of adaptive leadership to each research question (Appendix B) under the guidance and approval of the three faculty research experts. As required by university guidelines for research, I obtained the course completion certification on human subject research for social-behavioral-educational researchers from CITI (Appendix H) and the approval from the UMass Global University Institutional Review Board (IRB) to conduct the study (Appendix L) before engaging in data collection using the interview protocol.

Data were collected from 10 nurse executives who met the study criteria. Upon identification of their eligibility, each participant was emailed the invitation to participate (Appendix I) with a request for availability to schedule the interview, the informed consent form (Appendix J), and the Researcher Participant's Bill of Rights (Appendix K). Once a date and time were confirmed, the participant received a formal calendar appointment that included a reminder of the purpose of the study, the interview questions, and corresponding study definitions as developed by a thematic team of peer researchers and faculty advisors (Appendix C). Seven participants returned a signed informed consent before the interview date. The other three participants confirmed receipt and

agreement of the informed consent at the beginning of their recorded interview. Nine interviews were conducted using the Webex application with audio and transcription recording; one used Zoom for audio and recording. The interview protocol was employed for each interview to support the consistency and reliability of the thematic study. In alignment with the written interview protocol, all participants were allowed to ask questions or share concerns regarding the informed consent and the Research Participant's Bill of Rights. Probing questions were used when applicable to clarify participants' thoughts and ideas during the interview process. After the interview protocol, I informed participants that the transcript would be provided for validation of accuracy and the opportunity to provide additional thoughts and supportive artifacts based on our discussion. Each of the interviews was between 30 and 50 min in length, averaging about 40 min.

After all interviews, each video recording from Zoom and Webex was uploaded separately into Rev, a transcription service tool (membership only) for audio transcription. I reviewed each transcription for accuracy, removing all participant-specific information. The transcripts were emailed to each participant for review and approval to ensure that the information captured aligned with the shared thoughts and ideas. Upon confirmation of accuracy, the transcriptions were renamed and saved using Participant 1, Participant 2, … Participant 10 in a password-protected Google folder (accessible only by me). In addition to the interview transcripts, artifacts collected and signed informed consent documents were securely stored using the same password-protected Google folder. The transcriptions and artifacts were coded for frequency and themes using the

Delve qualitative coding software. Data triangulation was established based on the data obtained from interviews and identified artifacts.

## Population

The population for this study was nurse executives serving or who have served in acute care hospitals, including for-profit and not-for-profit, in the United States. Acute care hospitals provide inpatient-level medical care and other related services for short-term episodes of illness or conditions such as surgery, injuries, or disease-related conditions (U.S. Centers for Medicare & Medicaid Services, n.d.). The nurse executive role, with the job title of chief nursing officer (CNO) or chief nurse executive (CNE), is an organization's most senior leadership role for a nurse. Nurse executives serve on the hospital's executive team, driving the mission to deliver high-quality, safe, and compassionate care through multistakeholder teams and partnerships while leveraging facility resources effectively (NurseJournal Staff, 2023).

According to McMillan and Schumacher (2010), a population should serve as the group needed to exhibit particular criteria meeting the generalization. Based on the purpose of this study, the overall population of identified nurse executives in hospitals throughout the United States was 41,447 (Zippia, 2022). It was determined that analysis of the overall population was not feasible; thus, the population was narrowed to a sampling frame of the estimated 2,634 nurse executives employed in Florida (Zippia, 2022).

## Sample

The sample for this research study included 10 nurse executives who served in either Southeast, West, or North Florida and met a minimum of four of the six

delimitation criteria. The thematic peer researchers established the delimitations and determined the sample size of 10 sufficient to collect meaningful data to support this phenomenological qualitative study's purpose, credibility, and feasibility (McMillan & Schumacher, 2010; Patton, 2015). Participants must have served at the time of this study or previously served as a nurse executive in an acute care hospital (for-profit and not-for-profit) in Southeast, West, or North Florida and met four of the following six delimitation criteria to participate:

1. evidence of successful relationships with stakeholders.
2. evidence of breaking through conflict to achieve organizational success.
3. five or more years of experience in that profession or field.
4. evidence of having written, published, or presented at conferences or association meetings.
5. recognition by their peers.
6. membership in associations of groups focused on their field.

The selection process included convenience sampling and a panel of nursing and health care administration experts. The panel was asked to nominate study participants throughout Florida to address all regions as described. As nominees were identified with their contact information, each nurse executive was emailed directly to extend an invitation to participate. Of the 13 nominees, 10 responded with interest and met eligibility requirements. Table 1 displays how each nurse executive met the established criteria to participate in the study.

**Table 1**

*Study Participant Criteria*

| Study criterion | Participant | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1. Has shown evidence of successful relationships with stakeholders | X | X | X | X | X | X | X | X | X | X |
| 2. Has shown evidence of breaking through conflict to achieve organizational success | X | X | X | X | X | X | X | X | X | X |
| 3. Has 5 or more years of experience in the profession or field | X | X | X | X | X | X | X | X | X | X |
| 4. Has had articles written, published, or presented at conferences or association meetings | X | X | | | X | X | | X | X | |
| 5. Is recognized by his or her peers | X | X | X | X | X | X | X | X | X | X |
| 6. Holds memberships in associations or groups focused on his or her field | X | X | | | X | | | X | X | |

## Demographic Data

The participants in the study included 10 nurse executives who served or had served as CNOs and met the specific eligibility criteria. Participant names and organizational identifying information were excluded from the study's findings to ensure confidentiality and privacy as described in the informed consent process. Therefore, each participant was assigned a numerical alias, beginning with "Participant 1" and ending with "Participant 10."

All 10 participants were female, between 46 and 65 years old. Participants' ethnicity included White (nine) and African American (one). In a review of the highest level of education, five participants held master's degrees, four participants held doctoral degrees, and one held a bachelor's degree. Despite the various tenures within their

organization and time served as a CNO, all participants had been in the nursing field for over 9 years. Table 2 illustrates the demographic information of the study participants.

**Table 2**

*Participant Demographic Information*

| Participant | Identified gender | Identified ethnicity | Age range | Years in the organization | Years in the position | Years in the field | Highest level of education |
|---|---|---|---|---|---|---|---|
| 1 | Female | White | 56-55 | 4–8 | 4–8 | 16+ | Bachelor's |
| 2 | Female | White | 46–55 | 16+ | 16+ | 16+ | Doctorate |
| 3 | Female | White | 46–55 | 9–15 | 16+ | 16+ | Master's |
| 4 | Female | White | 56-55 | 4–8 | 4–8 | 16+ | Master's |
| 5 | Female | African American | 46–55 | 9–15 | 9–15 | 16+ | Doctorate |
| 6 | Female | White | 46-55 | 4–8 | 9–15 | 9–15 | Master's |
| 7 | Female | White | 56-55 | 16+ | 9–15 | 16+ | Master's |
| 8 | Female | White | 56-65 | 4–8 | 4–8 | 16+ | Doctorate |
| 9 | Female | White | 56-65 | 9–15 | 9–15 | 16+ | Doctorate |
| 10 | Female | White | 46–55 | 4–8 | 4–8 | 16+ | Master's |

## Presentation and Analysis of Data

Applying a qualitative research design, narrative and artifact data were collected through one-on-one interviews with 10 nurse executives who served as CNOs and met the minimum eligibility criteria. The data collected supported the purpose of this study, which was to identify and describe the strategies used to build an adaptive capacity based on the key characteristics of adaptive leadership identified by Heifetz et al. (2009). The standardized and structured interview questions allowed nurse executives to communicate their lived experiences and leadership strategies for building adaptive capacity. Upon analysis of the data collected by the research question, prominent themes related to the five key characteristics of adaptive leadership were identified.

## Data Analysis

To support the data analysis for this study, each transcript was uploaded into the Delve tool. Data were then coded in Delve based on the five key characteristics of adaptive leadership: making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning. Each transcript was assessed and analyzed to support the quality of coding. Deductive and inductive coding strategies were used to identify patterns and key themes from the interview responses. Frequency tables were created from the identified themes and data sources in alignment with each key adaptive leadership characteristic and companion research questions.

## Intercoder Reliability

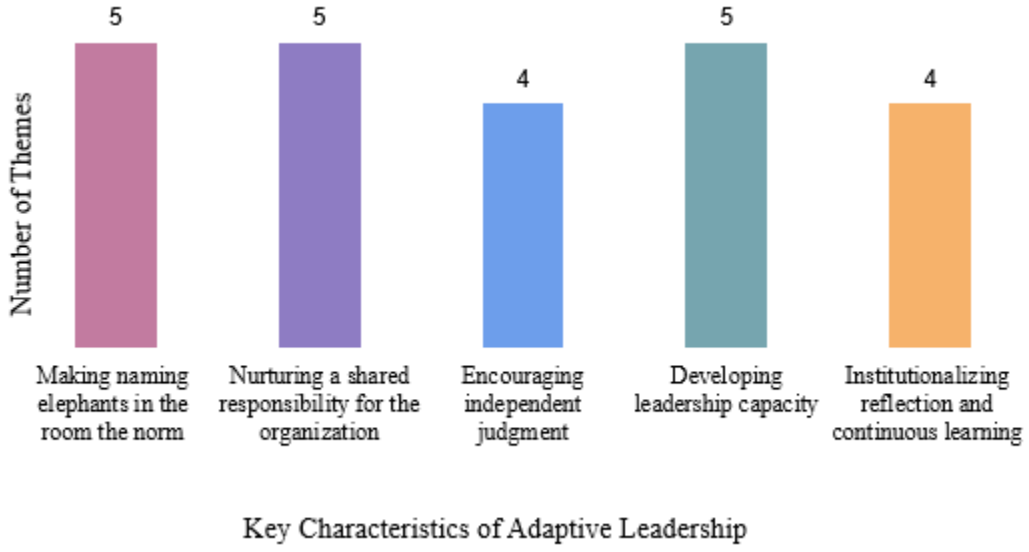
Reliability was established through field-testing of the interview protocol developed and conducted by the nine peer researchers. As an added layer of intercoder reliability, 10% of the data (equal to one interview transcript) was analyzed and coded by a peer researcher with experience in qualitative coding. A 91% agreement level was established among raters, exceeding the minimum 80% threshold for reliability, as described by Patton (2015).

## Data by Research Question

Based on the 10 interviews, 1,983 coded entries were attained, including 1,979 interview-associated frequencies and four artifact-specific frequencies. The coded data resulted in 23 key themes. Figure 4 displays the themes identified for each of the five key characteristics of adaptive leadership.

**Figure 4**

*Distribution of Themes Per Key Characteristics of Adaptive Leadership*




Of the 23 emergent themes, making elephants in the room the norm, nurturing a shared responsibility for the organization, and developing leadership capacity generated five distinct themes. Four distinct themes emerged from the remaining characteristics of encouraging independent judgment and institutionalizing reflection and continuous learning. Table 3 summarizes all coded data by research question, total frequency count, and frequency percentages by key characteristic.

Figure 5 is a visual of the distribution of frequency counts and percentages of all codes identified for each key characteristic of adaptive leadership in alignment with the study's research questions.

Of all the data coded on key characteristics of adaptive leadership, nurturing a shared responsibility for the organization had the highest overall frequency count of 620, representing 31.3% of total frequencies. The second highest frequency of 523 representing 26.4% of the data, was making naming elephants in the room the norm.

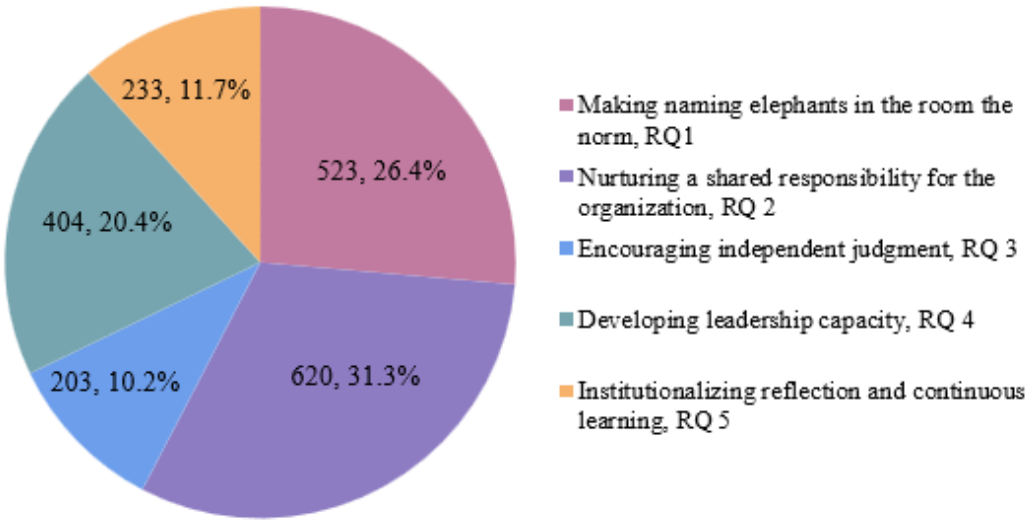
**Table 3**

*Tabulation of All Coded Data*

| Key characteristic of adaptive leadership | Research question | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Making naming elephants in the room the norm | 1 | 522 | 1 | 523 | 26.4 |
| Nurturing a shared responsibility for the organization | 2 | 618 | 2 | 620 | 31.3 |
| Encouraging independent judgment | 3 | 203 | 0 | 203 | 10.2 |
| Developing leadership capacity | 4 | 403 | 1 | 404 | 20.4 |
| Institutionalizing reflection and continuous learning | 5 | 233 | 0 | 233 | 11.7 |

**Figure 5**

*Frequencies and Percentages: Data by Key Characteristic of Adaptive Leadership*




Developing leadership capacity had a frequency of 404, representing 20.4%, and institutionalizing reflection and continuous learning had a frequency of 233, representing

11.7% of the data. Encouraging independent judgment, which had the lowest frequency of 203, represented 10.2% of the data.

The subsequent sections analyze the data collected by each research question based on the standardized definitions, interview questions, and corresponding prompts within the interview protocol (Appendix D), which were used in each interview for consistency. Each theme is displayed by frequency.

**Research Subquestion 1**

Research Subquestion 1 inquired, *"How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?"* For this study, making naming elephants in the room the norm is defined as the act of openly addressing sensitive underlying issues, or undiscussables, to resolve potential barriers that interfere with an organization realizing its full potential (Baker, 2004; Heifetz et al., 2009; Toegel & Barsoux, 2019). Furthermore, Heifetz et al. (2009) suggested that "in a highly adaptive organization, no issue is too sensitive to be raised at the official meeting, and no questions are off-limits" (p. 102).

Based on the interview protocol, each participant was asked two questions with supporting prompts to support the inquiry, "How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?" The first question was to understand specific practices used to address sensitive underlying issues as an organizational norm. The second question focused on understanding how the organization created an environment for individuals and groups to resolve potential barriers that prevent the organization from realizing success.

After the responses and artifacts provided by the participants were analyzed, 523 total frequencies and five key themes emerged from the two interview questions and prompts. The interview responses yielded 522 frequencies, and the artifact provided one frequency. Making naming elephants in the room the norm was the second highest yielding key characteristic of adaptive leadership for this study. The five themes identified were actively engaging and seeking honest feedback, establishing and maintaining supportive environments, creating formal and informal opportunities to check in, building trusting relationships, and acknowledging concerns and ensuring loop closure. Table 4 displays the five themes associated with making naming elephants in the room the norm, corresponding source counts, and frequency data. Each theme is presented in descending order from highest to lowest frequency count.

**Table 4**

*Themes for Research Question 1: Making Naming Elephants in the Room the Norm*

| Theme | Sources | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Actively engaging and seeking honest feedback | 10 | 148 | 0 | 148 | 28.3 |
| Establishing and maintaining supportive environments | 10 | 126 | 1 | 127 | 24.3 |
| Creating formal and informal opportunities to check in | 10 | 125 | 0 | 125 | 23.9 |
| Building trusting relationships | 10 | 80 | 0 | 80 | 15.3 |
| Acknowledging concerns and ensuring loop closure | 9 | 43 | 0 | 43 | 8.2 |

### *Actively Engaging and Seeking Honest Feedback*

Actively engaging and seeking honest feedback was the most frequently referenced theme in response to the strategies used by nurse executives to make naming elephants in the room the norm, producing 148 frequencies from interviews. This frequency count represented 28.3% of the data on this characteristic. Notably, 100% of all participants called out the need to actively seek feedback on sensitive issues, emphasizing the need for intentional prompting and strategic interactions,

> Participant 5 discussed the importance of direct engagement for feedback:
>
> I'm decently good at reading faces and stuff. And so, if I felt like somebody had something to say, I would invite them in. If we're in a safety huddle and even my leader is speaking about something, and I could see something on my IT director's face, I may say, hey, do you have a comment? Yeah, let me know what that is. So, we got to invite them. And then I think you have to ensure they accept that invitation continuously. And if they're not, you have got to invite them in a little bit more and show the value of bringing them in and collaborating and what that will do.

Participant 8 added,

> Sometimes people are very intimidated to speak up in group settings, but I'm a person who reads a room, and I can take a look around, and I know those that don't speak up, and so later I'll do a one-to-one, and I'll ask them, are there some hard things you need me to hear? Or who should we recognize? What's keeping you up at night? Asking them some critical questions but in a different kind of setting.

Participant 3 continued,

> I will start a meeting and pull people in. I hate to say it, but if we have meetings about plans or have an opportunity as leaders, I think we often go in knowing the solution. How do you get your stakeholders to verbalize the same thing? And I may say, we are here coming together to meet today. We have to look at our telemetry process. So, talk to me about the current process and where you see the need for change. And I think especially in health care, we often hear, well, we used to do that. Or again, our process is this: Okay, but we are not doing it, so how do we get the team to verbalize that and get to a common solution?

Finally, Participant 4 added,

> I don't know if you've ever done colors about people, and in one of them, yellow, are some of your most brilliant people, but they're not going to tell you anything unless you ask them. And I had a nurse coordinator who was yellow. I understand he's so quiet, but if you ask him, he'll give you the right answer. And he takes it all in and listens to everything, but if you don't ask him, he won't tell you. And so, when I have a meeting, I need feedback from everybody in the room and I do a round table and ask them, where are you at with this? What is your feedback, or what do you need from this team? I think it's really important that you get their voice, and you can't leave them out because some won't speak up. That's just their nature; that's their color.

### *Establishing and Maintaining Supportive Environments*

Establishing and maintaining supportive environments was the second most frequently referenced theme in response to the strategies used by nurse executives to

make naming elephants in the room the norm, producing 127 frequencies from interviews and one artifact. This total frequency count represented 24.3% of the data on this characteristic. Additionally, 100% of all participants called out the need to ensure supportive environments so that individuals feel comfortable speaking up even when the topic is sensitive.

Participant 10 discussed the importance of creating supportive foundations:

> The first fundamental practice of a leader is that you have to build a sense of trust and respect from the teams. And so, specifically, as a leader coming back here … I think there's been more of an authoritative leadership. There was a fear of speaking up and reaching out if there was a gap in a different department's practice. So, you have to create that foundation for staff and especially colleagues and leaders to be able to voice their concerns … especially develop the leaders because our leaders had to be the ones to drive that cultural change. And so, we saw it across: you walked into the organization, nobody lifted their head up, nobody acknowledged each other. So those are the fundamentals, that's the fundamentals of mankind, of human behavior.

Similarly, Participant 2 added,

> There were a lot of sensitive topics that we very transparently addressed, which went to building a safe environment where people felt comfortable and able to share those items respectfully and receive them in a respectful tone. It was meant to be collaborative and come from a space of growth and development, or what I would call a kind place.

Participant 1 continued,

> Some people would shy away and not really want to participate. But then I think the more you talked about it, and then if I would sometimes tell an uncomfortable story and let them know it's okay to say stuff like this. Everything that we talk about in this room stays within this room. And what we're going to do is have a conversation about what you witnessed and what you saw. I think people would tell a funny story, which would break the ice. And then people start joining in and stuff. And then we would individually call on them and not make them uncomfortable, but say, what do you have to? What did you see? What isn't going good in your department? And they start to talk. They don't start saying much, but after maybe 40 minutes, the last 20 minutes, I think everybody gets pretty comfortable. And then speaking up even when it has nothing to do with their actual role as a respiratory therapist, radiology, or lab person. When I go to the floor, the nurses aren't always nice, okay, tell me about that... Sometimes people are very intimidated to speak up in group settings, but I'm a person who reads a room, and I can take a look around, and I know those that don't speak up, and so later I'll do a one-to-one, and I'll ask them, are there some hard things you need me to hear? Or who should we recognize? What's keeping you up at night? Asking them some critical questions but in a different kind of setting.

Participant 7 described the use of a visual cue (stuffed animal) for an icebreaker during times when sensitive issues must be discussed:

> When there is a delicate or sensitive conversation about to take place, I put that (stuffed animal) in the room kind of as an icebreaker, softens the vibe in the room, and then everybody understands.

Participant 7 also provided the artifact to triangulate the theme via direct observation of the stuffed animal during the interview.

### *Creating Formal and Informal Opportunities to Check In*

Creating formal and informal opportunities to check in was the third most frequently referenced theme in response to the strategies used by nurse executives to make naming elephants in the room the norm, producing 125 frequencies from interviews. This frequency count represented 23.9% of the data on this characteristic, and 100% of all participants emphasized the importance of regularly checking in with team members to create intentional opportunities for sharing experiences and any needs,

Participant 6 discussed the importance of regular meetings that encourage speaking up:

> We have multiple meetings a day wherein just all disciplines are represented. Safety huddles are the biggest where all essential services are represented. In addition to this, we have a follow-up meeting in the afternoon, where we also have a component of essential services where issues are raised. My leaders know again that I support them. They are empowered to raise issues on their own with the individual leaders. I would say that the one thing we value here is the ability of departments to work together.

Participant 10 added,

> I think I see this as twofold, right? I see from an informal, and so that's why I try to teach my leaders. Okay, tell me how that meeting just went. And so, we all got together after that meeting, so their people are starting to speak up and be able to ask questions and be able to give input then. But also, on the other level, do we

> have a fundamental learning process? So, we didn't, because you have to build structure. And so, you have to have those fundamental structures in place. And we're starting to build those and see those. Now, we can grow and build upon them. And so, I think the two have to come together, and you have to have a formal method, a formal foundation structure, whatever that may be.

Participant 3 shared,

> It's also important for me that when I'm doing my one-on-ones, I go to them and show them that they're a priority, and I go to their space and place and do that there so that, hopefully, they're more comfortable. And selfishly, I can also see how they interact in their habitat. But even as I'm scheduling meet and greets with everybody here, or I have my one-on-ones with my directors and other people, I go to them because then I think they're more comfortable, and you can pull out the good stuff.

Similarly, Participant 8 added the value of senior and executive leaders purposefully checking in through rounding,

> Leaders and people in the C-suite have to walk the talk. And we go out, and if you are always in your office, no one ever knows what you stand for. But if you're out and having conversations with staff members … and it's not just nursing or the nursing profession as a CNO, I learned in the food area that I actually prepared meals. I learned what they do, and I did that with housekeeping and in pharmacy. Still, I was able to talk about, Hey, tell me a little bit about what your barriers are or what your issues are and have those conversations with them so that when you are in a hallway or you are someplace that your staff feels that you listen to them

> and that you're approachable. So, if you're approachable and get back to them, it's all circular.

***Building Trusting Relationships***

Building trusting relationships was the fourth most frequently referenced theme in response to the strategies used by nurse executives to make naming elephants in the room the norm, producing 80 frequencies from interviews. This frequency count represented 15.3% of the data on this characteristic, and 100% of all participants emphasized the significance of establishing relationships and gaining trust to lead effectively,

> Participant 7 discussed the importance of trust and creating space for honesty: When you're fostering a trusting relationship, you have a group of individuals who aren't just telling you the answers you want to hear; they're telling you, I always say, I want to know what I don't want to know.

Participant 1 added,

> Well, I have to say that the leaders in the hospital where I just finished working had very close relationships with each other and the staff and were never shy. I think everything works because of relationships, and when things are uncomfortable, I'm very comfortable saying to somebody, I have to talk to you about something, and it's not an easy topic, but this is what I want to say. I say it, I wait for their response, and then I judge where I take it from there and how they respond back to me.

Participant 6 continued,

> My leaders know I create a safe space for them. They know that they can come to me with anything. And again, that all goes back. That's a positive reinforcement

> cycle. That's them coming to me sharing something, me responding to it in a way they can see as palatable, and then working through it together. So, it's not something that happens overnight, it's not a trust built overnight, it takes time, that takes us continuously having the dialogue, me responding to it, them reacting in whatever way, and us working towards a solution together. And again, it takes time to establish that level of responsibility and trust. It is not something that just comes about by saying in a meeting, don't worry, we can talk about things here.

Participant 5 concluded,

> It really is about relationship building, especially as you go bigger and you go to groups. It's about relationship building in the background so that when they come, because absolutely there are barriers every day in our hospitals, but the more our leaders will speak up, identify those barriers, and really work together and collaborate to partner, you're going to start knocking out those barriers so the organization can reach its full potential.

### *Acknowledging Concerns and Ensuring Loop Closure*

Acknowledging concerns and ensuring loop closure were the least referenced themes in response to the strategies used by nurse executives to make naming elephants in the room the norm, with 43 frequencies from interviews. This frequency count represented 8.2% of the data on this characteristic. However, 90% of all participants spoke to acknowledging concerns and ensuring loop closure collectively during existing daily touchpoint opportunities (huddles, focused meetings, posthuddle follow-ups, and debriefs). Notably, senior leader rounding was the most leveraged strategy to receive and

acknowledge information and then close the loop directly with team members on an individual level.

Participant 10 discussed the importance of ensuring loop closure when concerns are expressed:

> Our CEO does an awesome job taking every question that they have. And then, in our following town hall addresses, every single one is addressed. And it's transparent. If there was one, compensation was always one, right? For last year's compensation. And so, he would hit it on the head right away and say, what? Be transparent and say, you know what? There will not be across-the-board raises, but we are now looking at it. He would also be able to articulate our percentage of travelers in certain areas. So, in procedural areas, we're a hundred percent travel. So, we have to see how we can create a feeder program for them, but we have to be competitive in the market. So, please give them the why, provide them with the understanding instead of, or give them the empty promise that said, okay, we'll look into it.

Similarly, Participant 8 emphasized the following:

> Communication is circular. If somebody tells you something that they feel strongly about and you tell them that you're going to do something about it or you're going to investigate it, if you never get back to them, how does that make them feel? They feel unheard. They feel that I've minimized their issue or problem. So, as a leader, it's my responsibility to make sure that I always take that back to the staff. At the end of the day, it's important for me to look each week to see who I need to get back with. What conversations did I have? What

> conversations didn't I have that didn't go well that I might need to touch back with? So, it's all about who I am as a leader and making sure that the people I work with know who I am as a leader.

Participant 4 added,

> We would ask them (the staff) to tell us what's good and why they like working here. And then ask them what doesn't work. We had human resources in that meeting, and at the same time, we were writing down those specifics. And then she would take it back and come back with answers and make sure that the whole group got that answer and sometimes even would put it out to the entire hospital, hey, we heard this, and maybe you all have the questions. So, we're going to give you that answer.

**Research Subquestion 2**

Research Subquestion 2 asked, *"How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?"* DeRue (2011) and Hayashi and Soo (2012) emphasized that the key to successful adaptive leadership was thoughtful collaboration among all persons within an organization and intentionally fostering a culture conducive to communication and ultimately, a shared responsibility. For the purpose of this study, the characteristic of shared responsibility is defined as the collective ownership among team member roles for the decision making of operational goals and outcomes of the organization's future (Harris & Spillane, 2008; Heifetz et al., 2009; Heifetz & Linsky, 2002; Northouse, 2016; Tremblay et al., 2016). Each participant was asked two interview questions with supporting prompts that reinforced an understanding of how shared ownership for

organizational goals was facilitated and strategies used to elicit feedback across stakeholders regardless of their defined areas of responsibility.

Based on the responses and artifacts provided by the participants, 620 total frequencies and five key themes emerged, placing nurturing a shared responsibility for the organization as the highest-ranking key characteristic of adaptive leadership in this study. The interview responses yielded 618 frequencies, and the artifacts provided two frequencies. The five key themes identified were linking individualized performance to organizational outcomes, ensuring a clear understanding of goals and connecting the work to the why, prioritizing transparency and effective communication at all levels, prioritizing inclusive environments, and ensuring meaningful meetings through focused agendas. Table 5 displays the five themes associated, corresponding source counts, and frequency data. Each theme is presented in descending order from highest to lowest frequency count.

**Table 5**

*Themes for Research Question 2: Nurturing a Shared Responsibility for the Organization*

| Theme | Sources | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Linking individualized performance to organizational outcomes | 9 | 205 | 0 | 205 | 33.1 |
| Ensuring a clear understanding of goals, connecting the work to the why | 9 | 122 | 0 | 122 | 19.7 |
| Prioritizing transparency and effective communication at all levels | 7 | 118 | 1 | 119 | 19.2 |
| Prioritizing inclusive environments | 8 | 96 | 1 | 97 | 15.6 |
| Ensuring meaningful meetings through focused agendas | 6 | 77 | 0 | 77 | 12.4 |

### *Linking Individualized Performance to Organizational Outcomes*

Linking individualized performance to organizational outcomes was the most frequently referenced theme in response to the strategies used by nurse executives for nurturing a shared responsibility for the organization, producing 205 frequencies from interviews. This frequency count represented 33.1% of the data on this characteristic. Nine of the 10 participants described the significance of driving a connection to the greater work by developing teams with shared goals that funnel up at the organizational level,

Participant 1 discussed the importance of leveraging visual tools and ongoing communication to connect performance to goals:

> We talk about patient experiences endlessly. So, one thing that I did was create scorecards for all the nurse managers that reported to me. Respiratory therapy was reported through me, and outpatient and ambulatory were also reported through me. And so, I put them on teams. And so, what we would do was we had patient experience, we had three domains that we focused on: relationship with nurses, relationship with physicians, and what we call the transitional care domain from the Press Ganey.

Participant 6 added,

> So, when the nursing strategy was better defined in my eyes, we divided it into each of the pillars, and there were definite goals within each of the pillars or defined tactics within each. Yes, we divided up the pillars so that each director took ownership, and it really was our way of ensuring that they were in tune with

the nursing strategy from a corporate level. Otherwise, it's me preaching it to you all the time. And that doesn't always work.

Participant 8 shared the importance of physical presence by rounding:

> I think it's really important that in today's world, we focus a lot on customer satisfaction. … In the health care setting, our customers are the patients, their families, and each other. It's each department, the physician, and everyone that you come in contact with. Really, that's your customer. So, you should be rounding on a nursing area if you're a lab director, and you should say, how are my people doing? How are we doing? And that nursing isn't your area of responsibility, but you are interacting. The lab director interacts with that department, so they should ask how we are doing and what we can do better. So, I think leader rounding is really important. I think when you randomly go round on staff and say, hey, how are you? Is there anything you need or missing for you to do your job (and listen)? And that can be anybody that's not even in your department. Do you have everything? And hearing from them and saying, thank you, I appreciate you giving that to me, and I'm going to let me think about that and maybe take that to the right people and see what we can do about that. But rounding is super important, and just making sure that the culture isn't one is one of tendering at mentoring, growing that kind of response rather than jumping down someone's throat for bringing something up that doesn't belong to them, staying in your lane kind of mentality doesn't really work.

Similarly, Participant 10 added a focus on physical presence at the point of care:

I think the biggest thing here, patient experience, is about the safety and the quality of care we provide. It is not customer service. Patient experience is, and I truly believe in this; it is not just the nurse who's at the bedside driving that. It is an entire organization that drives it. Our nurse leaders, were not rounding our allied health leaders, were not rounding our executive team. We're not rounding. So, we have made that and done it. Other organizations do that collectively as a team. So, what we did is that we created partnerships. So, we created partnerships so that it was our oncology unit.

We have a cancer infusion center. And so the leader is purely outpatient and has nothing to do with inpatient, but we saw an opportunity. He has such a vast knowledge. So he rounds on that unit with the leadership team, and what that's done has tangible benefits. So, he not only drives the inpatient experience, but what you've been able to do, and we've shown this with a tangible benefit, he's actually navigated patients who maybe had no funding, maybe there were charity cases and then newly diagnosis of an oncology diagnosis. He's been able to connect them then. So now, as a person, navigating them through our system expedites care because most treatment methodology is done in an outpatient setting. And for these patients, it probably would've taken in the past 6 to 8 weeks that he has gotten downward. They truly now have a lifeline and connection to somebody else within the four walls. That is what drives the care of an organization and, especially, us. So, we truly take care of the whole community.

A good example is one of our oncologists. We brought her into the team because of our goal. And our goal, first of all, patient experience service line

> growth, all of those things, but were our biggest gaps. Because now we've created that partnership where everybody feels like, yes, they make a difference. Yes, I can now cascade that down to my colleagues. So, the imaging team is on our neuroscience floor. And so, just to let you know, we are now at the 70th percentile.

### *Ensuring a Clear Understanding of Goals, Connecting the Work to the Why*

Ensuring a clear understanding of goals and connecting the work to the why became the second most frequently referenced theme in response to the strategies used by nurse executives for nurturing a shared responsibility for the organization, producing 122 frequencies from interviews. This frequency count represented 19.7% of the data on this characteristic. Nine of the 10 participants mentioned the need for ongoing messaging of the why associated with organizational goals.

Participant 6 discussed the importance of identifying shared goals:

> Again, we continue the message of why we are here. We are here for our patients, we're here for their families, and we're here for our teams. It's that consistent messaging of what our vision should be, what our goals should be, and how we're going to support each other towards those goals.

Participant 8 added,

> So, if you think we have to make people aware that those things do matter, those small things do matter, they add up, and it affects the bottom line. We talk to staff in town halls and say things to them: how can you participate in our goals? And that's part of it. And then talk to them about their clock-ins and productivity. If you clock in and clock out on time and don't have incremental overtime, that

affects the bottom line. And if we make a budget, then there's more room for us to buy equipment and technology and all of the things that make us better. So, using those examples and making sure you can say that once a year or you can have town halls multiple times yearly, the message is always consistent. And how you get that message out to staff and have them buy in is super important.

Participant 10 shared,

> It was interesting, yesterday we had 22 leaders out there rounding in three different teams. And so, they're all given four units, but they go together as a team. I had the risk manager come back to me. He says, oh my gosh, tell me what the infection control process is for this and this. I'm like, but now he's becoming the expert because he can, so take them out of their comfort zones. But if you all have the same mission and vision in your head and drive and want to drive, but you have to know where you're going, I think that has to start at the top. I think I've always been privileged to be part of organizations that have given me the vision and know where to go. And that set me up for success as a leader because I've learned from people who have that. And I think, unfortunately, I talk to colleagues, and sometimes they've not had that exposure to people who bring that sense of purpose to the table but then want to ignite and keep that flame within me growing as well. I think that's our role as leaders. How do we ignite in them to be the best they can be? I think that's how we do adaptive leadership.

Participant 5 noted,

> I have to create a space. I have to value those other leaders, especially those in nursing. Unfortunately, this happens not as much as it used to, but where the CNO

> is only worried about nursing, I'm focused on nursing. I always would tell my nursing leaders that at the end of the day, my job is to focus on them, but my job is also to focus on every leader in the building because every leader in the building plays a role in the impact of my patients and the impact to my staff. So, I have to create an environment where the other leaders understand I am also their support. I created that at North Florida, so whether it was IT, lab, or radiology, if you have an opportunity to impact the patient, I am your support.

### *Prioritizing Transparency and Effective Communication at All Levels*

Prioritizing transparency and effective communication at all levels was the third most frequently referenced theme in response to the strategies used by nurse executives for nurturing a shared responsibility for the organization, producing 118 frequencies from interviews and one artifact. The total frequency count represented 19.2% of the data on this characteristic. Seven of the 10 participants highlighted the significance of leading with transparency and prioritizing two-way communication to achieve common goals,

Participant 2 aligned open-door policies and implementing structures for anonymous feedback:

> I think an open-door policy for all organization members is very telling. We did some unique things like having a phone line where every staff member in the organization at all levels to call and leave a message for any concern they had or raise any issue, whether it be patient safety, process improvement, an item, or a supply item. As we see in the world, sometimes supply items change without excellent communication. So, we started a phone line that was really something that the risk manager managed for us, and it was for the staff and the providers

> within the organization just to comment on things. And it was a safe space. They didn't have to leave their name if they didn't want to follow up. However, over time, we found that the messages left on that line were extremely beneficial to the organization from a process improvement and quality improvement perspective. But that goes back to building that trusting relationship and providing some creative tools for the staff at all levels to be able to access and utilize.

Participant 10 explained,

> I have quarterly forums with 70 nurse leaders who, truly, are the ones who work 24/7; they drive the care 24/7. … We asked them what content they would like, and they knew nothing about productivity. They knew nothing about service line growth (essential to organizational survival) and why it should matter to them, looking at volumes. Thus, we had the CFO come to us … we have elevated their knowledge, but then they also have a voice to say, okay, well, how do they want to continue to grow? Then, it gives transparency for communication and the sharing of dialogue because now they know the CFO and the COO, and they can speak up. However, we started a nursing newsletter as well. And so, our nursing newsletter included all the departments who report out, but we, our COO, report out, move, and show them what he has done. So, we call it on the move and make it fun for them. The more they can be part of something, the more we will hear their voice. I know they feel comfortable and confident in raising that voice.

Similarly, Participant 8 shared,

> When you work in a private setting, you get paid to do your job, but there's a performance bonus that happens in the private sector, and in the performance

bonus, they tell you what you need to meet to get there. The first rule of thumb is always to meet the budget. So, meeting the budget is super important, and it's super important to the CFO. As a CNO, my job is to make sure that I utilize and am a good steward of my budget. So, then I have to be able to talk to my leaders and say, hey, we have to be good stewards of what we're doing and make sure that we are meeting those organizational goals, which are, it's all about we're the business of health care, it's around business principles and finance is a huge part of that, so let's make sure we're doing our part.

Participant 9 added,

> I drive sensitive information in three ways, and I found this was really important. I find that nurses are often underestimated in our degree of comprehension in our education level. And so, this is about a respect thing to me. So, I lead using transparency, I lead using authenticity, and then I use the data. One of the reasons that I feel that nursing has often not had a seat at the table is because of how we are engineered to care for people we often don't use [data]. We use, I think, and I feel a lot as our leading statements, so I have purposely become a very data-driven leader. And so I will lead, especially with sensitive topics; I will lead. I've been accused of being exactly who I am. People often tell me when they look at my title that they feel intimidated, but when they have a conversation with me, I break down those barriers quickly. People know they're always going to get the truth out of me to do the best of my ability. And I always give the qualifier that I'm going to share everything that I possibly can share but understand at my level. Sometimes, there are things that I'm not authorized to share, but what I can share

> is what I'm going to share, especially as it relates to resolving conflict or anything of sensitivity.

Participant 10 provided the artifact to triangulate the theme via direct observation of the newsletter during the interview.

### *Prioritizing Inclusive Environments*

Prioritizing inclusive environments was the fourth most frequently referenced theme in response to the strategies used by nurse executives for nurturing a shared responsibility for the organization, producing 97 frequencies from interviews and one artifact. The total frequency count represented 15.6% of the data on this characteristic. Eight of the 10 participants highlighted the need for an inclusive environment to expand knowledge across disciplines and support patients and organizational goals,

Participant 5 discussed the importance of inclusion and the positive effect on any organizational silos:

> When it comes to the safety of our patients, our cultures, and our patient experience … it is about everybody, not just one individual, not just my team, that I directly oversee every day. Furthermore, culture and patient experience … my job was not just to go to nursing to drive that. … I was the leader in driving that for the organization and helping everybody understand in the room that they had shared responsibility and the goal. … I remember my last hospital, where I was a CNO for 7 years. I really built a culture that our patient experience is everybody's job. … It may look different depending on the role we are in. … Yours includes supporting the nurses so that they have time to give the care they want. And so, we honestly made T-shirts in my last organization, and it was … we're one team,

one mission. And I said because that is what we have done here, right? We have driven quality, culture, and patient experience, and the way we did it is that every leader in that organization owned every component of the goals we were looking to achieve.

When I started in that organization, it was very siloed across departments. Nursing was very siloed. … So, coming into a very siloed organization and leaving an organization where we wore that shirt, one team, one mission, so when you think about what was ahead of that organization, it would continue to go through COVID. … I always used to say if we are siloed, the patient will be impacted, the patient will be impacted siloed. … We worked hard to break down those silos, and the patient did not get caught in the middle. That is why the outcomes improved. In the work that we are doing, we have to be collaborative, we have to partner, and we cannot be siloed, or the patient will be impacted.

Participant 9 continued,

In our fourth magnet designation, we got seven exemplars. In that report out, one of the things that the surveyors said to us was that they had never seen an essential ancillary team and a nursing department come together. This group had that if you talk to the ancillary people, there appeared to be no disconnection between nursing. And they said things, my nurses, our nurses, they didn't say nurses.

Participant 2 added,

I encouraged them to build a relationship that was not dependent on me being present. So, as I was working with my team, I always encouraged them to reach out to the CFO or the controller, schedule an appointment, and build a

> relationship that was separate from my relationship. Now, that meant that I had to give up some control or give up some being the facilitator a hundred percent of the time. But it also enabled my team to work more independently to have autonomous decision making in a lot of spaces and to really move the agenda forward without me having to be involved in all of the small details of how we got from A to Z. And to facilitate that, I met with the executive team ahead of time. I said, this is what I've asked of my team, that they build those relationships with you independent of their relationship with me, which had so many benefits in the long run.

Last, Participant 3 shared,

> When you're adding work, you really need to look at the value and how you offset or balance it. And you can't always, but I think that helping people to see everything we do, we don't do in silos, especially in health care. It's not just its care experience, employee engagement, and quality; it's all in one. So how do we take that and really combine everything to bring it together so that it's all happening?

Participant 5 shared the artifact, the team t-shirt, to triangulate the theme during the Webex session.

### *Ensuring Meaningful Meetings Through Focused Agendas*

Ensuring meaningful meetings through focused agendas was the least referenced theme in response to the strategies used by nurse executives for nurturing a shared responsibility for the organization, producing 77 frequencies from interviews. This frequency count represented 12.4% of the data on this characteristic. Six of the 10

participants discussed the need to ensure meetings have focused structures to support engagement and focus the conversation on organizational goals.

Participant 10 shared regarding the perspective of ensuring meetings have a clear, structured focus, bringing the right people to the table:

> In some of our committees, I am not the lead. I am just a participant. And so, because otherwise they would hear from me and it's not my voice that they need to hear, they need to be able to share amongst their peers. … None of my leaders led facility-wide committees' initiatives. And so now, I have probably about 60% of my leaders who lead a facility-wide initiative. And they've, so with that, they've never put a PowerPoint together, they've never built an agenda, never built that follow through, never talked to physicians, never created who needs to be those key stakeholders and those partners in the committee meetings, it was only a handful of nurses in the committee meetings, but now it's seeing them blossom.
>
> And so, I can be a participant and not the facilitator, and that is where, and they come to me and say, and they ask for my feedback after the meeting. We've grown along the way. I've had to allow them to make some mistakes and present some. Maybe the presentation wasn't as polished and didn't have as much content, to begin with, but now, seeing the content grow and its driving outcomes, the critical care committee is a good example.

Participant 4 added,

> So, it's you who wants to run in and start a meeting and go, and we're always running and going, but how truly do we bring it back to mission? How do we

bring it back to people? And then also, how do we tie it back when we end it? I think the wrap-up is so important. Alright, guys, we just spoke about this, and I want to go back to here's what I'm going to ask you guys to go and carry forth and just back to here's why. Another thing super important to me, and I think really makes a difference, is that words matter. So, it's so easy to say, all right, we're going to go, and the staff can't be doing this.

Participant 8 continued,

I think when you do something on your unit, you need to report into a leadership format. So, I have leadership meetings once a month that I've kept minutes on, and I would go around the room and ask everybody what they're doing in their area, and it's a 2-minute blurb about what is happening in your area. So afterward, other people would say, oh, she's doing that. Can I do that? And oh, this is what's happening here. I see that. That's welcome. So other people would follow, and you would see, and then when those meetings were over, you would see them kind of congregate around a little bit to ask each other what's happening, how's that going, and what's working? And I appreciate that. So, I think meetings are tough because you don't really want to have meeting after meeting after meeting after meeting, but necessary in a professional setting. But the content of how they're structured makes the difference.

Last, Participant 3 added,

It's very important to me that time together spent in groups or meetings is fruitful and productive. I make sure that there's loop closure. And so how do we have a meeting? How do we, and whether or not, and honestly, I'm not good with

agendas and things like that. I am a copious note taker, but we stay on course that everybody knows when we're coming together, what we're there for, that we stay on track, and then that we close and have action items when we leave. But then, going back to the next meeting or a follow-up meeting, we're holding people accountable for those action items. Otherwise, there are just meetings in perpetuity, and nothing gets resolved.

**Research Subquestion 3**

Research Subquestion 3 asked, *"How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?"* This characteristic is defined as a leader's capacity to provide an opportunity for team members to make choices based on personal and professional experience regardless of the position held within the organization (Casavant et al., 1995; Heifetz et al., 2009; Shanbhag, 2002). Edmonson et al. (2016) noted independent judgment provided a form of psychological safety similar to a learning culture in which ideas are discussed, whether they worked well or not, and opportunities to improve collectively are identified.

Each participant was asked two interview questions with supporting prompts that supported an understanding of how the participants encouraged employees to make choices based on existing knowledge through experiences and examples of structures that support individuals' ability to apply independent judgment to make choices. Based on the responses provided by the participants, 203 total frequencies and four key themes emerged, placing encouraging independent judgment as the lowest ranking key characteristic of adaptive leadership in this study. The four key themes identified included providing supportive autonomy and permission to make strategic decisions,

encouraging solution-oriented mindsets, implementing controlled environments to test change ideas, and ensuring voices are heard and acknowledged. Table 6 displays the four themes associated, source counts, and frequencies. Each theme is presented in descending order from highest to lowest frequency count.

**Table 6**

*Themes for Research Question 3: Encouraging Independent Judgement*

| Theme | Sources | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Providing supportive autonomy and permission to make strategic decisions | 10 | 110 | 0 | 110 | 54.2 |
| Encouraging solution-oriented mindsets | 9 | 41 | 0 | 41 | 31.8 |
| Implementing controlled environments to test change ideas | 8 | 30 | 0 | 30 | 21.2 |
| Ensuring voices are heard and acknowledged | 5 | 22 | 0 | 22 | 12.9 |

### *Providing Supportive Autonomy and Permission to Make Strategic Decisions*

Providing supportive autonomy and permission to make strategic decisions was the most frequently referenced theme in response to the strategies used by nurse executives to encourage independent judgment, producing 110 frequencies from interviews. This frequency count represented 54.2% of the data on this characteristic. Notably, 100% of all participants described strategies that supported deferring to the experts nearest to the work.

Participant 6 highlighted the executive role in providing support:

> My perspective is that the role of the executive is important, especially in the health care environment. I am here to, yes, drive strategy, but I'm also here to remove barriers. So, my teams have the ideas; they're the professionals and the ones who see the patient's day in and day out. They're the ones who know their units, and they know their staff. So, if they come to me with an idea, it is my job as the executive to support that and remove the barriers to help them achieve that. Because again, at the end of the day, inherently, they're trying to do the right thing. So, when we talk about our executive roles, everybody has this: oh my God, you're supposed to do this and that. But inherently, at the core of what we're doing is supporting our teams.

Participant 2 added,

> Come to the table with what you can do and facilitate that. Then, I will return to one of my favorite books by Joe Tye, *Florence Prescription*, and proceed until it is apprehended [a book phrase that suggests ask forgiveness, not permission]. I always shared with my team that if it's ethical and it's the right thing to do for the patient at that moment, and it's within standards, proceed until apprehended, and then we'll deal with whatever happens on the backend, but in that moment, deal with it and proceed to do the right thing … which played over into the organizational structure into the C-suite.

Participant 8 continued,

> As a CNO, directors will always come to you with ideas, and I like to ask them questions: tell me about your plan. … Why don't you try it on your unit for 30

> days, bring it back, and tell me everything that happened? So, give them that freedom and levity to do that. And then when they bring it back, say, how did that go your next 30 days? How did that go? Okay, if it didn't work, why not? What do you think? Do you want to continue? What do you want to change? … As a new director, I wanted to put a notice on everyone's door of my patients. And the notice said something to the effect of this is a private healing space. Kindly knock before entering. And it changed the dynamics on my floor of health care providers just barging into the room. My CNO at the time allowed that and came up and saw that, and then later asked me about it, and I was able to talk about what I saw and what I noticed was happening. Later, I saw people imitating that. But if she would've said, no, we can't do that because we don't put laminated notes on the door, then that would've stopped that. So, I always encourage that type of thinking.

### *Encouraging Solution-Oriented Mindsets*

Encouraging solution-oriented mindsets was the second most frequently referenced theme in response to the strategies used by nurse executives to encourage independent judgment, producing 41frequencies from interviews. This frequency count represented 20.2% of the data on this characteristic. Nine of the 10 participants called out the need to elicit solution-oriented ideas and dispositions within the organization to address ongoing challenges.

Participant 2 discussed the importance of positive mindsets to focus on achieving goals:

> With the support of the C-Suite … we developed that can-do spirit and not, we cannot, we can't do it, or we've always done it this way or those types of things. We always came to the table with what we could accomplish and what we could move forward with versus letting the barriers, whether internal or external, really press us down along the way.

Participant 10 added,

> I think one of the things we looked at is I challenged them. They did not allow new grads in. I said, tell me why. And so, they said, well, this and that. I said, well, you tell me what you want to do. I'm telling you that we have to rebuild the workforce of the future. I knew what we had to do. … We lost so many of these nurses, nurse experts. We don't have any; how are we going to orient people? How are we going to do this? So, I asked each of them to come up with what that would look like. And so, they returned to me and said, okay, we would need a facility-wide class for student nurse onboarding. I met with our educational team, and we developed an onboarding class for student nurses to work in externships. I said, okay, well, now you tell me, and what would you like them to do? We know we have the job description, but what do you think are their immediate needs and weaknesses? We went from 10, and I gave them a goal; however, they got there, and we're now at 75 nurse externs. But it was all because they didn't have a process or structure to support them in the past.

Finally, Participant 5 shared,

> I put together a PCT (patient care technician) Shared Governance Council a bit after I started as CNO, and we selected high performers, sat them around the

table, and I went to kick off the meeting, and I said, my challenge for you all is I've chosen you. You're high performers; you're amazing. I want you to help develop what our team looks like in this space. I said, but I want you to help create what good looks like. I want you to help because you are what good looks like, so I want you to challenge the organization. What does that look like? What do we need to do differently? How do we need to develop the rest of our team? All that kind of stuff. So, they went to thinking, and at the next meeting, these PCTs invited me back, and they said we had a proposal. And I said you do? And they said, yes, we do. And they said our first thing is what we look like. Our scrubs are horrible. They put them in cream scrubs and PCTs in cream scrubs. Apparently, they had been trying to get them changed for years, and nobody would let them change them. And they said we will, without a shadow of a doubt, help create what good looks like as far as taking care of our patients, being responsive the way we communicate, but it starts with how we're showing up professionally and these scrubs aren't cutting it. And guess what? Those scrubs got changed. I allowed them to have a voice. And so, they went and thought about it and said, okay, we're going to create what good looks like. But I loved it because they challenged it even though, for years, their voice hadn't been heard. They said no, but this is what we need.

### *Implementing Controlled Environments to Test Change Ideas*

Implementing controlled environments to test change ideas was the third most frequently referenced theme in response to the strategies used by nurse executives to encourage independent judgment, producing 30 frequencies from interviews. This

frequency count represented 14.8% of the data on this characteristic. Eight of 10 participants described the need to allow leaders to develop, implement, and test their ideas within parameters for evaluation of efficacy and ability to enhance organizational performance.

Participant 8 discussed the importance of setting parameters and clarifying what success does not look like:

> I had an ICU director who wanted to have closed staffing, and against my better judgment, I told her you go ahead; let's give it a try. We'll do it for 14 days because I knew how this would go. And I said, let's check back in 14 days and see how that's working. And if it looks okay and you can cover yourself, we'll do it for a full schedule and see how that works. In the end, there are consequences to those things as well … they're not always just beneficial … when you don't have staff members, and you say that you're closed in staffing and your plan isn't working or doesn't work, what will happen? You are going to have to ask your team members to come in, or you are going to have to come in, or something's going to happen that everyone's not going to like. It did when it ended up they didn't have enough staff members being closed. … Really, it works out in one direction, but it doesn't work in the other direction.

Participant 9 shared about breaking work and teams into smaller project groups:

> We set up a capacity command center last June; I had gotten here the June before. When we started talking about setting up a capacity command center, everybody became paralyzed with the concept of doing something big in the organization and couldn't see the benefits. We didn't really have data available to us in the way

that we needed it to be available to us. We broke out into small and multidisciplinary groups, so every nurse and specialty, including physicians, was involved in our groups. We really began to explore solutions that were already available in the organization. And so, when we first started, they said it would be 2025 before we could get it done, and we deployed it last June. So, we deployed it within a year of getting it, and what it really afforded our organization was we had the competitor hospital going out of business. So, all of their volume started coming in our direction. Before that, we lacked transparency in how patients moved across the system. This gift gave us transparency and control back into the hands of the organization where we had no control; we were blindly moving patients, and now we have a level of transparency in all patients.

Participant 10 continued,

> We are doing an office pilot group. And so, we've identified four different levels of service, so different tenures of service. And so, they're going to be our little cohort group here. They're running a program that they will put into a business plan and must have to do it … they must have KPIs (key performance indicators) and objectives. Still, they will have a mentor with a certain phased-in approach and a timeline who will meet with them so that they have a resource to be that sounding block. Are we going in the right direction? Rather than go out there, put a PI process into place, and then hopefully, it'll work. So then, to develop, it's all structure, right? We said, okay, you've given a title, but you weren't given the education or continual feedback. And it's that continual feedback loop. You have to have continual meetings with them to hear from them. And so I work with my

> nurse leaders to identify who will be that next because of section planning, and maybe they're not in the right position, but then how do we elevate them?

Participant 3 shared,

> To make things stick and be permanent, I think we really need to help the team with how to communicate it. And not only that but throw those curve balls because that's when they fail.

### *Ensuring Voices Are Heard and Acknowledged*

Ensuring voices are heard and acknowledged was the least referenced theme in response to the strategies used by nurse executives to encourage independent judgment, producing 22 frequencies from interviews. This frequency count represented 10.8% of the data on this characteristic. Five of 10 participants described the importance of encouraging the voice of the organization in decisions,

Participant 5 discussed the importance of ensuring all voices are included in decisions:

> The day of the leader who thinks that they're going to dictate what will happen is done. And it was part of leadership. This is not to say those leaders aren't still out there, but they will not have successful outcomes. But I'll tell you multiple examples of leaders providing voice. I would even vote a lot because that was another technique to ensure that if I felt like some of my team was being quiet, I didn't want to decide for them all the time. Of course, if there's emergency stuff and patient safety, you've got to make the call sometimes as a CNO. But we often go through our discussions, and I would say, okay, guys, let's make sure everybody's voice is included in what we're talking about.

Participant 6 added,

> There's a piece of it that allows them to have a voice to know that when they speak up, they're being heard, they're being listened to, their opinion is valued, they're not being shot down. They're having that conversation. And sometimes it's not all roses and sunshine, right? Roses and sunshine. There are times when someone opens their mouth, and something comes out. I'm like, what was that? So, then you're like, but you don't disrespect them in a formal environment. You pull them aside afterward, provide some individual coaching, and say, hey, I know you said this. Maybe. Let's think about it this way. Nobody likes to be embarrassed. Nobody likes to be shot down in public. It all goes back to professional respect creating a safe environment. Yeah, that's the way people are going to open up. It's not by creating a punitive environment where people fear being themselves.

Participant 4 continued,

> Professional practice councils support letting them know how incredibly important their work is, that they are at the bedside, and that they are the experts. And so, I want them to give that voice and to take on an assignment. And even if they have an assignment, let's talk about it and know that I support them in their work.

Finally, Participant 8 added,

> I worked in a facility that was trying to obtain magnet [designation]... It was interesting because that is how you develop leaders to get people, or let's say, in the nursing world, you would get nurses to participate in committees and ask them

for their help. So, for example, peer review, there's a peer review committee where people are given examples of things in the risk management system with, of course, omitted: here's what happened, here's tell us what should occur here. And then being able to bring that back. However, I think peer review is always very strong. I think that other committees will help as well by including the staff. We also had a very big safety committee, which was across the board for everyone to be part of. So, we had staff only; we came in the beginning, we read through the guidelines, and they elected a leader. They talked about and reported a lot of safety issues or things that they felt were safety concerns, and we would have to resolve them and get back to them within 30 days, but we allowed them to have that safety meeting on their own.

**Research Subquestion 4**

Research Subquestion 4 asked, *"How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?"* This characteristic is defined as the systemic focus on expanding competencies and resources and intentionally motivating groups or individuals to increase leadership potential proactively (Eade, 1997, 2007; Elmore, 2003; Eyben et al., 2006; Harris, 2011; Heifetz et al., 2009; Sharratt & Fullan, 2009). Each participant was asked two questions with supporting prompts that supported an understanding of the important leadership competencies of focus by the organization and how the participant in their role motivates others to increase their leadership potential.

Based on the responses and artifacts provided by the participants, 404 total frequencies and five key themes emerged, placing developing leadership capacity for the

organization as the third highest ranking key characteristic of adaptive leadership in this study. The interview responses yielded 403 frequencies, and the artifacts provided one frequency. The five key themes identified were establishing baseline learning expectations for leaders, investing fiscally in professional growth and development at the organizational level, providing confidence-building opportunities and activities, managing up by celebrating successes and ensuring a sense of belonging, and providing structure to evaluate performance effectively. Table 7 displays the five themes associated, corresponding sources, and frequency data. Each theme is presented in descending order from highest to lowest frequency count.

**Table 7**

*Themes for Research Question 4: Developing Leadership Capacity*

| Theme | Sources | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Establishing baseline learning expectations for leaders | 10 | 150 | 0 | 150 | 37.1 |
| Investing fiscally in professional growth and development at the organizational level | 10 | 93 | 1 | 94 | 23.3 |
| Providing confidence-building opportunities and activities | 10 | 67 | 0 | 67 | 16.6 |
| Managing up by celebrating successes and ensuring a sense of belonging | 7 | 50 | 0 | 50 | 12.4 |
| Providing structure to evaluate performance effectively | 5 | 43 | 0 | 43 | 10.6 |

### *Establishing Baseline Learning Expectations for Leaders*

Establishing baseline learning expectations for leaders was the highest referenced theme in response to the strategies used by nurse executives to develop leadership capacity, producing 150 frequencies from interviews. This frequency count represented

37.1% of the data on this characteristic, and100% of the participants called out the need for foundational competencies to include soft skills for success in leading people that ultimately align with the organization's values,

Participant 6 discussed her organization's stance on shared responsibilities and role modeling for staff:

> One of the components that we cover in every interview, regardless of the level of interview, whether it be a nurse, a respiratory therapist, whether it be a director of Cath lab, whether it be our COO [Chief Operations Officer], we are very clear upfront that we don't operate in silos. Don't; this isn't my space and your space at any given time; you go into one of my areas, you address what you need to address, you talk to that leader, and if there's something that needs to be addressed, you address it. I will go into your area. So, my thought process is if the staff sees that happening, then they know it happens on their side, too, and they'll address the issues between themselves. So, you cannot have silos and be effective.

Participant 5 added,

> Leading teams is the most complicated part of what a nurse leader does today. And so, we would give them skills in how to lead people and the team as a whole, but then we would talk a lot about how we lead them on an individual level. You can't just lead everybody the same. So, I would say huge focus on how to lead teams and how to do that in a way that you are connecting with your staff to really drive the results you're looking for. The other piece, I would say, is communication. It's always huge. And I would say that's been a couple of different pathways. One is truly how we're communicating, how we're showing

> up, how we're communicating with our team, our positivity, just our behaviors, how we're showing up. The other thing, though, with communication, I would say the structures and how we're doing that.

Participant 9 noted,

> People don't have to like what you say, but if they believe that you have their best interest at heart and that you're going, to be honest to the degree that you can move things along and people are willing to hear hard things.

Finally, Participant 3 highlighted,

> When you're adding work, you need to look at the value and how you offset or balance it. And you can't always, but I think that helping people to see everything we do, we don't do in silos, especially in health care. It's not just its care experience; it's employee engagement, quality, and all in one. So how do we take that and really combine everything to bring it together so that it's all happening.

### *Investing Fiscally in Professional Growth and Development at the Organizational Level*

Heifetz et al. (2009) described the importance of on-the-job approaches to growing leadership capacity and potential. Participants described developing leadership potential from a hands-on perspective by investing local resources and their time to develop those who exhibited potential. These approaches were supported by the lived experiences of participants who supported organizational viability through internal succession planning, which Weiss et al. (2010) described as bridging the leadership capacity gap. Investing fiscally in professional growth and development at the organizational level was the second highest referenced theme in response to the strategies

used by nurse executives to develop leadership capacity, producing 94 frequencies from interviews and one artifact. This total frequency count represented 23.3% of the data on this characteristic, and 100% of the participants called out the need to align growth and development activities during working hours,

Participant 9 emphasized the need to develop and socialize specific learning expectations that build leadership capacity sharing:

> We do a leadership academy, and we do a physician leadership academy where we take our lean methodology, and then we take the book John Maxwell's five levels of leadership. We have broken it down into a 12-month series where we teach each leadership level.

Participant 3 added,

> I walked in last week, and they were role-playing crucial conversations. So, I think it's those skills. I think again, historically, in nursing, I got promoted, I was a charge nurse, and I was a good clinician. And then because I was a good clinician, a good charge nurse, and a manager. And so, how do we step through it and give people the things they need?

Last, Participant 4 added,

> I decided to have my first quarterly meeting back in December, but with the work around the CNCs (clinical nurse coordinators) that development and so adaptive culture and that work that needs to be done, I had to go to my CFO and my CEO for permission to invest in the CNCs. We had our second meeting just, oh gosh, it's been about a week ago. But you can feel it in the room and hear it from them. And I do believe it'll be in the employee engagement survey. I think they

> appreciate the investment and time we spend with them. When they come to the meetings, they feel they have gained much knowledge. So, when you take the time with these individuals, I think it's important that the time is valuable; it's worth it to them.

Participant 9 provided the artifact to triangulate the theme via direct observation of John Maxwell's book *The 5 Levels of Leadership* during the interview.

***Providing Confidence-Building Opportunities and Activities***

Providing confidence-building opportunities and activities was the third most frequently referenced theme in response to the strategies used by nurse executives to develop leadership capacity, generating 67 frequencies from interviews. This frequency count represented 16.6% of the data on this characteristic, and 100% of the participants shared approaches at aligning stretch assignments and prompting leadership pathways for individuals they identified,

Participant 9 shared an experience that highlighted the importance of supportive confidence builders and ensuring successes are celebrated along the way to motivate leaders:

> I had a charge nurse in the emergency department who was exceptional. And when I tell you exceptional, I mean exceptional in every way. She was focused, motivated, and driven. I arrived at the organization, and she was in the emergency department; the emergency department director was ineffective, and I needed to exit that person off the bus. The team felt coerced and bullied by this person, and I asked the charge nurse to step up and be an interim leader. And she said, Nope, I have little kids. I cannot do this. And so I went back at her several times and said,

> I do not understand. Maybe we are not connecting here. You are already doing all of these things for your department. Do you think I will ask you to go to the roof and parachute off or bungee jump off? You are already doing all these things. You work 5 or 6 days a week to keep your department going. And so, eventually, she really got into it, and she started allowing me to develop her. She went from charge nurse to assistant manager and then to director, to ACNO (assistant chief nursing officer) and finally to CNO of the organization in 3 years. She started as the charge nurse with an associate degree, ended up 3 years with a master's degree, and became the chief nursing officer. And so, there is a method to my madness when I pick and identify leaders and then how I develop them.

Similarly, Participant 4 added,

> I think early in my career, sometimes we, and I am one of us, you do not see your potential, and you'll have people that you look up to that will tap you on the shoulder and say, I want you to interview for this job that's coming open. I think you would be great. And I have turned down that same thing because sometimes you do not realize that you have that potential and need to do that. So, I have a couple of people that I am working with because I want them, and the sky is the limit for them. They have the ability, but for whatever reason, they are in their jobs and have stayed there. I have to tell this story about myself. I was a director of Med-Surg, which was a tough job for 19 years. It was the most challenging job I had ever done, but I never wanted to leave it. I did not want to leave my people. But when you decide to go to school and want to finish your career strong, you do what you do. However, I want people to know that they have leadership abilities,

> and if they do not, again, you have to go to school and open that door because you have all that talent and can get that leadership potential. I voice that a lot to them. The ones that I see it in, I do not tell it to people that I do not see it in. Sometimes, people are at their capacity, but many do not realize their capacity.

Finally, Participant 5 continued,

> I believe in them and always highlight the impact that I see them making. And then, as I do that, making sure that they know I believe in them and that their potential, at the end of the day, limits their potential more than sometimes their skills limit their potential. And I think I have been an example, right? So, I am using the example of my career journey because some people do not believe in themselves. So, it truly is believing in them. And then, sometimes, I use my personal experiences to say that if I can do it, you can do it. And this is what I see in you; this is how I see you as unique.

### *Managing Up by Celebrating Successes and Ensuring a Sense of Belonging*

Managing up by celebrating successes and ensuring a sense of belonging was the fourth highest referenced theme in response to the strategies used by nurse executives to develop leadership capacity, producing 50 frequencies from interviews. This frequency count represented 12.4% of the data on this characteristic. Seven of the 10 participants described the necessity of verbal affirmations and celebrating successes.

Participant 6 discussed connecting departmental and organizational successes back to the individual:

> But then it's also a time for us to potentially take a look back and say, what went well? What hasn't gone well? What do we need to focus on? What should we be

looking at? But it's really a time for them to be able to step away from the madness of the building and take a look back. And then obviously, the biggest piece of it, and it's interesting, I was just saying it to my team as I was doing their evaluations: sometimes we get so caught up in the day-to-day. We get so caught up in the initiatives, the rapid cycles, and everything else that we don't often take time to look back on what we have accomplished in the past year. Those evaluations were an amazing time to do that because even I would say the critical care director, who I don't know for one reason or another, felt like she wasn't doing very well. But then she did her job, and she was like, wait a minute, I had a pretty good year.

Participant 4 continued,

> It is really important for me as a CNO to prompt and compliment the strengths of our nursing leaders when I introduce them and the value they bring to our nursing team. I think it's important that my nurses hear from me about how strong they are and how much I appreciate them and love working with them. And I think that comes as a package because there will be another project right around the corner that's like a comma to us. I know patient experience is another one, and my gosh, that's all hands on deck, I need them to perform, and I need them to do everything we're asking them to do. And so, it starts with everything you're doing, and you keep, we add, we keep adding. We don't take much away, but they actually will volunteer. I'm not joking. They'll volunteer to do stuff. I'll take that on, I'll do this, and I'll do that.

Finally, Participant 5 added,

> When you have that culture of recognition, that culture of pausing to bring out the positive, I think you developed a mindset in your teams that you can do. And it's almost that mindset of glass half full versus glass half empty, which some of our teams in health care walk away around when I can't do, versus you develop this team that says, I can do because I've won all these times, we've had all these successes, and guess what, I'm going to keep winning. And so I think your team is agile. They are problem solvers. They are: how do I get to the goal? So, they expand their capacity and achieve results.

***Providing Structure to Evaluate Performance Effectively***

Providing structure to evaluate performance effectively was the least referenced theme in response to the strategies used by nurse executives to develop leadership capacity, producing 43 frequencies from interviews. This frequency count represented 10.6% of the data on this characteristic. Five of the 10 participants expressed the importance of implementing consistent performance monitoring to support real-time action needs and achieving organizational goals.

Participant 1 discussed the value of using supportive structures to monitor performance to drive ownership and accountability:

> I think the scorecards really help everybody stay on track. When I talk to them, I say that hourly rounding makes a difference in the patient's perspective. When I would show a scorecard of somebody who had good hourly rounding scores, their patient experience scores matched it, and I go, it doesn't lie. It's right here on the

paper, you guys. So, make sure you're getting out there, and your patients feel that you're rounding on them hourly.

Participant 10 continued,

> And so, it is just that's when you see those departments in the first and second percentile grow because they are proud of the care they provide but can speak to that, which then reflects the mission and vision. They may not realize the connection there. That is the mission vision, and maybe they do, but truly, to be able to say, okay, well, this is what we're doing well, and now you have the ability to bring in, but this is our one opportunity. It's not a negative; it's a positive because somebody has been able to identify that gap. And I think by constantly driving that dialogue, I think that reflection is what they are proud of and share that with each other because now I hear, I listen. And now, maybe if I wasn't doing that as a colleague working that night, I could look at my practice and then build up on that. And we do that at all different levels. We do that with the leaders. We do that at the base level.

Finally, Participant 9 shared existing multidisciplinary settings and structures in which organizational performance is reviewed:

> We have a multidisciplinary meeting, our strategy and performance excellence, at the huddle (every day) that is designed to do that, and every department or unit has that capability. Then, the things uncovered there and at employee rounding are brought up to what we call our set group, which is a multidisciplinary group where we assimilate all of those things and then act on them for organizational healthiness. And so, we have deployed throughout the organization, so I'm a lean

> review course facilitator, and so we have deployed a methodology throughout the organization. And so, each department and each unit have a strategy; we call it a performance excellence strategy. … And what we've done is each unit has bubbled up its most important goals that align with the organizational goal. Every morning at the huddle, we huddle around those strategy boards, and we really talk through any barriers to people achieving the goal of their units or any barriers to performing excellence, performing excellently, or anything. We want to eliminate the potential for defects to reach our patients and customers.

**Research Subquestion 5**

Research Subquestion 5 asked, "*How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?"* This characteristic is defined as providing a culture conducive to the safe exploration of new ideas and sharing of lessons learned both from an individual and organizational perspective and creating a sustainable learning culture driven by a willingness to overcome engrained mental models across all levels of the organization (Cojocar, 2008; Pearson & Smith, 1986; Ramalingam et al., 2020; Senge et al., 2015; Veldsman et al., 2016; Vera & Crossan, 2004). Each participant was asked two questions with supporting prompts that supported an understanding of how reflection and continuous learning are part of the organizational culture.

Based on the responses provided by the participants, 233 total frequencies and four key themes emerged, placing institutionalizing reflection and continuous learning as the second to lowest ranking key characteristic of adaptive leadership in this study. The interview responses yielded 233 frequencies. The four key themes identified were setting

aside dedicated time for individualized and collective reflection. They shared learnings, creating a culture of transparency, reflecting starts at the top, and encouraging and role modeling investment in personal and professional growth. Table 8 displays the four themes associated, corresponding source counts, and frequency data. Each theme is presented in descending order from highest to lowest frequency count.

**Table 8**

*Themes for Research Question 5: Institutionalizing Reflection and Continuous Learning*

| Theme | Sources | Interview frequency | Artifact frequency | Total frequency | Frequency % |
|---|---|---|---|---|---|
| Setting aside dedicated time for individualized and collective reflection and shared learning | 9 | 71 | 0 | 71 | 30.5 |
| Creating a culture of transparency | 8 | 62 | 0 | 62 | 26.6 |
| Reflecting starts at the top | 9 | 60 | 0 | 60 | 25.8 |
| Encouraging and role-modeling investment in personal and professional growth | 9 | 40 | 0 | 40 | 17.2 |

### *Setting Aside Dedicated Time for Individualized and Collective Reflection and Shared Learnings*

Setting aside dedicated time for individualized and collective reflection and shared learnings was the highest referenced theme in response to the strategies used by nurse executives to institutionalize reflection and continuous learning, producing 71 frequencies from interviews. This frequency count represented 30.5% of the data on this characteristic. Nine of the 10 participants described the importance of intentional and scheduled reflection and learning for ongoing connection to goals and outcomes.

Participant 3 discussed the need for awareness of bias:

> I think we're always reflecting and we're always outcome driven. And so again, I think it's so important to have reflection, to be present in the moment and to make sure that the lens, we're looking really with an unbiased lens that we can go back and even be able to say, okay, you know what?

Participant 8 added,

> It's about the formal structures. Obviously, we have our safety. How do we have our sink if we do have an adverse event? It's the group coming together to talk about the event. Lessons learned very clearly upfront are not about punitive; they are about learning a lesson. And so again, we have those formal, and we continue to message them, right? We continue, that is always the message of, again, why are we here? We are here for our patients, we're here for their families, and we're here for our teams. It's that consistent messaging of what our vision should be, what our goals should be, and how we're going to support each other towards those goals.

Finally, Participant 7 shared,

> We did a nursing leader retreat last fall, where we met at the beach, and 30 of us met at sunrise. We had prayer and reflection at sunrise and had all the towels out. Then we went inside for just that, reconnecting to why we do what we do as nurses. Setting aside dedicated time for reflection and learning, we reflect a lot during that time. What should we do? What could we do? One of our sayings now is that once we know better, and I forget who said this, we need to do better.

### *Creating a Culture of Transparency*

Creating a culture of transparency was the second highest-referenced theme in response to the strategies used by nurse executives to institutionalize reflection and continuous learning, producing 62 frequencies from interviews. This frequency count represented 26.6% of the data on this characteristic. Eight of the 10 participants described the value of transparency and normalizing the practice across roles,

Participant 8 highlighted the importance of transparency in the health care industry:

> Leaders are involved with the staff; when bad things happen in the hospital, you're quickly able to recover. If you can recover a little more quickly, it doesn't go away, but it helps with the pain if I can say that. Yeah. I think stuffing things under the mattress or carpet doesn't work. And so, things have to, I always say this, it's a horrible thing. Let's rip the bandage off, look at the wound, and then begin the healing process. It will take a while, but we're going to do it right. If you don't do it this way, it'll fester or infect.

Participant 3 described the importance of dedicated reflection time starting at the top while also highlighting the need for transparency to understand when the next logical step in a situation is to change the course:

> As I said earlier, we go in there, we know what the answer should be when it is something else, that is when always looking back to say, okay, so think about the holes and think about, but is it a better process? And is that where we change course? It is a fine line between being consistent and not throwing everything, the whole kitchen cabinet, at something. However, taking something and having the

> patience to watch it, having the patience to support it, and then being able to make a sound judgment and go back and say, I need to change course.

Finally, Participant 2 added,

> Sometimes, you think you know what you need, but maybe you need a second set of eyes to say your team really needs this diversity component. And diversity is so much more than what we've really considered it over the last few years. It's not just us about gender, race, or what we traditionally … there's so much more to diversity and skillset experiences. Whether you were in the Midwest or now in North Florida, it's such a diverse environment change. How do you look at the makeup of your team and add diversity in so many more ways than what we've even brushed the concept of? Then, build that transparency culture and just build that comfort and be able to have those conversations along the way.

### *Reflecting Starts at the Top*

Reflecting starts at the top, which was the third highest referenced theme in response to the strategies used by nurse executives to institutionalize reflection and continuous learning, producing 60 frequencies from interviews. This frequency count represented 25.8% of the data on this characteristic. Nine of the 10 participants described the need for ongoing reflection as leaders and as care providers.

> Participant 10 discussed the connection between storytelling and reflection:
>
> Well, I think reflection is another way. Self-reflection is looking at the stories, looking at self... Stories are powerful. And the story does not have to be about the experience. The story can be about our interventions and what we did, but the story is powerful. And I think that's a self-reflection. And so, we're trying to

> reflect even at the team levels. And so, at our team level, I think that's our greatest opportunity. But what we're doing is we're having our leaders tell me what your team shared. Tell me what your team shared about the care they provided over the last 12 hours. I'm not going to give it to you. And now I have my nurse leaders listening in the Face Timing into the weekend huddle, not to provide the huddle, but to hear what was.

Participant 6 stated,

> We intentionally try to block out time on Friday afternoon so they can look back at the week and see what they have accomplished, what they still need to achieve, and what they need to get done before the end of the week so they can start the next week fresh. We have meetings where mission moments are more about our patients, but how do we reflect on the patient's voice, especially in those types of meetings? So, you have, again, the formal, and then we take our team out on the nursing side. We try to do it at least once a quarter. And again, that's really, it's time to be together. It's time to bond and be social.

Last, Participant 5 added,

> We're going to be the best we can be, and we're going to go for the results that our patients deserve, that our physicians deserve, that our colleagues deserve. And sometimes they're doing that and saying, we're going to be the best at what we do. They start to strive higher than they thought they could. And so, you get better performance and suddenly, you're the best. You look around at other people who are better than you and all of a sudden, you're better than them because you

finally believe that you can do it. And so especially on the team side, I do a lot of we can do it, we can do this together. If they can be good, we can be better.

### *Encouraging and Role Modeling Investment in Personal and Professional Growth*

Encouraging and role modeling investment in personal and professional growth was the lowest referenced theme in response to the strategies used by nurse executives to institutionalize reflection and continuous learning, producing 40 frequencies from interviews. This frequency count represented 17.2% of the data on this characteristic. Nine of the 10 participants described the necessity for nurse leaders' direct involvement to ensure organizational leaders seek personal and professional growth.

Participant 8 discussed the importance of self-awareness for growth:

> I think I kicked off with authenticity and transparency, and one of the things that I teach as I'm working with my leaders over time is that self-awareness is the greatest gift you give yourself as a leader. Is that always recognizing the role you play when communication breaks down? I think, as human beings, we often want to be defensive when things don't go our way. And I think you have to step back and say, okay, did I write that email as effectively as possible? Did I communicate that as effectively as I could have? Did I approach that person in the right way? And my team has been very responsive to it. I can tell you that I've had; I could tell you that I haven't been in an organization where I haven't been successful in turning the culture around regarding self-awareness and reflection. And it creates better teams when people think about it because there's no way you'll go through life and not offend people or maybe say things that aren't always right in the

situation. But if you can deploy some self-reflection and then go back and say, hey, I didn't say that, I didn't say that in the best way. Can we replay that, please?

Participant 4 added,

> I have a manager who just applied for the director development program, and she was super hesitant because she doesn't want to leave, and it's uncomfortable for her. She's getting ready to leave the position she's in. And she's a tiny bit afraid she wants to be here, but she has talent, and I encourage her to use that talent. She's got a personal goal to be a higher leader. She's a manager right now. But I've talked to her about making an exit plan. She was so, reassigning her roles and the things that she's taken on to some of the other people. We have a meeting scheduled to go over all of that plan before she leaves. But I think that giving her permission to tap the resource to pass off the baton helps her know that things will get taken care of. It also encourages her to know it's okay and that she can achieve her personal goals and not feel like she's leaving so many loose ends. So, it really stays connected to her as she takes on that next journey, and it gives her permission to do it and to be able to walk away knowing that she's given those important things that she does to very capable people.

Participant 8 added,

> I think it starts with role modeling. I have a bachelor's, two dual master's degrees, and a doctoral degree from Vanderbilt. I also have my certification in nursing practice (CENP). And I think if you want people to be continuous learners, then you role model that for them, that way you let them know that even in the highest places in the organization, you are still seeking out knowledge and that you, for a

fact, that you don't know everything about doing this. That is one of the things we talked about as we developed our leadership academy. So, what will it look like after that 12-month intensive is over how we're going to do that? And those need assessments year after year that keep the new content flowing very fresh and keep people practicing to the top of their ability, the top of their license, or to the top of their position.

## Summary

This qualitative study aimed to identify and describe the strategies used by nurse executives to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). The sample of 10 participating nurse executives from Southeast, West, and North Florida who served as CNOs in acute care hospitals and met the eligibility criteria for the study were identified using purposeful and convenience sampling methods by which recommendations were sought through a panel of nursing and health care administration experts. Each interview conducted and qualitative data obtained aligned with the five research subquestions, resulting in the findings for the study.

The data collection and analysis process produced 1983 individual frequency counts, which included 1,979 frequencies resulting from interviews and four frequencies from collected artifacts. Based on the analyzed data by each research question, 23 themes surfaced for the five key characteristics of adaptive leadership. Five themes were identified for the key characteristics: making naming elephants in the room the norm, nurturing a shared responsibility for the organization, and developing leadership capacity. At the same time, four themes were identified for each of the remaining key

characteristics (encouraging independent judgment and institutionalizing reflection and continuous learning). Nurturing a shared responsibility for the organization had the highest frequency count of 620 adaptive leadership characteristics, representing 31.3% of the total data collection. The variable with the lowest frequency count encouraged independent judgment, representing 10.2% of the data collection. Table 9 shows the total frequency count and percentage for each of the 23 themes presented in descending order.

Based on the data obtained from all interviews, 10 key themes were identified with frequencies equal to or greater than 4.7% of the data. Three of the 10 themes were derived in response to Research Question 1, four for Research Question 2, one for Research Question 3, and two for Research Question 4.

Additional analysis identified five of the top 10 themes focused on the need for supportive and engaging environments with structured opportunities to encourage multidisciplinary stakeholder feedback. Three of the top 10 themes called out the need to communicate organizational goals clearly and effectively to gain buy-in and individualized support to improve organization-wide outcomes. The final two top 10 themes focused on developing leaders' capacity through intentional development and supportive autonomy.

Each of the top 10 themes was referenced by at least 90% of the study's participants, had a total frequency count of 94 or greater, and was triangulated by at least one artifact within each of the three top 10 theme domains described. Table 10 provides the key findings, aligned and cross-referenced research questions, and total frequency percentage.

**Table 9**

*Overview of Frequencies for Themes*

| Theme | Research question | Characteristic | Frequency | |
|---|---|---|---|---|
| | | | Total | % |
| Linking individualized performance to organizational outcomes | 2 | Nurturing a shared responsibility for the organization | 205 | 10.3 |
| Establishing baseline learning expectations for leaders | 4 | Developing leadership capacity | 150 | 7.6 |
| Actively engaging and seeking honest feedback | 1 | Making elephants in the room the norm | 148 | 7.5 |
| Establishing and maintaining supportive environments | 1 | Making elephants in the room the norm | 127 | 6.4 |
| Creating formal and informal opportunities to check in | 1 | Making elephants in the room the norm | 125 | 6.3 |
| Ensuring a clear understanding of goals, connecting the work to the why | 2 | Nurturing a shared responsibility for the organization | 122 | 6.2 |
| Prioritizing transparency and effective communication at all levels | 2 | Nurturing a shared responsibility for the organization | 119 | 6.0 |
| Providing supportive autonomy and permission to make strategic decisions | 3 | Encouraging independent judgment | 110 | 5.5 |
| Prioritizing inclusive environments | 2 | Nurturing a shared responsibility for the organization | 97 | 4.9 |
| Investing fiscally in professional growth and development at the organizational level | 4 | Developing leadership capacity | 94 | 4.7 |
| Building trusting relationships | 1 | Making elephants in the room the norm | 80 | 4.0 |
| Ensuring meaningful meetings through focused agendas | 2 | Nurturing a shared responsibility for the organization | 77 | 3.9 |
| Setting aside dedicated time for individualized and collective reflection and shared learning | 5 | Institutionalizing reflection and continuous learning | 71 | 3.6 |
| Providing confidence-building opportunities and activities | 4 | Developing leadership capacity | 67 | 3.4 |
| Creating a culture of transparency | 5 | Institutionalizing reflection and continuous learning | 62 | 3.1 |

Table 9 (*continued*)

| Theme | Research question | Characteristic | Frequency | |
|---|---|---|---|---|
| | | | Total | % |
| Reflecting starts at the top | 5 | Institutionalizing reflection and continuous learning | 60 | 3.0 |
| Managing up by celebrating successes and ensuring a sense of belonging | 4 | Developing leadership capacity | 50 | 2.5 |
| Acknowledging concerns and ensuring loop closure | 1 | Making elephants in the room the norm | 43 | 2.2 |
| Providing structure to evaluate performance effectively | 4 | Developing leadership capacity | 43 | 2.2 |
| Encouraging solution-oriented mindsets | 3 | Encouraging independent judgment | 41 | 2.1 |
| Encouraging and role modeling investment in personal and professional growth | 5 | Institutionalizing reflection and continuous learning | 40 | 2.0 |
| | 3 | Encouraging independent judgment | 30 | 1.5 |
| Ensuring voices are heard and acknowledged | 3 | Encouraging independent judgment | 22 | 1.1 |

Chapter IV reintroduced and reviewed the study's purpose, central research question, research subquestions, methodology, population, and sample. In addition, the data collection and analysis process was defined as supporting alignment to the purpose of the study. Each study participant's demographic information was shown in aggregate through a de-identified table representation. All of the collected data were depicted in alignment with each research question by commentary and the visual frequency tables. A summary of all collected data with key findings concluded the chapter. Chapter V includes the major findings, unexpected findings, the conclusion, implications for action, and recommendations for further research. The chapter then concludes with closing reflections.

**Table 10**

*Key Findings of the Study*

| Theme | Research question alignment | Frequency total | Frequency % |
|---|---|---|---|
| Linking individualized performance to organizational outcomes | 2, 4, 5 | 205 | 10.3 |
| Establishing baseline learning expectations for leaders | 4 | 150 | 7.6 |
| Actively engaging and seeking honest feedback | 1, 2, 3, 5 | 148 | 7.5 |
| Establishing and maintaining supportive environments | 1, 2, 3, 4, 5 | 127 | 6.4 |
| Creating formal and informal opportunities to check in | 1, 2, 3, 4, 5 | 125 | 6.3 |
| Ensuring a clear understanding of goals, connecting the work to the why | 2, 3, 4, 5 | 122 | 6.2 |
| Prioritizing transparency and effective communication at all levels | 1, 2, 4, 5 | 119 | 6.0 |
| Providing supportive autonomy and permission to make strategic decisions | 2, 3, 4 | 110 | 5.5 |
| Prioritizing inclusive environments | 1, 2, 4, 5 | 97 | 4.9 |
| Investing fiscally in professional growth and development at the organizational level | 4 | 94 | 4.7 |

# CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

## Overview

This phenomenological qualitative study was conducted to identify and define the strategies used by leaders to develop organizational adaptive capacity based on Heifetz et al.'s (2009) five key characteristics of adaptive leadership. The population for this study was nurse executives in the hospital setting, and data were collected from 10 semistructured interviews and four artifacts that were presented and summarized in Chapter IV. Chapter V provides a comprehensive summary of the research study and revisits the purpose statement, research questions, methodology, population, and sample. Furthermore, Chapter V discloses the major and unexpected findings of the study, conclusions, implications for action, and recommendations for future research. The chapter concludes with final remarks and reflection.

## Purpose Statement

The purpose of this exploratory phenomenological study was to identify and describe the strategies used by nurse executives in acute care hospitals to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

## Research Questions

### Central Research Question

What strategies did nurse executives in acute care hospitals use to build an organization's adaptive capacity based on Heifetz et al.'s (2009) five key characteristics (making naming elephants in the room the norm, nurturing a shared responsibility for the

organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning)?

**Research Subquestions**

1. How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?
2. How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?
3. How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?
4. How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?
5. How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?

## Methodology

This thematic-based qualitative, phenomenological study included one-on-one semistructured, open-ended interviews with 10 nurse executives who served in acute care hospital settings to explore the various strategies used to build organizational adaptive capacity based on Heifetz et al.'s (2009) five adaptive leadership characteristics. Patten and Newhart (2018) described qualitative research as exploratory research, in which words are the data (Patten & Newhart, 2018). Using a phenomenological methodology allowed the team of nine peer researchers to gain insight into practical capacity-building strategies by collecting rich details, perspectives, and reflections based on participants' lived experiences (McMillan & Schumacher, 2010; Patton, 2015).

## Population

McMillan and Schumacher (2010) emphasized the importance of a population meeting the researcher's defined criteria and characteristics for generalization. Based on the purpose of this study, the population encompassed nurse executives who served or had served in acute care hospitals in the United States. Nurse executives are an organization's most senior leadership role for a nurse with the chief nursing officer (CNO) or chief nurse executive (CNE) job title. According to Zippia (2022), 41,447 nurse executives served in hospitals across the United States.

According to NurseJournal Staff (2023), nurse executives serve on the hospital's senior executive team and drive the mission to deliver high-quality, safe, compassionate care through multistakeholder teams and partnerships while strategically managing supportive resources. Additional consideration of the definition of acute care hospitals in providing inpatient level of medical care and other related services for short-term episodes of illness or conditions, such as surgery, injuries, or disease-related conditions, further clarifies the broad scope of the role (U.S. Centers for Medicare & Medicaid Services, n.d.).

The population was narrowed to a sampling frame of the estimated 2,634 nurse executives employed throughout Florida (Zippia, 2022) to ensure the feasibility of the study with a more manageable number. Florida was selected because it is among the top employers for nurses nationwide and because there are existing challenges compounded by nursing shortages (Nurse.org Staff, 2023; Staff Reports, 2022). Sampling frames narrow population characteristics to support feasibility while maintaining relevance and alignment for generalizing the overall population (McMillan and Schumacher, 2010).

## Sample

A purposeful and convenient sampling panel of nursing and health care administration experts was used to select the 10 study participants who met the criteria defined in the study and aligned with the sampling frame. Participants must have served at the time of this study or previously served as a nurse executive in an acute care hospital (for-profit and not-for-profit) in Southeast, West, or North Florida and met four of the following six delimitation criteria to participate:

1. evidence of successful relationships with stakeholders.
2. evidence of breaking through conflict to achieve organizational success.
3. five or more years of experience in that profession or field.
4. evidence of having written, published, or presented at conferences or association meetings.
5. recognition by their peers.
6. membership in associations of groups focused on their field.

## Major Findings

This study aimed to identify and describe the strategies used by nurse executives to build adaptive capacity based on Heifetz et al.'s (2009) key characteristics of adaptive leadership. Research subquestions were identified for each of the five key characteristics of adaptive leadership: making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning. Data collected from the interviews and artifacts were analyzed in Chapter IV, resulting in 23 themes and 10 key findings. Based on the literature, data, and key findings, five major

findings were identified in alignment with the data collected from this study, existing research, and literature review. The five major findings are presented in the following sections.

**Major Finding 1 for Research Subquestion 1**

Research Subquestion 1: *How do nurse executives in acute care hospitals build an organization's adaptive capacity through making naming elephants in the room the norm?*

Major Finding 1: *Nurse executives make naming elephants in the room the norm by establishing supportive environments to actively engage and seek honest feedback through strategic interactions.*

The nurse executives in this study emphasized the importance of establishing cultures in which team members are empowered to speak up on sensitive issues and concerns and are comfortable sharing honest feedback. All 10 participants discussed strategies that support a culture of providing honest feedback, which included reinforcing supportive environments and settings where individuals feel safe to share concerns, establishing relationships built on trust, ensuring opportunities exist to share by leveraging consistent physical presence, and actively engaging and seeking feedback within those settings. Examples of supportive environments included their offices, units, and, at a broader level, hospital culture. To address potential barriers impeding organizational success, all 10 participants emphasized the need to enact intentional processes and practices to foster open dialogue and develop personal connections. The methods described included strategic interactions that engage and elicit feedback, such as

daily huddles, scheduled meetings (individual and group), initiation of committees and works groups, and leader rounding at points of service.

In addition to strategic interactions, nurse executives described setting expectations through direct and transparent communication on the type of dialogue expected and actively seeking it. Some of the language used was "inviting them in, "pulling them in," and "we need your voice." All 10 participants acknowledged the importance of paying attention to what is "not being said" and the potential reasons (intimidation, competing priorities or people present, etc.) and then following up in one-on-one interactions or engaging smaller teams to initiate dialogue on sensitive issues. Nine of the 10 participants mentioned loop closure of previous feedback as a supportive strategy to reinforce the value of using their voice, thus encouraging future sharing of perceived sensitive issues. Additionally, consistent, supportive communication and reactions (both verbal and nonverbal) on sensitive topics were identified as a strategy to support the evolution of trusting relationships. Notably, rounding at points of service was explicitly referenced to validating supportive environments, establishing and maintaining relationships, and leveraged to regularly elicit honest feedback conversation outside of scheduled meetings and huddles. The findings of this study and the nature of unspoken sensitive issues require an additional layer of interaction to solicit feedback, aligning with those identified in the context of an undiscussable by Klonsky (2010) in an examination of adaptive leadership strategies. Nurse executives determined the need for supporting environments and trusting relationships as foundational to achieving honest feedback and dialogue. The findings support Heifetz's (1994) assertion that without trust, there is a reduced capacity to face complex adaptive challenges.

**Major Finding 2 for Research Subquestion 2**

Research Subquestion 2: *How do nurse executives in acute care hospitals build an organization's adaptive capacity through nurturing a shared responsibility for the organization?*

Major Finding 2: *Nurse executives nurture a shared responsibility for the organization by linking individualized performance to organizational outcomes and ensuring a clear understanding of organizational goals.*

Nine of the 10 nurse executive participants emphasized the importance of connecting individual performance to organizational outcomes and ensuring all leaders (and their teams) clearly understand organizational goals, emphasizing the organization's why. These nurse executives connected desirable patient outcomes with organizational performance and each team's role in ensuring patients are safe from harm and receive quality care. Additional outcomes mentioned by four of the 10 participants were growth and financial stability of the organization and department budgets and activities at the individual level that directly impact the bottom line. One example included staff using resources appropriately or causing waste.

Strategies mentioned to nurture shared responsibility included using data and tools for ongoing monitoring of performance and outcomes. The participants further described the need to ensure accountability by intentionally using scorecards and presentations on strategic milestones (weekly, monthly, mid and end of the year, etc.) and in regular meetings (huddles, performance evaluations, committees) to show progress toward goals. The term meaningful was described within the topic of meetings; nurse executives described the need for oversight, ensuring there is value to the time spent by

providing the structure of what will be covered and ultimately, a summary of the next steps. Two of the 10 participants discussed the addition of their finance executives to meetings and rounds. Additional strategies included shared governance structures, strategic and task-based workgroups and committees, and promoting an inclusive environment instead of fostering silos. Nurse executives would identify cochairs and assign facilitators to give the work back to the experts, which the nurse executives described as "the people who do the work" while shadowing and mentoring to maintain a supportive environment and relationships. This perspective aligns with Heifetz and Laurie's (1997) concept of "giving the work back to the people" (p. 129).

**Major Finding 3 for Research Subquestion 3**

Research Subquestion 3: *How do nurse executives in acute care hospitals build an organization's adaptive capacity through encouraging independent judgment?*

Major Finding 3: *Nurse executives encourage independent judgment and build adaptive capacity by providing supportive autonomy to make strategic decisions and encouraging solution-oriented mindsets.*

Nurse executives demonstrated support for team members' independent judgment by providing supportive autonomy and permission to make strategic decisions, as all 10 nurse executive participants described. At the same time, nine of the 10 participants pointed out the need to encourage solution-oriented mindsets. The strategies nurse executives employed to provide supportive autonomy included encouraging reflection on opportunities to improve, communicating openness to change ideas reinforced by structure (the what and the why, data, structure, timelines, etc.), asking supportive questions to ensure viability, defining time frames for updates and reports to evaluate

successes or needs to pivot (with grace), and implementation of shared governance and professional practice council structures for collective decision making. They were implementing shared governance structures that were aligned with encouraging solution-oriented mindsets in their decision-making capacities.

Additional thoughts and experiences shared by each participant highlighted the need for encouraging independent judgment and how it empowers their leaders and their teams while ultimately supporting the organizational goals and mission of providing quality and safe care, in alignment with Chen et al. (2007) and Scheuerlein et al. (2018) who described empowerment and autonomy in decision making leading to enhanced performance. Participant 3 shared, "There are so many things that we have to do, but there's also those want to-dos, and I think that we have to blend in those want to-dos because then it makes the have-to-dos not as stressful."

**Major Finding 4 for Research Subquestion 4**

Research Subquestion 4: *How do nurse executives in acute care hospitals build an organization's adaptive capacity through developing leadership capacity?*

Major Finding 4: *Nurse executives develop leadership capacity in their teams by establishing baseline learning expectations and providing on-the-job growth and development support.*

All 10 nurse executives participating in the study acknowledged the importance of developing leadership capacity within their teams by establishing baseline learning expectations of what tools a leader in the organization needs to be successful. Specific baseline learning expectations were best described as what the nurse executives shared as foundational for success. Concepts called out specifically included effective

communication, crucial conversations, conflict resolution, and the power of influence. In contrast, others described assigned competencies and modules through organization-specific leadership academies and courses focusing on culture. Nurse executives described existing leadership academies for emerging and future leaders with dedicated curricula on leadership development, implemented within their organization structures (platforms), which were described as aligning with their cultures, missions, and values. Participant 10 noted, "The common goal was always about the patient. And so that is fundamental when you look to see those leadership competencies."

Additionally, all 10 nurse executives emphasized prioritizing and socializing on-the-job development opportunities and providing confidence-building opportunities and activities for empowerment through stretch assignments. Day (2000) described stretch assignments as placing an individual in an unfamiliar situation outside their knowledge base to learn and grow while working through a new project or task. Participant 6 described the power of stretch assignments:

> Giving them stretch assignments and celebrating their success to see that not everybody thinks of themselves as a leader. Not everyone thinks of themselves as having the potential to be a leader. So, it's building their confidence, letting them recognize they're doing a great job.

Based on the variety of responses, which also included certifications and degrees as baseline needs, what was clear was that baseline leadership competencies are not a one-size-fits-all-all. However, leadership development increases leaders' capacity to be effective within their organizations with specific norms, cultures, processes, and expectations (McCauley et al., 1998).

**Major Finding 5 for Research Subquestion 5**

Research Subquestion 5: *How do nurse executives in acute care hospitals build an organization's adaptive capacity through institutionalizing reflection and continuous learning?*

Major Finding 5: *Nurse executives institutionalize reflection and continuous learning by setting aside dedicated time for individualized and collective reflection and shared learning.*

The nurse executives in this study emphasized the importance of developing leadership capacity through institutionalizing reflection and continuous learning. Nine of the 10 participants described the need to operationalize reflection and shared learning by setting aside dedicated time for individualized and collective reflection and shared knowledge. Strategies included leveraging existing meeting structures (huddles, debriefs, one-on-ones, town halls, etc.). Nurse executives reinforced dedicating the time by ensuring reflection and sharing lessons learned are on meeting agendas, examples included, and opening reflections on every agenda. Opening reflections were described as stories or recognitions (positive patient feedback and outcomes, colleague recognition, good catches, error prevention, organizational awards, achievements, etc.).

Additional strategies to initiate reflection in meeting settings included scorecard reviews (week-over-week, month-over-month, etc.), debriefs after programs and activities, huddles after adverse outcomes, and celebrating success and recognition touchpoints. Nine of the 10 participants noted that reflection starts at the top. Individualized reflection strategies included internal reflection on the day and personal impact on team members. Participants also described off-site reflections, which included

team-building activities, department retreats, book clubs, sunrise prayers, and so forth. Reflection is considered nonnegotiable for effective leadership and learning (Senge et al., 2015).

## Unexpected Findings

Two unexpected findings were identified from this research study. The first unexpected finding was related to the demographics of the 10 participants. Notably, 100% of nurse executives in the study were female. Within the study's parameters and use of an expert panel, the lack of gender diversity stood out, as evidence has shown. However, women represent 70% of the health care workforce (89% of the 70% serve in nursing-specific roles), and women hold only 25% of the senior health care leadership roles in the United States (Zippia, 2022). Notably, data on ethnicity aligned as the most common ethnicity of CNOs is White (61.5%), followed by Hispanic or Latino (14.0%), Black or African American (11.7%), and Asian (7.8%). In this study, 90% of the nurse executives were White.

The second unexpected finding was the variation in the responses on institutionalizing continuous learning. This characteristic is defined as providing a culture conducive to the safe exploration of new ideas and sharing of lessons learned both from an individual and organizational perspective and creating a sustainable learning culture driven by a willingness to overcome engrained mental models throughout all levels of the organization (Cojocar, 2008; Pearson & Smith, 1986; Ramalingam et al., 2020; Senge et al., 2015; Veldsman et al., 2016; Vera & Crossan, 2004). Interview Question 10 explored institutionalizing continuous learning. Responses were varied and included the following:

- Participant 1: Interdisciplinary rounding, the why behind the why

- Participant 2: Self-awareness and reflection
- Participant 3: Get feedback
- Participant 4: Advanced degrees
- Participant 5: Certifications, professional development, degrees
- Participant 6: Provide tools, consortium, and conferences
- Participant 7: Keep learning, keep growing
- Participant 8: Continued education credits offered
- Participant 9: Role modeling, degrees, and certifications
- Participant 10: Using data to understand the story

I did not pursue inquiry back to the definition or use inductive reasoning to align responses back to the definition and overcome engrained mental models. However, there was a theme of learning cultures and an argument that advances knowledge through degrees, professional development, reflection feedback, and so forth.

## Conclusions

In concurrence with supporting literature, the major findings of this study were used to form conclusions for the strategies used by nurse executives to build adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). The five key characteristics include making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning. The following sections discuss the five conclusions.

### Conclusion 1: Nurse Executives Who Actively and Strategically Seek Honest Feedback to Resolve Potential Barriers Build Adaptive Capacity

Based on this study's findings and a literature review, it is concluded that nurse executives resolve potential barriers that could impact the organization by actively engaging and seeking feedback through strategic touchpoints and interactions. In addition to seeking feedback, it is evident that nurse executives must set a foundation that includes a supportive culture, trusting relationships, effectively communicating expectations, and closing the loop. Nurse executives implemented purposeful rounding at points of service and performed environmental scans to determine the need to increase presence and provide focused support. Based on observations during the interview and the artifact submitted, nurse executives prioritize supporting their teams physically and emotionally through purposeful connections. To encourage an adaptive capacity culture, leaders should encourage individuals at all levels to speak up by normalizing perceived undiscussable as more of a job expectation or requirement than an option (Baker, 2004; Heifetz et al., 2009; Toegel & Barsoux, 2019).

### Conclusion 2: Nurse Executives Who Link Individual Performance to Organizational Outcomes to Establish Shared Accountability Build Adaptive Capacity

Based on the findings of this study and a review of the literature, it is concluded that nurse executives establish shared ownership and accountability by linking individual performance to organizational outcomes through consistent, transparent communication. Prior to connecting individual action to performance, nurse executives ensure there is a clear understanding of the organizational goals through the lens of the why (why does the

organization exist, what is the mission) and then connect how each role, from the boardroom to the bedside, play a part. Contribution is an expectation for all team members for collaboration, shared accountability, and shared commitment to organizational outcomes (Harris & Spillane, 2008). Adaptive leaders maintain awareness of the current environment in the context of existing organizational goals and then inspire, influence, and mobilize support throughout the organization to ensure critical goals, tactics, and performance align (Arthur-Mensah & Zimmerman, 2017; Heifetz et al., 2009; Heifetz & Linsky, 2002).

**Conclusion 3: Nurse Executives Who Provide Supportive Autonomy and Encourage Solution-Oriented Mindsets Encourage Independent Judgment and Build Adaptive Capacity**

Based on this study's findings and a literature review, it is concluded that nurse executives encourage independent judgment by providing supportive autonomy to identify needs (through reflection) and the authority to implement the solutions in a controlled environment to ensure success. In addition, because of the nature of health care and consistent changes (regulatory, staffing challenges, etc.), driving solutions-oriented mindsets is nonnegotiable. Nurse executives described their leadership roles as removing barriers and developing others through empowerment and shared governance. Independent judgment aligns with learning culture and a safe space for discussing what has worked well, what has not, and specific areas of opportunity to improve as an organization or department (Edmonson et al., 2016). Encouraging independent decision making has proved to enhance job performance (Chen et al., 2007), and autonomy incentivizes engagement and supports shared leadership (Kouzes & Posner, 2017).

### Conclusion 4: Nurse Executives Who Set Fundamental Leadership Expectations and Invest in On-the-Job Development to Increase Their Team's Leadership Capacity Build Adaptive Capacity

Based on this study's findings and a literature review, it is concluded that nurse executives increase their team's leadership capacity by setting fundamental leadership expectations for success and investing in their development by encouraging participation in on-the-job training opportunities. Nurse executives regularly invested time mentoring new leaders (new to the field or the organization), provided confidence-building activities through stretch assignments and projects, provided focused training on foundational concepts, and normalized managing up and recognition of team member successes. Based on observations during the interview and the artifact submitted that supported baseline leadership expectations, these actions support growth and development that impact leader capacity. Weiss et al. (2010) stressed the importance of bridging the leadership capacity gap to ensure the sustainability of organizations. Approaches to developing their team's leadership capacity align with adaptive leadership because capacity development does not send the employee away to dedicated workshops on leadership development; instead, it focuses on an on-the-job approach to growing an individual's potential (Heifetz et al. (2009).

### Conclusion 5: Nurse Executives Who Set Dedicated Time for Individual and Collective Reflection and Shared Knowledge Sustain Continuous Learning Cultures and Build Adaptive Capacity

Based on this study's findings and a literature review, it is concluded that nurse executives sustain continuous learning cultures by setting dedicated time for

individualized and collective reflection and shared knowledge. Nurse executives described strategic opportunities through existing meetings and touchpoints to lead with reflection and end with reflection whenever possible while ensuring safe spaces for transparency are welcomed. It challenges the "that's just the way we have always done it" thinking to ensure the organization can adapt to the ongoing change needs in health care. Reflection and learning are essential in developing leadership capacity (Senge et al., 2015).

## Implications for Action

This study illustrated the strategies nurse executives use to build adaptive capacity based on Heifetz et al.'s (2009) five key characteristics of adaptive leadership. The major findings confirmed the participants' application of common strategies to support building adaptive capacity within their hospitals. Adaptive leadership strategies are essential to ensure organizational viability amid rapid change needs and challenges through effective mobilization of teams to drive expected outcomes through shared ownership (Heifetz et al., 2009; Heifetz & Linsky, 2002). Based on the findings and conclusions, implications for action were developed. The subsequent implications for action have the potential to positively support nurse executives in building organizational adaptive capacity and being successful and effective leaders.

### Implication 1: Training on Emotional Intelligence

Hospital-based health care leaders must develop in the four areas of emotional intelligence (EQ): self-awareness, self-management, social awareness, and relationship management. The EQ skills learned support the data and findings by development in reflection and communication and the ability to deal with crises in a way that maintains

supportive environments and builds trusting relationships with peers and colleagues throughout the hospital.

Training would be required for all leadership roles, and the rollout would start at the most senior level roles in the hospital (C-Suite). Therefore, training would include the senior leadership (executive team), middle managers (director and manager), and supervisors. After completing the initial training (by all assigned leaders), an annual refresher should be the cadence for ongoing development. However, hospitals may consider a quarterly refresher approach with one of the EQ highlighted (e.g., relationship management) and an associated activity. Monitoring of training compliance would include human resource teams, with oversight by the leader's supervisor, to reinforce completion.

**Implication 2: Training on Communicating to Inspire**

Because of the nature of health care and changing needs, new initiatives, system enhancements, product changes, evidenced-based care delivery practices, and so forth, leaders and staff can become desensitized to new strategies and initiatives. The data, findings, and conclusions showed that creating clarity and connecting to the 'why' supported leaders in building adaptive capacity. Therefore, health care organizations must enact and require dedicated communication training to inspire. The proposed communicating to inspire training (CTI) content would be developed with the framework of focusing on the following: storytelling, elevator mission statements, effective communication of organizational goals and expected outcomes, individual roles in organization success, and techniques to gain the buy-in of skeptics. Training would aim to develop hospital-based health care leaders to communicate to gain buy-in.

The training would be required for all leadership roles, and the implementation cadence would start at the top and funnel to ensure effective role modeling and messaging on the importance. Therefore, training would include the senior leadership (executive team), middle managers (director and manager), and supervisors. After all assigned leaders complete the initial training, they should receive an annual refresher for ongoing development. However, hospitals may consider a quarterly refresher approach by breaking out key domains. Monitoring of training compliance would include human resource teams, with oversight by the leader's supervisor, to reinforce completion.

**Implication 3: Transition Programs for Emerging Leaders**

Nurse executives shared the ways they sought out emerging leaders. Examples included providing stretch assignments and personal investment in their careers and success. Another recommended layer is a standardized program to ensure emerging leaders are socialized (before being placed) to the role's requirements and realistic expectations, as job descriptions can be vague or overly complex. The program's goal would be to make transition digestible and foster succession readiness to ensure no organizational gaps.

Participants would gain the technical and tactical knowledge needed to transition successfully. This program would require a final assignment, which would include drafting a 90-day plan. Based on the plan's development, the leaders could be effectively placed in the promotion area and feel more confident during the first 90 days of their new role. In addition, the organization could expect reduced turnover and increased engagement, as monitored by the human resources team.

Emerging leaders would be selected based on nominations from hospital leadership teams and managed by existing Learning and Organizational Development (L&OD) structures dedicated to leader development and success. L&OD departments, in my experience, L&OD departments have aligned with human resources, which would support the conversion from emerging to actual based on job title changes to evaluate the program's benefit on an ongoing basis.

**Implication 4: Adaptive Capacity Building Program for Leadership**

Hospital-based health care leaders must develop adaptive leadership strategies to successfully mobilize teams to support organizational viability amid rapid change needs and challenges (Heifetz et al., 2009; Heifetz & Linsky, 2002). Senior leaders (executives) and middle management (directors and managers) should engage in a 12-week program founded on Heifetz et al.'s (2009) *The Practice of Adaptive Leadership*. Every 2 weeks, a concept and companion project would be introduced and loaded into existing learning platforms for tracking to validate participants' ability to identify best practices strategies across the five key characteristics of adaptive leadership. The program should include a formal kick-off with all participants, a midpoint touchpoint, and a final presentation in which leaders describe the new skills and how they plan to implement each strategy in a formalized action plan. This required training would be layered into existing leadership development hours allotted by the organization, warranting no additional costs to the organization and would still allow for deep and sustained study and learning regarding the critical components of adaptive leadership.

### Implication 5: Developing Purposeful Meetings

Meetings are prime opportunities to have all key players at the table reflect, seek honest feedback, address opportunities, share current information, provide updates, connect to purpose, recognize our peers, celebrate success, and so forth. As the findings suggested, there is an opportunity to build structures to ensure meetings have clear objectives and end with defined next steps. One participant described how more than 60% of her team had not created an agenda PowerPoint or facilitated a meeting. Health care chairs and cochairs of existing committees, workgroup leads, and so forth, can access minimum requirements and documents to facilitate purposeful meetings. Approval and development of templates should be encouraged through shared governance structures and work groups for executive approval and sharing across departments.

## Recommendations for Further Research

This exploratory phenomenological study aimed to identify and describe the strategies used by nurse executives to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). Based on the findings of this study, I propose the following recommendations for further research.

### Recommendation 1: Other Nurse Executives in Florida

It is recommended that this study be replicated with a focus on nurse executives serving in other counties in Florida. Examining results across a broader population and identifying patterns in adaptive leadership strategies would be beneficial. Geographical determinants, including culture, could identify new patterns and trends in how nurse executives build adaptive capacity.

**Recommendation 2: Impact of Role Models and Mentorship Support**

It is recommended that qualitative research be conducted to explore the impact of role models and mentorship support in building the adaptive capacity of nurse executives. It should investigate nurse executives' perceptions of their career pathway (bedside to board room), leadership styles encountered, the extent of mentorship, and baseline leadership training and its impact on their adaptive leadership capacity.

**Recommendation 3: Impact of Reporting Structures**

It is recommended that qualitative research be conducted to explore the impact of organizational reporting structures on organizational adaptive capacity. The investigation should include nurse executives' perceptions of their direct supervisor in building adaptive leadership capacity. Nurse executives would disclose their supervisor's role and title to support the ability to analyze themes, patterns, and trends across reporting structures. The sample criterion would specify an equal number of nurse executives from each reporting structure.

**Recommendation 4: Impact of Corporate Support**

It is recommended that qualitative research be conducted to explore the impact of corporate governing bodies in building adaptive capacity. The investigation should include perceptions of standardized training and development methodologies building adaptive leadership capacity.

**Recommendation 5: Nurse Executive and Bedside Nurse Perceptions of the Impact of Adaptive Leadership Strategies on One-Up Development**

It is recommended that a mixed methods study be conducted with nurse executives and bedside nurses that surveys and rates the perceived impact of the

strategies from this study on building the leadership capacity of their one-up (unit managers and director), followed by qualitative interviews with nurse executives using the aggregated outcomes from bedside nurses for further reflection.

**Recommendation 6: Future Health Care Executives**

It is recommended that a Delphi study be conducted using health care executive experts who serve in senior executive roles in hospital settings (president, finance officer, operations officer, medical officer, or human resource officer), to forecast the strategies needed for future nurse executives from varying lenses to effectively build organizational adaptive capacity in response to the ongoing innovation in the health care space. The results of such a study could be beneficial in determining foundational leadership strategies for current and future leaders and leaders and informing training programs for adaptive leadership.

**Recommendation 7: Thematic Meta-Analysis**

Based on the thematic study and framework, it is recommended that the nine dissertations with disparate populations and organizational structures, customers (the mission statements, who, and why), and overall dynamics be combined into one study to identify the commonalities and differences of the key findings identified by each researcher.

**Recommendation 8: Male Nurse Executives**

It is recommended that this study be replicated with a sample population of male nurse executives. Examining results across the demographic group not represented in this study may identify commonalities and differences of the key findings from female peers

on adaptive leadership strategies. Demographic determinants, including gender, can identify new patterns and trends in the way nurse executives build adaptive capacity,

## Concluding Remarks and Reflections

When reflecting on leadership, I remember a particular scripture, and it says, "To whom much is given, from him much will be required; and to whom much has been committed, of him they will ask the more" (Luke 12:48). Leadership extends beyond a title or role; it is a responsibility. A great responsibility, so much so that Heifetz and Linsky (2002) developed a book entitled *Leadership on the Line,* which provided strategies to survive because leading organizations, people, and metrics requires sacrifice, dedication, resilience, grit, patience, kindness, and notably adaptability. Adaptive leadership has been proven effective in leading teams and inspiring and developing people amid uncertainty while continuing to achieve organizational goals (Arthur-Mensah & Zimmerman, 2017; Heifetz & Linsky, 2014).

As a nurse professional, I understand the perils and joys of being "on the line" because our hospitals are open 24 hr a day, 365 days a year, and that is what support looks like. I also resonate with A. H. James and Bennett (2020), who highlighted change as one constant in health care. Adaptive leadership is a strategic leadership model that is effective in health care organizations because of the unpredictable and urgent nature of the health care business. Organizations with existing leadership training programs and academies may unknowingly have concepts of adaptive leadership embedded in their curriculum. However, there is a need to intentionally define and incorporate the five key characteristics of adaptive leadership discussed in this study to ensure that evidence-

based approaches and strategies are implemented at a minimum to support leadership effectiveness.

I am beyond grateful to the ten nurse executives who assisted in this research and my ability to examine adaptive leadership strategies employed in the hospital setting in Southeast, West, and North Florida. These executives were professional, knowledgeable, compassionate, and dedicated to this beautiful profession that sacrifices for others daily. They are adaptive leaders who pour into their teams' patients in their buildings and communities. They are role-modeling what good and adaptive leadership looks like, which makes me proud.

I was a division-level nurse executive at the time of this study, serving as an assistant vice president of academic engagement and strategies. Our division supports diverse teams and executives across 14 hospitals in Southeastern Florida. The findings from this study will be invaluable to my ability to provide greater support. I am committed to further socialize the concepts, strategies, and learnings from this study to ensure they are embedded in my sphere of control and practices. Additionally, I plan to share with peers and colleagues to support their growth as well as with leaders in the Learning and Organizational Development team within our division to support the incorporation of the key characteristics in future training for our leaders to enhance further the support we already provide to our leaders, nurses, and teams. I believe the strategies employed to build adaptive capacity as identified in this research can perpetually benefit nurses from the bedside to the boardroom because, as you learned in this study, adaptive leaders remove barriers and provide support. I pray this study inspires

current and health care leaders to lead this way from an adaptive mindset, and as one extraordinary leader in my life would say, your teams and your patients deserve it.

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# APPENDICES

APPENDIX A

# Synthesis Matrix

| Reference | Themes | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A Time for Crisis Leadership | Background on Role of Leadership in Organizations | Leadership in Times of Crisis | Theoretical Foundations on the Adaptive Leadership Model | Adaptive Leadership | Seminal Studies on Crisis and Adaptive Leadership | The Practice of Adaptive Leadership Over the Years | The Practice of Adaptive Leadership Today | Theoretical Framework on the Practice of Adaptive Leadership | Heifetz' s Five Key Characteristics of Adaptive Leadership | Naming Elephants in the Room | Nurturing a Shared Responsibility | Encouraging Independent Judgement | Developing Leadership Capacity | Initializing Reflection and Continuous Learning | Summary of the Adaptive Leadership Model as aa Theoretical Framework | Literature on Adaptive Leadership in Healthcare Organizations | The Role of Adaptive Leadership in Healthcare Organizations | Nurse Leaders Practicing Adaptive Leadership in Acute Care Hospitals |
| **Alingh, C. W., van Wijngaarden, J. D., van de Voorde, K., Paauwe, J., & Huijsman, R. (2018).** Speaking up about patient safety concerns: The influence of safety management approaches and climate on nurses' willingness to speak up. BMJ Quality & Safety, 28(1), 39–48. https://doi.org/10.1136/bmjqs-2017-007163 | | | | | | | | | | | | | | | | | | X | |
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| **Bass, B. M., & Riggio, R. E. (2006).** Transformational leadership. | | | | X | | | | | | | | | | | | | | | |
| **Bennis, W. G. (2009).** *On becoming a leader* . Basic Books. | | X | X | X | | | | | | | | | | | | | | | |
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| Reference | Themes | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| Reference | Themes | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| **Heifetz, R. A., Grashow, A., & Linsky, M. (2009).** *The practice of adaptive leadership: Tools and tactics for changing your organization and the world* . Harvard Business Press. | | X | X | | | X | X | | X | X | X | X | X | X | X | X | | X | |
| **Heifetz, R. A., & Laurie, D. L. (1997).** The work of leadership. *Harvard Business Review* , *75* , 124-134. | | X | | | X | X | X | | | | | | | | | X | | | |
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| **Hughes, R. L., Beatty, K. M., & Dinwoodie, D. (2014).** Becoming a strategic leader: Your role in your organization's enduring success. John Wiley & Sons. | | X | | X | | | X | | | | | | | | X | | | | |
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| **James, E. H., & Wooten, L. P. (2004).** *Leadership in turbulent times: Competencies for thriving amidst crisis* . https://dx.doi.org/10.2139/ssrn.555966 | X | X | X | X | X | X | X | | | | | | | | | X | | | |
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| Reference | Themes | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A Time for Crisis Leadership | Background on Role of Leadership in Organizations | Leadership in Times of Crisis | Theoretical Foundations on the Adaptive Leadership Model | Adaptive Leadership | Seminal Studies on Crisis and Adaptive Leadership | The Practice of Adaptive Leadership Over the Years | The Practice of Adaptive Leadership Today | Theoretical Framework on the Practice of Adaptive Leadership | Heifetz's Five Key Characteristics of Adaptive Leadership | Naming Elephants in the Room | Nurturing a Shared Responsibility | Encouraging Independent Judgement | Developing Leadership Capacity | Initializing Reflection and Continuous Learning | Summary of the Adaptive Leadership Model as aa Theoretical Framework | Literature on Adaptive Leadership in Healthcare Organizations | The Role of Adaptive Leadership in Healthcare Organizations | Nurse Leaders Practicing Adaptive Leadership in Acute Care Hospitals |
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APPENDIX B

## Interview and Research Questions Alignment Table

Purpose: The purpose of this exploratory phenomenological study was to identify and describe the strategies used by *organizational leaders** to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009).

| Research Question | Variable | Definition | Interview Question and Prompt | Literature Support |
|---|---|---|---|---|
| #1. How do *leaders** build an organization's adaptive capacity through making naming elephants in the room the norm? | Making naming elephants in the room the norm. | The act of openly addressing sensitive underlying issues, or undiscussables, to resolve potential barriers that interfere with an organization realizing its full potential (Heifetz et al., 2009; Toegel & Barsoux, 2019; Baker, 2004). | IQ#1<br>What practices do you use as a leader in your organization to make addressing sensitive underlying issues an organizational norm?<br><br>Prompt<br>How do these practices facilitate adaptive leadership development? Can you give an example?<br><br>IQ#2<br>How does your organization create an environment for individuals and groups to resolve potential barriers that prevent the organization from reaching its potential?<br><br>Prompt<br>Can you provide some examples of how you create an environment for individuals and groups to identify barriers to the organization reaching its potential? | Baker, A. C. (2004). Seizing the moment: Talking about the "undiscussables." *Journal of Management Education, 28*(6), 693-706. https://doi.org/10.1177/1052562903252661<br><br>Klonsky, M. F. (2010). *Discussing undiscussables: Exercising adaptive leadership* (Publication No. 3426112) [Doctoral Dissertation, Fielding Graduate University]. ProQuest Dissertations and Theses Global.<br><br>Schlaerth, A., Ensari, N., & Christian, J. (2013). A meta-analytical review of the relationship between emotional intelligence and leaders' constructive conflict management. *Group Processes & Intergroup Relations, 16*(1), 126-136. https://doi.org/10.1177/1368430212439907<br><br>Toegel, G., & Barsoux, J.-L. (2019). It's time to tackle your team's undiscussables. *MIT Sloan management review, 61*(1), 37-46. |
| #2. How do *leaders* build an organization's adaptive capacity through | Nurturing a shared responsibility for the organization. | The collective ownership across team member roles for the decision making of | IQ#3<br>Can you describe a time (in your current role) when you facilitated shared ownership of | Harris, A., & Spillane, J. (2008). Distributed leadership through the looking Glass. *Management* |

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|---|---|---|---|---|
| nurturing a shared responsibility for the organization? | | operational goals and outcomes of the organization's future. (Harris & Spillane, 2008; Heifetz & Linsky, 2002; Heifetz et al., 2009; Northouse, 2016; Tremblay et al., 2016). | organizational goals amongst team members?<br><br>Prompt: How would you describe the outcome and its relation to the organization's future?<br><br>IQ#4<br>As a leader, how do you provide opportunities for members to comment on and raise issues that are not within their area of responsibility?<br><br>Prompt: How do you encourage participation across teams and roles throughout the organization? | *in Education*, *22*(1), 31–34. https://doi.org/10.1177/0892020607085623<br><br>Heifetz, R. & Linsky, R. (2002). *Leadership on the line*. Harvard Business School Press.<br><br>Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership*. Harvard Business Review Press.<br><br>Northouse, P. (2016). *Leadership theory and practice* (7th edition). SAGE Publications.<br><br>Tremblay, D., Latreille, J., Bilodeau, K., Samson, A., Roy, L., L'Italien, M.-F., & Mimeault, C. (2016). Improving the transition from oncology to primary care teams: A case for shared leadership. *Journal of Oncology Practice*, 12(11), 1012-1019. https://doi.org/10.1200/jop.2016.013771 |
| #3. How do *leaders* build an organization's adaptive capacity through encouraging independent judgment? | Encouraging independent judgment. | A leader's capacity to provide an opportunity for team members to make choices based on personal and professional experience, regardless of the position held within the organization (Heifetz et al., 2009; Shanbhag, 2002; Casavant et al., 1995). | IQ#5<br>Describe a situation where you encouraged employees to make choices based on personal and professional experience?<br><br>IQ#6<br>What are some systems and structures that you have in place for team members to exercise independent judgment and choice?<br><br>Prompt<br>Could you give me a specific example of teams exercising choice in those structures? What was the result of that? situation? Was the result for one of those examples when the | Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world.* Harvard Business Press.<br><br>Shanbhag, N. (2002). Responsible direction and the supervisory status of registered nurses. *Yale Law Journal*, *112*(3), 665. https://link.gale.com/apps/doc/A96306891/AONE?u=irv3447&sid=bookmark-AONE&xid=23a3cd01.<br><br>Casavant, R., Elrod, P. F., Jr., & Mayo, C. M. (1995, April). Communicate: make your expertise known. *Appraisal Journal*, |

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| | | | teams exercised choice using the structures? | *63*(2), 155. https://link.gale.com/apps/doc/A17015338/AONE?u=irv3447&sid=bookmark-AONE&xid=c2916bea |
| #4. How do *leaders* build an organization's adaptive capacity through developing leadership capacity? | Developing Leadership Capacity. | The systemic focus on expanding competencies and resources, and intentionally motivating groups or individuals to increase leadership potential proactively (Eade, 1997; Eade, 2007; Elmore, 2003; Eyben et al., 2006; Harris, 2011; Heifetz et al., 2009; Sharratt & Fullan, 2009). | IQ#7<br>What are the important leadership competencies that your organization focuses on in developing leaders?<br><br>Prompt<br>Can you give some examples of activities that are encouraged to develop these leadership competencies?<br><br>IQ#8<br>As a leader, how do you motivate individuals and groups to increase their leadership potential?<br><br>Prompt<br>Can you provide some examples of when your strategies to motivate leaders to develop have been effective? | Hull, R., Robertson, D., & Mortimer, M. (2018). Wicked leadership competencies for sustainability professionals: Definition, pedagogy, and assessment. *Sustainability 11*(4), 171-177. http://doi.org/10.1089/sus.2018.0008 |
| #5. How do *leaders* build an organization's adaptive capacity through institutionalizing reflection and continuous learning? | Institutionalizing reflection and continuous learning. | Providing a culture conducive to the safe exploration of new ideas and sharing of lessons learned both from an individual and organizational perspective and creating a sustainable learning culture driven by a willingness to overcome engrained mental models across all levels of the organization (Cojocar, 2008; Pearson & Smith, 1986; | IQ#9<br>How do you institutionalize or make reflection a permanent part of your organizational culture?<br><br>Prompt<br>How is reflection used to facilitate adaptive capacity? Can you give an example?<br><br>IQ#10<br>How do you institutionalize or make continuous learning a permanent part of your organizational culture?<br><br>Prompt<br>How is continuous learning used to facilitate adaptive | Cojocar, 2008;<br>Pearson & Smith, 1986;<br>Ramalingam et al., 2020;<br>Senge et al., 2015;<br>Vera & Crossan, 2004;<br>Veldsman & Johnson, 2016 |

| | | | | |
|---|---|---|---|---|
| | | Ramalingam et al., 2020; Senge et al., 2015; Vera & Crossan, 2004; Veldsman & Johnson, 2016). | capacity? Can you give an example? | |

APPENDIX C

## Interview Questions with Study Definitions

Five Adaptive Leadership Characteristic Definitions

**Making naming elephants in the room the norm.** The act of openly addressing sensitive underlying issues, or undiscussables, to resolve potential barriers that interfere with an organization realizing its full potential.

**Nurturing a shared responsibility for the organization.** The collective ownership across team member roles for the decision making of operational goals and outcomes of the organization's future.

**Encouraging independent judgment.** A leader's capacity to provide an opportunity for team members to make choices based on personal and professional experience, regardless of the position held within the organization.

**Developing leadership capacity.** The systemic focus on expanding competencies and resources, and intentionally motivating groups or individuals to increase leadership potential proactively.

**Institutionalizing reflection and continuous learning.** Providing a culture conducive to the safe exploration of new ideas and sharing of lessons learned both from an individual and organizational perspective and creating a sustainable learning culture driven by a willingness to overcome engrained mental models across all levels of the organization.

**Interview Questions**

**Characteristic: Making naming elephants in the room the norm.**

IQ#1
What practices do you use as a leader in your organization to make addressing sensitive underlying issues an organizational norm?

IQ#2
How does your organization create an environment for individuals and groups to resolve potential barriers that prevent the organization from reaching its potential?

**Characteristic: Nurturing a shared responsibility for the organization.**

IQ#3
Can you describe a time (in your current role) when you facilitated shared ownership of organizational goals amongst team members?
IQ#4

As a leader, how do you provide opportunities for members to comment on and raise issues that are not within their area of responsibility?

**Characteristic: Encouraging independent judgment.**

IQ#5
Describe a situation where you encouraged employees to make choices based on personal and professional experience?

IQ#6
What are some systems and structures that you have in place for team members to exercise independent judgment and choice?

**Characteristic: Developing leadership capacity.**

IQ#7
What are the important leadership competencies that your organization focuses on in developing leaders?

IQ#8
As a leader, how do you motivate individuals and groups to increase their leadership potential?

**Characteristic: Institutionalizing reflection and continuous learning.**

IQ#9
How do you institutionalize or make reflection a permanent part of your organizational culture?

IQ#10
How do you institutionalize or make continuous learning a permanent part of your organizational culture?

APPENDIX D

## Adaptive Leadership Thematic Interview Protocol

My name is Kristian Poitier and I am a doctoral candidate at University of Massachusetts Global in the area of Organizational Leadership. I am a part of a team conducting research to identify and describe the strategies used by organizational leaders to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz, Grashow, and Linsky (2009) as perceived by nurse executives in acute care hospitals (for-profit and not-for-profit) in Southeast, West, and North Florida.

I want to thank you for agreeing to participate in the interview on Adaptive Leadership. The information you give, along with the others participating in this study, hopefully will provide a clear picture of how organizational leaders build an adaptive capacity. I provided the interview questions and five key characteristic definitions for adaptive leadership prior to the interview to help you understand the aims of the study and the concepts related to the interview questions I will be asking. The questions I will be asking are the same for everyone participating in the study. The reason for this is to try to guarantee, as much as possible, that my interviews with all participating nurse executives will be conducted in the same manner.

**Informed Consent**

I would like to remind you that any information that is obtained in connection to this study will remain confidential. All the data will be reported without reference to any individual(s) or any institution(s). For ease of our discussion and accuracy I will record our conversation as indicated in the Informed Consent sent to you via email. I will have the recording transcribed to a Word document and will send it to you via electronic mail so that you can check to make sure that I have accurately captured your thoughts and ideas. The digital recording will be erased.

Did you receive the Informed Consent and UMass Global Bill of Rights I sent you via email? Do you have any questions or need clarification about either document? Do you consent to move forward with the interview?

We have scheduled an hour for the interview. At any point during the interview, you may ask that I skip a particular question or stop the interview altogether.

Do you have any questions before we begin? Okay, let's get started, and thanks so much for your time.

First, I have some demographic questions to ask you. The input gained from these questions helps to better understand the background of the participants and to provide context to the results. Per the informed consent, your participation in this study will remain confidential and comments made or demographic information will only be presented in summary format to maintain confidentiality. You are not required to answer any question that would be uncomfortable.

**Demographic**
Please indicate your gender
Male
Female
Non-binary
Other
Please indicate the years of experience in your organization
1-3, 4-8, 9-15, 16+
Please indicate the number of years in this position
1-3, 4-8, 9-15, 16+
Please indicate the number of years in this field
1-3, 4-8, 9-15, 16+
Please indicated your highest level of education
CC, BA, MA, MBA, DOCTORATE
Other earned degrees:
Please select your age from the list below
25-35, 36-45,46-55, 56-65, 66+
Please indicate the ethnicity(s) with which you identify.
African American
Asian/Asian American
Filipino
Hispanic/Latinx
Native American/Alaskan Native
Native Hawaiian/Pacific Islander
White

**Interview Questions & Prompts**

Characteristic: Making naming elephants in the room the norm.

IQ#1
What practices do you use as a leader in your organization to make addressing sensitive underlying issues an organizational norm?

Prompt
How do these practices facilitate adaptive leadership development? Can you give an example?

IQ#2
How does your organization create an environment for individuals and groups to resolve potential barriers that prevent the organization from reaching its potential?

Prompt
Can you provide some examples of how you create an environment for individuals and groups to identify barriers to the organization reaching its potential?

Characteristic: Nurturing a shared responsibility for the organization.

IQ#3
Can you describe a time (in your current role) when you facilitated shared ownership of organizational goals amongst team members?

Prompt: How would you describe the outcome and its relation to the organization's future?
IQ#4
As a leader, how do you provide opportunities for members to comment on and raise issues that are not within their area of responsibility?

Prompt: How do you encourage participation across teams and roles throughout the organization?

Characteristic: Encouraging independent judgment.

IQ#5
Describe a situation where you encouraged employees to make choices based on personal and professional experience?

IQ#6
What are some systems and structures that you have in place for team members to exercise independent judgment and choice?

Prompt
Could you give me a specific example of teams exercising choice in those structures? What was the result of that? situation? Was the result for one of those examples when the teams exercised choice using the structures?

Characteristic: Developing leadership capacity.

IQ#7
What core leadership competencies does your organization focus on in developing leaders?
What are the important leadership competencies that your organization focuses on in developing leaders?

Prompt
Can you give some examples of activities that are encouraged to develop these leadership competencies?

IQ#8
As a leader, how do you motivate individuals and groups to increase their leadership potential?

Prompt
Can you provide some examples of when your strategies to motivate leaders to develop have been effective?

Characteristic: Institutionalizing reflection and continuous learning.

IQ#9
How do you institutionalize or make reflection a permanent part of your organizational culture?

Prompt
How is reflection used to facilitate adaptive capacity? Can you give an example?
IQ#10
How do you institutionalize or make continuous learning a permanent part of your organizational culture?

Prompt
How is continuous learning used to facilitate adaptive capacity? Can you give an example?

**"Thank you very much for your time. If you would like, when the results of our research are known, we will send you a copy of our findings."**

**General Probes** For researcher's eyes only ☺
The General probes may be used during the interviewee when you want to get more information or expand the conversation with them. These are not questions you share with the interviewee. It is best to familiarize yourself with these probes and use them in a conversational way when appropriate to extend their responses.

1. "Would you expand upon that a bit?"
2. "Do you have more to add?"
3. "What did you mean by …"
4. "Why do you think that was the case?"
5. "Could you please tell me more about …"
6. "Can you give me an example of ..."
7. "How did you feel about that?"

APPENDIX E

**Field Test Researcher Feedback Form**

Conducting interviews is a learned skill set/experience. Gaining valuable insight about your interview skills and affect with the interview will support your data gathering when interviewing the actual participants. As the researcher you should reflect on the questions below after completing the interview. You should also discuss the following reflection questions with your 'observer' after completing the interview field test. The questions are written from your perspective as the interviewer. Provide your observer with a copy of these reflective questions prior to the field-test interview. Then you can verbalize your thoughts with the observer and they can add valuable insight from their observation. After completing this process you may have edits or changes to recommend for the interview protocol before finalizing.

1. How long did the interview take? Did the time seem to be appropriate?
2. Were the questions clear or were there places when the interviewee was unclear?
3. Are there any words or terms used during the interview that were unclear or confusing?
4. How did you feel during the interview? Comfortable? Nervous? For the observer: how did you perceive the interviewer in regard to the preceding descriptors?
5. Did you feel prepared to conduct the interview? Is there something you could have done to be better prepared? For the observer: how did you perceive the interviewer in regard to the preceding descriptors?
6. What parts of the interview went the most smoothly and why do you think that was the case?
7. Are there parts of the interview that seemed to be awkward and why do you think that was the case?
8. If you were to change any part of the interview, what would it be and how would you change it?
9. What suggestions do you have for improving the overall process?

APPENDIX F

## Field Test Observer Feedback Form

Conducting interviews is a learned skill set/experience. Gaining valuable insight about your interview skills and effect with the interview will support your data gathering when interviewing the actual participants. As the interview observer you should reflect on the questions below after completing the interview. You should provide independent feedback at the conclusion of the interview field test.

1. How long did the interview take? Did the time seem to be appropriate?
2. Were the questions clear or were there places when the interviewee was unclear?
3. Are there any words or terms used during the interview that were unclear or confusing?
4. How did you feel during the interview? Comfortable? Nervous? For the observer: how did you perceive the interviewer in regard to the preceding descriptors?
5. Did you feel prepared to conduct the interview? Is there something you could have done to be better prepared? For the observer: how did you perceive the interviewer in regard to the preceding descriptors?
6. What parts of the interview went the most smoothly and why do you think that was the case?
7. Are there parts of the interview that seemed to be awkward and why do you think that was the case?
8. If you were to change any part of the interview, what would it be and how would you change it?
9. What suggestions do you have for improving the overall process?

APPENDIX G

## Field Test Participant Feedback Form

While conducting the interview you should take notes of their clarification request or comments about not being clear about the question. After you complete the interview ask your field test interviewee the following clarifying questions. **Try not to make it another interview; just have a friendly conversation**. Either script or record their feedback so you can compare with the other members of your team to develop your feedback report on how to improve the interview questions.

1. How did you feel about the interview? Do you think you had ample opportunities to describe what you do as a leader when working with your team or staff?
2. Did you feel the amount of time for the interview was ok?
3. Were the questions by and large clear or were there places where you were uncertain what was being asked?
4. Can you recall any words or terms being asked about during the interview that were confusing?
5. And finally, did I appear comfortable during the interview … (I'm pretty new at this)?

APPENDIX H

## CITI Certification

Completion Date 20-May-2022
Expiration Date N/A
Record ID 49007800

This is to certify that:

**Kristian Poitier**

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

**Human Subjects Research**
(Curriculum Group)
**Social-Behavioral-Educational Researchers**
(Course Learner Group)
**1 - Basic**
(Stage)

Under requirements set by:

**University of Massachusetts Global**

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wd69a78d6-7fbb-4c86-bc6e-85b17eb86bf7-49007800

APPENDIX I

## Participant Invitation

Date:

Dear Potential Study Participant,

I am a doctoral candidate at UMass Global, completing research toward a doctorate in Organizational Leadership. I am one of nine researchers in a thematic dissertation group studying the strategies used by organizational leaders to build adaptive capacity. My phenomenological research study aims to identify and describe nurse executives' strategies to build an adaptive capacity in the acute hospital setting based on the five key characteristics of adaptive leadership identified by Heifetz et al. (2009). The five key characteristics are making naming elephants in the room the norm, nurturing a shared responsibility for the organization, encouraging independent judgment, developing leadership capacity, and institutionalizing reflection and continuous learning.

To participate in the study, each nurse executive must serve or have served in an acute hospital setting in Florida and have contributed to the adaptive capacity of their organization by identifying and addressing the challenges they are currently facing. The participants must also meet four of the six following criteria:

1. Evidence of successful relationships with stakeholders
2. Evidence of breaking through conflict to achieve organizational success
3. Five or more years of experience in that profession or field
4. Written, published, or presented at conferences or association meetings
5. Recognized by their peers
6. Membership in associations of groups focused on their field.

I am asking for your assistance in the study by participating in a virtual Zoom or Webex interview, which will take 45-60 minutes and be set up at a convenient time. If you agree to participate in the interview, you will be assured that it will be completely confidential. No names will be attached to any notes or records from the interview. All information will remain in locked files accessible only to the researcher. No one from your hospital or health system will have access to the information obtained during the interview. You will be free to stop the interview at any time.

I am available to answer questions you may have via telephone at xxx-xxx-xxxx or via email at xxxxxxxx@mail.umassglobal.edu. Please email or call me if you are willing to consider participating in this study. Your participation would be greatly valued.

Sincerely,

Kristian Poitier
Doctoral Candidate, UMass Global
Assistant Vice President, Academic Engagement and Strategies, HCA Healthcare - East Florida Division

APPENDIX J

## Informed Consent Form

**INFORMATION ABOUT:** Adaptive Leadership: Nurse Executives Building Organizational Adaptive Capacity During Times of Crisis, Challenge, and Change

**RESPONSIBLE INVESTIGATOR:** Kristian Poitier, RN. BSN, MBA, MHSM

**PURPOSE OF STUDY:** You are being asked to participate in a research study conducted by Kristian Poitier, a doctoral student from the School of Education at UMass Global. The purpose of this phenomenological study is to identify and describe the strategies used by organizational leaders to build an adaptive capacity based on the five key characteristics of adaptive leadership identified by Heifetz, Grashow, and Linsky (2009) as perceived by nurse executives in acute care hospitals (for-profit and not-for-profit) in Southeast, West, and North Florida.

The interview(s) will last approximately 45 – 60 minutes and will be conducted in a one-on-one virtual interview setting (using Zoom).

I understand that:

a) There are minimal risks associated with participating in this research. I understand that the Investigator will protect my confidentiality by keeping the identifying codes and research materials in a locked file drawer that is available only to the researcher.
b) I understand that the interview will be audio recorded. The recordings will be available only to the researcher. The audio recordings will be used to capture the interview dialogue as a text document and to ensure the accuracy of the information collected during the interview. All information will be identifier-redacted and my confidentiality will be maintained. Upon completion of the study all recordings will be destroyed. All other data and consents will be securely stored for three years after completion of data collection and confidentially shredded or fully deleted.
c) The possible benefit of this study to me is that my input may help add to the research regarding adaptive leadership and the impact it has on building organizational adaptive capacity during times of crisis, challenge, and change. The findings will be available to me at the conclusion of the study and will provide new insights about this study in which I participated. I understand that I will not be compensated for my participation.
d) If you have any questions or concerns about the research, please feel free to contact Kristian Poitier at xxxxxxxx@mail.umassglobal.edu or Dr. Cindy Petersen (Advisor) at xxxxxxxxx@umassglobal.edu.
e) My participation in this research study is voluntary. I may decide to not participate in the study and I can withdraw at any time. I can also decide not to answer particular questions during the interview if I so choose. I understand that I may refuse to participate or may withdraw from this study at any time without any negative consequences. Also, the Investigator may stop the study at any time.

f) No information that identifies me will be released without my separate consent and that all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call the Office of the Vice Chancellor of Academic Affairs, UMass Global, at 16355 Laguna Canyon Road, Irvine, CA 92618, (949) 341-7641.

I acknowledge that I have received a copy of this form and the "Research Participant's Bill of Rights." I have read the above and understand it and hereby consent to the procedure(s) set forth.

Signature of Participant

Signature of Principal Investigator

Date

APPENDIX K

## Research Participant Bill of Rights – UMass Global

UMASS GLOBAL
A nonprofit affiliate of the University of Massachusetts

### UMASS GLOBAL UNIVERSITY INSTITUTIONAL REVIEW BOARD

### Research Participant's Bill of Rights

Any person who is requested to consent to participate as a subject in an experiment, or who is requested to consent on behalf of another, has the following rights:

1. To be told what the study is attempting to discover.
2. To be told what will happen in the study and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about the risks, side effects or discomforts of the things that may happen to him/her.
4. To be told if he/she can expect any benefit from participating and, if so, what the benefits might be.
5. To be told what other choices he/she has and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all before or after the study is started without any adverse effects.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressures when considering whether he/she wishes to agree to be in the study.

If at any time you have questions regarding a research study, you should ask the researchers to answer them. You also may contact the UMASS GLOBAL Institutional Review Board, which is concerned with the protection of volunteers in research projects. The UMass Global Institutional Review Board may be contacted either by telephoning the Office of Academic Affairs at (949) 341-9937 or by writing to the Vice Chancellor of Academic Affairs, UMASS GLOBAL, 16355 Laguna Canyon Road, Irvine, CA, 92618.

APPENDIX L

## Approval From the Institutional Review Board

**From:** Institutional Review Board <my@umassglobal.edu>
**Sent:** Monday, March 18, 2024 2:55 PM
**To:** kpoitier@mail.umassglobal.edu
**Cc:** cpeterse@umassglobal.edu; irb@umassglobal.edu
**Subject:** IRB Application Approved As Submitted: Kristian Poitier

Dear Kristian Poitier,

Congratulations, your IRB application to conduct research has been approved by the UMass Global Institutional Review Board. This approval grants permission for you to proceed with data collection for your research. Please keep this email for your records, as it will need to be included in your research appendix.

If any issues should arise that are pertinent to your IRB approval, please contact the IRB immediately at IRB@umassglobal.edu. If you need to modify your IRB application for any reason, please fill out the "Application Modification Form" before proceeding with your research. The Modification form can be found at the following link: https://irb.umassglobal.edu/Applications/Modification.pdf.

Best wishes for a successful completion of your study.

Thank you,
**David Long, Ed.D.**
Professor
Organizational Leadership
IRB Chair
dlong@umassglobal.edu
www.umassglobal.edu