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THE STAFF NURSE PERCEPTION OF THE NURSE PRACTITIONER LEADERSHIP ROLE

by

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BScN (Hons.), Ryerson University, 2005

A thesis

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requirements for the degree of

Master of Nursing

in the program of

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Abstract

The Staff Nurse Perception of the Nurse Practitioner Leadership Role

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The purpose of this quantitative descriptive study was to investigate staff nurses' perceptions of the leadership role of nurse practitioners (NP) in the acute care environment, and their potential as a source of leadership for frontline nurses. The following study was conducted at a large metropolitan university using a convenience sample size of 30 registered nurses ($n = 30$). The study framework used was derived from the leadership philosophy of Kouzes and Posners' (2002) model of transformational leadership and the Canadian Nurses Associations' (2008) national framework for advanced nursing practice. Overall, participants perceived NPs as performing transformational leadership practice below the 20th percentile. Staff nurses perceived NPs to perform the leadership behaviours on the subscale enabling others to act "*usually*", and "*seldom*" on the subscale inspire a shared vision. The findings of this study enhance the understanding of the leadership role of the NP from the staff nurse perspective.

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Table of Contents

CHAPTER I: INTRODUCTION	1
Background	2
<i>Changes in Administration</i>	3
CHAPTER II: REVIEW OF THE RELEVANT LITERATURE	7
Introduction	7
Leadership and the Nurse Manager	8
Historical Review	10
<i>Expanded Nursing Roles</i>	10
<i>Nurse Anesthetist</i>	11
<i>The Clinical Nurse Specialist</i>	12
<i>The Primary Care Nurse Practitioner Role</i>	13
<i>The Nurse Practitioner Role in the Acute Care Environment</i>	14
<i>The NP – An integral nursing role in the acute care sector</i>	15
<i>The Evolution of Leadership Theories in Nursing Practice</i>	16
<i>Instructional Leadership</i>	16
<i>Transactional Leadership</i>	18
<i>Transformational Leadership</i>	19
Leadership and Management – Distinct or Overlapping	22
Leadership and the Advanced Practice Nurse	24
The Nurse Practitioner as a Leader	26

Research Literature	27
<i>Effects of Nursing Leaderships on Staff Nurses</i>	27
<i>Studies of Advanced Practice Nurses' Perceptions of their Leadership Role</i>	30
<i>Nursing Studies that Incorporate the Leadership Practice Inventory</i>	36
Summary	39
CHAPTER III: CONCEPTUAL FRAMEWORK	41
Introduction	41
CNA Framework for Advanced Practice Nursing	42
Kouzes and Posners' Model of Transformational Leadership	43
<i>Conceptual Definitions</i>	43
<i>Model the way</i>	43
<i>Inspire a shared vision</i>	44
<i>Challenge the process</i>	45
<i>Enable others to act</i>	46
<i>Encourage the heart</i>	47
Summary	48
Problem Statement and Purpose	49
Research Questions	49

CHAPTER IV: METHODS AND PROCEDURES	51
Introduction	51
Design	51
Measurement	51
<i>Instruments and Measurement of Key Study Variables: The Leadership Practice Inventory</i>	52
Sample	56
<i>Target and Accessible Population</i>	56
<i>Sample Size</i>	56
<i>Sampling</i>	56
<i>Method</i>	57
<i>Inclusion Criteria</i>	57
<i>Exclusion Criteria</i>	57
Setting	58
Data Collection and Sampling Strategies	58
Ethics	60
<i>Informed Consent and Right to Withdraw</i>	60
<i>Potential Risks</i>	60
<i>Potential Benefits</i>	61
<i>Privacy and Confidentiality</i>	61
Data Analysis	62
<i>Alpha</i>	63
<i>Psychometric Testing</i>	63

<i>Descriptive Statistics</i>	63
<i>Demographic Data</i>	63
<i>Leadership Practice Inventory</i>	64
CHAPTER V: RESULTS	67
Psychometric Testing	67
Demographics	69
Leadership Practice Inventory	72
<i>Model the Way</i>	73
<i>Inspire a Shared Vision</i>	74
<i>Challenge the Process</i>	74
<i>Enable Others to Act</i>	75
<i>Encourage the Heart</i>	75
Performance on LPI Subscales according to Demographics	76
Summary	78
CHAPTER VI: DISCUSSION	81
Summary	90
CHAPTER VII: LIMITATIONS, IMPLICATIONS, AND CONCLUSION	92
Limitations	93
Implications for Nursing Practice	95
Implications for Nursing Research	96
Implications for Nursing Education	97
Conclusion	98
Appendix A: Leadership Practices	101

Appendix B: Demographic Questionnaire	105
Appendix C: Consent Form	109
Appendix D: Faculty Email and Information	113
Appendix E: Participant Information Package	117
Appendix F: Psychometric Properties and Normative Values of LPI	123
Appendix G: Leadership Practice Inventory: Percentile Ranking	127
References	131

List of Tables

Table 1: LPI-Observer Tool Reliability Testing for this Study's Sample	67
Table 2: Pearson Correlation Results for LPI Subscale Correlations (One-tailed)	68
Table 3: Demographic Characteristics of Sample: Gender and Level of Education	69
Table 4: Demographic Characteristics of Sample: Age, Total years of Nursing Experience and Total years of Nursing with an NP	70
Table 5: Demographic Characteristics of Sample: Current Nursing Practice Setting	71
Table 6: Mean Subscale Scores	72
Table 7: Mean Subscale Scores as compared to Normative Values	73
Table 8: T-test Results of Demographic Variables and LPI subscales	77
Table 9: Pearson Correlation Coefficient Results of Demographic Variables and LPI subscales	78
CHAPTER VI: DISCUSSION	81
Summary	80
CHAPTER VII: LIMITATIONS, IMPLICATIONS, AND CONCLUSION	92
Limitations	93
Implications for Nursing Practice	95
Implications for Nursing Research	96
Implications for Nursing Education	97
Conclusion	98
Appendix A: Leadership Practices	101

List of Appendices

Appendix A: Leadership Practices	101
Appendix B: Demographic Questionnaire	105
Appendix C: Consent Form	109
Appendix D: Faculty Email and Information	113
Appendix E: Participant Information Package	117
Appendix F: Psychometric Properties and Normative Values of LPI	124
Appendix G: Leadership Practice Inventory: Percentile Ranking	128

CHAPTER I: INTRODUCTION

A common thread throughout nursing history is the importance of leadership at nursing's frontline. This is evident from Florence Nightingale's role during the Crimean War to the role of the clinical nurse specialist during the mid 20th Century. Leadership is associated with improved quality of care and patient satisfaction (Antrobus & Kitson, 1999; Capuano, Bokovoy, Hitchings & Houser, 2005; Cragg & Spurgeon, 2007; Hay, 2004; Hyrakas & Dende, 2008; Kaiser, Hogan, & Craig 2008; Tornabeni & Fitzgerald, 2008; Wong & Cummings, 2007). Strong frontline nursing leadership is also associated with higher nurse job satisfaction, lower rates of nurse burnout and lower turnover rates (Capuano et al.; Gipe, 1998; Pryer & Distefano, 1971; Sieloff, 2004; Taunton, Krampitz, & Woods, 1989; Tornabeni & Fitzgerald; Volk & Lucas, 1991; Wong & Cummings).

This study investigates staff nurses' perceptions of the leadership role of nurse practitioners (NP) in the acute care environment, and their potential as a source of leadership for frontline nurses. The development and evolution of advanced practice nursing (APN) roles are discussed, and the NP role is explored within the context of leadership. The concept of leadership as part of the NP role is consistent with the guiding principles of advanced practice nursing (CNA, 2008). The concept of the NP as a leader has not been explicitly addressed within the literature. However, the importance of leadership to the function and retention of staff nurses, quality practice, and improved patient outcomes has been a recent focus within the literature (Hyrakas & Dende, 2008; Krejci, 1999; RNAO, 2001; Tornabeni & Fitzgerald, 2008; Wong & Cummings 2007).

The formal role of nursing leader in an acute care inpatient nursing unit has traditionally belonged to the nurse manager. However, since the nurse manager role has moved further away

from front-line nursing, a potential opportunity for the NP as a front-line leader arose. This new opportunity for the NP also highlights a gap existing within the literature and current knowledge base: What is the staff nurse's perception of the NP as a leader in the acute care environment? In order to address this question the leadership philosophy of Kouzes and Posner (2002a) and their model of transformational leadership was used as a framework.

Kouzes and Posner (2002a) defined transformational leadership as a set of actions and practices that inspire others to work together toward a common vision and goal.

Transformational leadership is conceptualized as a process that consists of five practices: model the way, inspire a shared vision, challenge the process, encourage the heart, and enable others to act. Individuals' fulfillment of the role of transformational leader is evaluated based on the use of the five leadership practices, and is measured using the Leadership Practice Inventory (LPI), which is a valid and reliable tool that specifically measures transformational leadership (Kouzes & Posner, 2003). This study sought to capture staff nurses' perceptions of NPs' fulfillment of the five transformational leadership practices. The intent of this thesis was to enhance the understanding of the leadership role of the NP from the staff nurse perspective.

Background

Historically, leadership for frontline nurses has been the domain of the nurse manager. However, as nursing administration roles have changed to accommodate the changing healthcare system, nursing leadership provided by the nurse manager to frontline nurses has become more elusive (Cragg & Surgeon, 2007; Hay, 2004; Krejci, 1999; Scherff & Siclovan, 2009). At the same time there has been an increase in the number of NPs utilized in the acute care sector (Cummings, Fraser & Tarlier, 2003; Krejci, 1999). The NP is prepared with expert clinical knowledge gained from experience and formal education (CNA, 2008). These nurses develop

various competencies in order to practice as outlined by the Canadian Nurses Association (CNA). One competency is that of leadership (CNA, 2008). Positioned to work alongside staff nurses and the medical team, NPs collaborate with their staff nurse colleagues to provide patients with health care. This offers unique opportunities for the NP to provide frontline nursing staff with leadership (Scherff & Siclovan, 2009). The implications of this could be far reaching in terms of maintaining nurse job satisfaction, standards of care, and reaching goals such as nurse recruitment and retention (Cameron & Masteson, 2000; Krejci, 1999; Neill & Saunders, 2008; Rosengren, Athlin, & Segesten, 2007; Scherff & Siclovan, 2009; Wong & Cummings, 2007).

Changes in Administration

The last four decades were characterized by the evolution of nursing roles, including the establishment of the NP. As nursing practice roles evolved, so too did nursing administration roles. These changes, which were required due to fiscal demands, changed the face of nursing administration and created a new leadership opportunity for the NP in the acute healthcare setting (Krejci, 1999; Scherff & Siclovan, 2009).

Historically, hospitals have bureaucratic and hierarchical structures that, since World War II, have influenced organizational expansion and reduction (Krejci, 1999). For the most part hospitals were able to respond independently and adjust their own budgets in alignment with fiscal demands. However, in Canada during the 1980s, it was recognized that healthcare costs were rising at alarming and unsustainable rates (Stone et al., 2003). By the 1990s the needs facing the hospital sector were so great, and funding so constrained, that hospitals could no longer continue to respond individually. The result of this was a tremendous macro restructuring period of Ontario's healthcare system that led to decreased numbers of staff nurses, increased workload, and fragmentation of services (McKey, 2002). An adequate fiscal resource is one of

the major issues facing the healthcare system (Krejci, 1999). Federal transfer payments to the provincial government were not increased to meet increased costs, which caused the hospital sector to put hospital administrators in the position to implement strategies to maximize cost efficiency (McKey).

Since nursing services accounted for the greatest proportion of operating expenditures in hospitals, these services became the main target of reorganization within healthcare (Stone et al., 2003). The era of restructuring was marked by changing skill mix to include less qualified, less expensive, unregulated care giver personnel, such as the personal care worker (Krejci, 1999). Nursing leadership positions across many organizations were eliminated in an attempt to contain costs during this time of re-organization. This included replacing nurse manager positions with more business oriented administrators, and decreasing the number of indirect nursing support positions, such as nurse specialists and educators (Stone et al.). The results of the reorganization were neither cost-savings on a large-scale, nor the achievement of quality care (Stone et al.).

Between 1994 and 2002, 6,733 nurse management positions in Canada were reduced by 29% (RNAO, 2006). The elimination of these management positions led to an increased span of control of the nurse manager role (Wong & Cummings, 2007). With fewer nurse managers to operate nursing units, roles and responsibilities of remaining nurse administrators were combined to the extent that leadership at the unit, or at a clinical level, became more remote (Hay, 2004). The nurse manager of the new millennium was expected to focus on broader organizational goals and budgetary issues, with little time available to concentrate on key components of leadership like human relations and team building at the unit level (Hay; Krejci, 1999; Wong & Cummings). Another outcome of restructuring was the elimination of a number of senior nursing

positions in hospitals (McKey, 2002). In many hospitals there was no nurse at the executive level to guide nursing practice and lobby for issues important to the nursing profession (McKey).

The effects of the change in leadership were numerous. Nurses felt frustrated with their lack of autonomy over decision-making at the patient care and organizational level. There was a decrease in communication between staff nurses and administrators. There was also a decrease in nurse job satisfaction and an increase in nurse burnout (Cook, 2001; Hay, 2004; Rosengren et al., 2007). These effects were compounded by a decrease in enrollment in schools of nursing, which had a negative impact on the pool of new nurse graduates from which to recruit (Krejci, 1999). Also, the nursing profession's already aging workforce suffered from the exodus of nurses from the profession. At the same time patient care was increasing in acuity and complexity. Nursing and healthcare were facing a crisis (Cummings et al., 2003; Hay; O'Brien-Pallas, Duffield, & Alksnis, 2004).

Taking the impending nursing shortage into consideration, the recruitment of new nurses and retention of experienced nurses are top priorities for Canadian healthcare organizations in order to create quality workplaces that address the needs of the healthcare system (Hay, 2004; RNAO, 2006). Hospital administrators are interested in enhancing quality patient care and nurses' job satisfaction, within finite resources. Strong frontline nursing leadership is one area that is considered important to achieve the aforementioned goals (Krejci, 1999; Neill & Saunders, 2008; Rosengren et al., 2007). Strong leadership in a healthcare organization contributes to the sustainability of the organization (Cameron & Masterson, 2000). Leadership allows for effective management of organizational work in the most efficient manner while providing high quality cost effective care (Cress, 1996; Krejci).

Frontline nursing leadership is an important factor that affects patient outcomes, nurse job satisfaction and the retention of experienced nurses (Cameron & Masterson, 2000; Krejci, 1999; RNAO, 2006). The NP is an expert clinician with educational preparation that includes leadership practices such as acting as a role model and influencing evidenced based practice. Thus, the NP in the acute care environment is positioned to provide transformational leadership in the evolving health care system “by building nursing knowledge, advancing the nursing profession and contributing to a sustainable and effective health-care system” (CNA, 2008, p. 2), which will affect patient outcomes, nurse job satisfaction, and nurse retention (Cameron & Masterson, 2000). However, if NPs in the acute care environment are not perceived by front-line nursing staff as a resource and leader, then this role may not fulfill the identified need for leadership. In order to understand if the NP provides transformational leadership to frontline nurses, an understanding of the NP role from the staff nurses’ perspective must be investigated. Therefore, the staff nurses’ perceptions of the NP’s leadership role in the acute care environment will provide a baseline understanding of transformational leadership fulfillment of this role. An unanswered question that remains is “What are staff nurses’ perceptions of NPs as leaders in the acute care setting?”

CHAPTER II: REVIEW OF THE RELEVANT LITERATURE

Introduction

A review of the current state of leadership as it relates to frontline nursing is discussed in the following literature review. Changes in nursing administration are highlighted since these changes have necessitated establishing leadership at nursing's frontline. The literature reviewed also includes a historical overview of advanced practice nursing (APN) roles. These roles include that of the nurse anesthetist, clinical nurse specialist, primary care nurse practitioner, and the nurse practitioner in the acute care environment. The evolution of these roles highlights the leadership capacity of the APN, including the NP. Different models of leadership were explored, with an emphasis on Kouzes and Posner's (2002a) conceptualization of transformational leadership.

The focus of this review is nursing leadership and the leadership practices of nurse practitioners in the acute care environment. Databases searched included CINHALL, Proquest Dissertations and Theses, and OVID. The websites provided by Scholars Portal, Lippincott and Wilkins, and Elsevier were also searched. The main search terms that were used were: acute care nurse practitioner (ACNP); ACNP; NP; Nurse Practitioner; clinical nurse specialist (CNS); CNS; Nurse Clinician; advanced practice nurse; APN; advanced practice nursing; advanced nursing practice (ANP); ANP; APN and role; APN and competencies; nurse manager; leadership; transformational leadership; Leadership Practice Inventory and nursing. In addition to the above search terms, searches were also combined; for example *ACNP* and *leadership*; *ACNP* and *competencies*. Some nursing journals were not accessible, either through the academic institution or the healthcare organization, electronically or in hard copy. The interlibrary loan resource *RACER* was utilized to retrieve two journal articles, but they had limited applicability to this

literature review. Initially the literature searched was restricted to the last five years. The yield was minimal, so the time restriction was removed and the results were numerous and dated from 1972 to 2009. A second literature review was performed during January 2009, after data collection was complete. This new search yielded one new empirical study, and more current literature that offered insight into the state of leadership as it relates to frontline nursing. Seminal theoretical articles that were used were published prior to 1990. Since there were so few nursing studies found, all articles that were relevant to the topic of nursing leadership were reviewed. Relevant theoretical, qualitative, and quantitative evidence that contributed to the understanding of the leadership role of the NP was identified, as well as existing gaps in current literature. Gaps included a lack of research of staff nurses' perceptions of the NP role in terms of its leadership capacity; the function of the NP as a leader in the acute care setting; and NPs' perception of their role as leaders. These gaps support the primary objective of the proposed study: to understand staff nurses' perceptions of the NP leadership role.

Leadership and the Nurse Manager

As research in the realm of leadership and nursing administration began to gain momentum, the nurse manager and the nurse leader were described as potentially different entities (Laurent, 2000). Although there is an important distinction between management and leadership, they are not mutually exclusive. In fact, Kouzes and Posner (2002a) identify the most influential manager as a transformational leader. The nurse manager, by definition, is responsible for the day-to-day operational administration of a defined work unit, its employees, and resources (Duffield, 1991). The nurse manager, who was once called the head nurse or ward-sister, is a registered nurse who has 24 hour accountability for the management of a nursing unit or area within the institution (Carroll & Adams, 1994; Miller & Hein, 1988). Additionally, the

nurse manager is responsible for ensuring the availability of support services; acting as a resource to the staff; interpreting philosophy, goals, standards, policies, and procedures; participating in policy formation; and being responsible for delivery of therapeutic, and cost-effective patient care (Cress, 1996).

The manager's role is described as a balance among "the use of self, the use of staff and use of the delivery systems" (Duffield, 1991, p. 1247). The nurse manager has been traditionally understood as the central leader on the nursing unit, providing guidance and support to staff nurses, while acting as the overall director of patient care and unit operation (Cress, 1996). In fact, the role as leader has been emphasized as a key element of the nurse manager (Cress). However, since the restructuring period during the 1990s, managerial responsibilities have increased as healthcare organizations aim for greater efficiency. Management positions have been broadened to include the responsibility of overseeing more than one work unit, and more complex environments (Hay, 2004; Surakka, 2008). The role has been decentralized.

The phenomenon of decentralization is an important one to explore since it has had an impact on the nurse manager role and staff nurse roles. An impact of decentralization on the nurse manager's role is a change in focus away from frontline nursing and those activities that directly support staff nurses to activities that focus on functionality and greater organizational goals (Duffield, 1991). Changes for staff nurses include the movement from team nursing to primary nursing (Antrobus & Kitson, 1999) and decreased access to nurse leaders (Duffield, 1991). Positive shifts in nursing practice have occurred. Individual nursing autonomy has increased and there is an impetus to create an environment of shared decision making amongst the multidisciplinary care team (MacPhee, Mclean, & Woo, 2005). Although some changes to individual nursing practice have been sought, in order for nursing practice to remain safe,

efficient, and in accordance with current standards, there is a need for consistent leadership at the clinical level (Tornabeni & Fitzgerald, 2008; Wong & Cummings, 2007). In light of nurse managers' extended responsibilities, their clinical presence has decreased (Rosengren et al., 2007). Where the ward-sister, or front-line manager, was once available to provide ongoing leadership to staff nurses, the manager's role now is farther removed from the bedside (Hay, 2004). Leadership has not become less important to frontline nursing staff. In fact, considering the challenges that are inherent in increasing patient acuity, changing technology and limited resources available to nurses, leadership is identified as something that cannot be compromised (Cragg & Spurgeon, 2007; Hyrakas & Dende, 2008; Steiert, 2008). The role of leader, according to Kouzes and Posner (2002a), is not exclusive to a manager. Accordingly, it is logical to look to other roles, more specifically the NP, to fulfill this role. In order to attain a better understanding of the NP's suitability for this role, the evolution of expanded nursing roles will be explored.

Historical Review

Expanded Nursing Roles

The emergence of APN roles in North America and the United Kingdom began with the Nurse Anesthetist (NA), followed by the Clinical Nurse Specialist (CNS), primary care NP, and NP specializing in acute care (AANA, 2007; NPAO, 2002). Initially the APN, including the NP role, was referred to as an "*extended*" nursing role because it was conceptualized as extending beyond traditional nursing practice and encompassing long-established medical practices, such as prescribing medication and specialized treatment for patient care (Hamric, Spross, & Hanson, 2005). However, as APN roles developed they were called "*expanded*" nursing roles since nursing practice was pushing practice boundaries that increased the scope of nursing practice (Hamric, Spross, & Hanson).

Nurse Anesthetist

Nurses represent the first professional group to provide anesthesia services in the United States (AANA, 2007). In Canada this role has not yet been implemented. However, the nurse anesthetist represents the first recognized nursing role that pushed the boundaries of nursing, allowing nurses with specialized experience and education to practice nursing in an expanded scope (AANA). Nurse anesthetists have provided anesthesia care in the United States since 1887 (AANA). This point in time marks the evolution of the professionalization of nursing. As pioneers in anesthesia, nurse anesthetists became involved in a range of specialty surgical procedures, as well as in the refinement of anesthesia techniques and equipment.

The first formal educational programs preparing nurse anesthetists were established in 1909 (AANA, 2007). However World War I greatly increased the need for nurse anesthetists. As a result, educational programs increased. During 1914, the American Association of Nurse Anesthetists (AANA) was founded. Shortly thereafter members of the AANA went to England and France to educate physicians and nurses about the administration of anesthesia (AANA).

This professional association now represents more than 28,000 Certified Registered Nurse Anesthetists (AANA, 2007). These healthcare professionals are an important resource. They are the sole anesthesia providers in approximately two thirds of all rural hospitals, and administer approximately 65% of all anesthetics given to patients each year in the United States (AANA). Nurse anesthetists have enabled healthcare facilities to offer obstetrical, surgical, and trauma services, and they are recognized as the first clinical nursing specialty (AANA). The role of the NA advanced nursing practice beyond the boundaries of the traditional nursing role, which in turn moved forward the professionalization of nursing.

The Clinical Nurse Specialist

The Clinical Nurse Specialist (CNS) is another expanded nursing role. The CNS uses scientific evidence, cost and clinical effectiveness strategies and clinical guidelines to direct patient care and drive patient outcomes (Scherff & Siclovan, 2009). Although only formally implemented in Canada during the 1960's, the development of the CNS role began in the USA during the 1940's and 50's (Montemuro, 1987). World War II was a prime historical event that influenced the development of advanced nursing specialties since there was an increasing need for clinical expertise. After World War II, there were developments related to nursing knowledge, new technology and the increasing complexity of healthcare and the healthcare system. This created the opportunity and the need for the clinical nurse specialist (Scherff & Siclovan).

The role of the CNS became important in meeting the increasing complexity of patient needs as well as advancing professional nursing knowledge (Scherff & Siclovan, 2009). The expert knowledge base of the CNS and the understanding of emerging issues at the clinical level optimally positioned their influence on nursing practice, positively affecting patient outcomes and expenditures (Scherff & Siclovan). The role of the CNS included practices that were traditionally performed by physicians and residents. An example is wound care where CNSs collaborated with the health care team to assess and prescribe treatments for complex wounds to improve patient outcomes and decrease length of stay (Carver, 1998; Duffield, Donoghue, & Pelletier, 1995; Scherff & Siclovan).

In conjunction with the changes that occurred post World War II, there was also a developing awareness amongst the public regarding quality health care. A major problem cited during the 1940's and 50's "was a lack of expert nurses at the bedside" (Montemuro, 1987, p.1).

The public's awareness and dissatisfaction, coupled with the evolving healthcare system, required practitioners who were able to critically analyze and solve clinical problems. The CNS role was envisioned as fulfilling the need for expertise at the bedside and furthering professional nursing practice (Scherff & Siclovan, 2009). This was achieved through CNSs' demonstration of professional nursing practice and leadership for bedside nurses in order to achieve appropriate standards of care (Montemuro).

The development of the CNS role was supported by academia. By the 1950's and 60's Masters level education to prepare nurses to function in the role of the CNS began to evolve. The University of Toronto introduced a graduate program to prepare CNSs in 1970. This was one of 10 programs in Canada preparing the CNS (Montemuro, 1987). During this time the four functions of the CNS role were identified as "expert practitioner, consultant, educator and researcher" (Montemuro, 1987, p. 3). These four main functions of the clinical nurse specialist support the postulate that the CNS was perceived as a competent nursing leader.

The Primary Care Nurse Practitioner Role

By the late 1960s a new class of nurse evolved – the primary care nurse practitioner (CNA, 1997). The primary healthcare needs of Canadians became a priority of the government and the formalization of expanded nursing roles began (CNA; Nurse Practitioners Association of Ontario (NPAO), 2002). In 1967, the first education program for NPs was started at Dalhousie University in Halifax (NPAO). In 1971, the government supported the NP initiative and published the Boudreau Report, stating that the implementation of the NP would be a high priority in Canada's health care system in order to meet the primary health care needs of Canadian citizens (Boudreau, 1972; DiCenso et al., 2007).

This expanded role of the nurse practitioner emerged as a response to the public's limited access to primary health care in Ontario due to a physician shortage, especially in rural communities (Angus & Bourgeault, 1999; de Witt & Ploeg, 2005). Nursing used the NP role as an opportunity to demonstrate leadership and promote change in the healthcare delivery system, addressing existing service gaps that ultimately resulted in increased public access to care (CNA, 2008).

Although the 1970s seemed promising with regards to the nurse practitioner role, the 1980s would make the NP role evolution difficult. NPs continued to function during the 1980s in "nurse practitioner-like" roles and they were registered as RN's, but worked under delegated medical functions (CNA, 1997; NPAO, 2002; Sidani, Irvine & DiCenso, 2000). Due to the lack of role support, legislation, and funding, in 1983 the last NP program in Ontario closed at McMaster University (NPAO, 2002; Sidani et al., 2000). By the end of the 1980s most NP initiatives in Canada had disappeared (CNA, 1997). However, at the same time that the primary care nurse practitioner initiative was experiencing a lull, a new opportunity for nursing arose. During the 1980s a sharp decrease in the number of medical residents provided yet another opportunity for nursing to advance its scope (NPAO, 2002).

The Nurse Practitioner Role in the Acute Care Environment

During the 1980's the role of the nurse practitioner in the acute care environment began to evolve (Irvine et al., 2000; NPAO, 2002). NPs in the acute care setting "are registered nurses who have a master's degree from a recognized acute care nurse practitioner education program in Ontario (or its equivalent)" (NPAO, p.1).

During the 1990s, teaching hospitals increasingly expressed interest in the new NP role (Scherff & Siclovan, 2009). The role was seen as a means to bridge the service gap created by a

reduction in the number of medical residents, physician shortages, and an increase in the number of admissions of patients who were acutely ill (Cummings, Frasier, & Tarlier, 2003; Irvine et al., 2000; Sidani et al. 2000). In light of demands placed upon the healthcare system from an aging population, increased technology, and increased wait times, the healthcare system had to make changes to keep pace (NPAO, 2002). One change was the implementation of an advanced practice nursing role of the NP in the acute care sector. Academia supported this need with the creation of two nurse practitioner post-Masters certificate programs; one in Toronto and one in London, Ontario (Irvine et al.; NPAO).

The NP – An integral nursing role in the acute care sector

Lobbying efforts by nurses and policy shifts at the provincial level of government continued from the time of the NP role implementation to the current day. As a result of lobbying efforts and support from the Ontario government, the NP role has become a valued and integral part of the Ontario health care system (Angus & Bourgeault, 1999). In August of 2007, the College of Nurses of Ontario (CNO) regulated the NP specialties in the Extended Class: NP-Pediatrics, and NP-Adult. The regulation of these new classes of nurses included title protection for Nurse Practitioners, also known as Registered Nurse (Extended Class) or RN (EC). This was a significant step toward the legitimization of the NP role (CNA, 2008; NPAO, 2002). The NP is regarded as an expert clinician, whose responsibilities include treating and overseeing the treatment of acutely ill patients, participating in research, and disseminating current knowledge within nursing. The NP role is grounded in the nursing profession's values, knowledge, theories, and practice (CNA, 2008). As such the nurse practitioner serves as an important resource for nursing colleagues.

NP practice is guided by a set of key competencies outlined by the Canadian Nurses Association (2008). These competencies are categorized as clinical, research, leadership, consultation, and collaboration. Positioned to work in close collaboration with staff nurses and educated at the master's level with an advanced theoretical understanding of leadership, the NP in the acute care environment is continually engaging in activities that advance nursing knowledge, and the profession of nursing. The NP in the acute care setting could potentially bridge the leadership gap between management and frontline nursing that has been identified in the literature.

The Evolution of Leadership Theories in Nursing Practice

Different views and conceptualizations of leadership are not new. Literature supports that differing views of leadership date back to the Plato, Caesar, Plutarch, and Machiavelli (McMillen, 2006). However the systematic, social, scientific study of leadership only began in the 1930s, with research focused on the behaviours of leaders (Gipe, 1998; McMillen, 2006). A review of the relevant theoretical literature yields important concepts related to leadership in nursing and leadership models. The literature addresses past and current trends of nursing's administrative leadership role within the greater healthcare system. Leadership models such as instructional leadership, transactional leadership, and transformational leadership are relevant in terms of their theoretical development and utilization within nursing. The two models of leadership that are most frequently studied are transactional leadership and transformational leadership (Stewart, 2006). Instructional leadership is less frequently studied.

Instructional Leadership

Instructional leadership is an autocratic style of leadership that is described as a prescriptive, linear, top-down approach aimed at instructing followers to achieve goals

6
determined by the leader. The leader holds all of the power in the relationship between the leader and the follower (Stewart, 2006). This is the first style of leadership that predominated nursing. Instructional leadership is now recognized as a less accepted model of leadership within nursing because it does not enhance synergy among nurses, nor does it achieve a professional climate of growth and development. Instead it decreases nurse job satisfaction and increases nurse burn-out (Hay, 2004). However, when this model of leadership was employed within nursing, it was credited for fostering the development of nursing as a profession.

Florence Nightingale was nursing's first visionary leader. She advocated that nurses be in command of nursing care provided to patients (Laurent, 2000). Credited for facilitating the progress that the nursing profession made in terms of value and credibility, Florence Nightingale achieved such feats by way of her linear, top down leadership style. Strong, overt control, an "I and you" difference in status, and the lack of consideration of subordinate nurses became the predominant style of nursing management (Murphy, 2005). This dichotomy amongst nurses was evidenced by the division of the "specials" (other valued nurses awarded authority) from the "regular" nurses (Murphy). This may have marked the beginning of the dichotomy in nursing between nursing management and "real nursing" (bedside nursing) (Bolton, 2004). In addition, Nightingale's subservience to the biomedical dominance influenced the development of hierarchical, patriarchal control that medicine had over nursing (Murphy). This autocratic leadership style permeated nursing administration for decades.

Eventually there would be a change in nursing leadership style in an effort to build a team-based environment that would achieve greater nurse job satisfaction (Heller, Drenkard, Esposito-Herr, Romano, Tom, & Valentine, 2004). It was during this time that organizations were becoming more concerned with patient satisfaction, and the link between nurse job

satisfaction and patient satisfaction with nursing care (Wong & Cummings, 2003). This marked a move away from the top-down, instructional leadership style towards transactional leadership (Heller et al, 2004).

Transactional Leadership

Although instructional leadership was still used, transactional leadership became a more predominant model used within management during the twentieth century (Murphy, 2005; Neill & Saunders, 2008). Burns (1978) stated that transactional leadership occurs when one person takes the initiative to contact others for the purpose of exchanging valued things. Both parties acknowledge the power relationships between them, and together they continue to pursue their respective purposes. The leader and follower(s) are not bound together by a mutually agreeable purpose, and the power within this relationship is held by the leader. Transactional leadership may not be the best model of leadership to use in the clinical nursing setting because nurses are constantly challenged to change practice and transactional leadership does not provide the motivation or inspiration amongst nurses to create such ongoing change (Aaron, 2006).

There was a conscious effort on behalf of many organizations to enhance nurse job satisfaction because evidence was accumulating that identified nurse sensitive outcomes, such as incidence of pressure related ulcers, were strongly associated with job satisfaction. Transactional leadership was used in order to achieve positive change in nursing practice, such as improved standards of care (Wong & Cummings, 2007). Transactional leadership, although achieving first order changes that effect policy and procedures, does not affect organizational or cultural change (Wong & Cummings, 2007). This style does not allow leaders to motivate and inspire followers. There is a clear delineation of power and the leader and respective followers do not share goal attainment (Aaron, 2006).

As nurse managers continued to be challenged with increasing responsibility and a greater span of control, the positive effects of transactional leadership began to decrease (Wong & Cummings, 2007). There was a developing need to move away from this model of leadership in order to respond to a change in organizational culture that focused on patient safety (Wong & Cummings). Transactional leadership styles lacked vision for the future. This leadership style was reactive and only supported the maintenance of the status quo (Murphy, 2005).

Decreased government funding, increasing patient complexity and length of stay, and increasing nursing workload shifted the focus of health care organizations toward efficiency and patient safety (Wong & Cummings, 2007). These changes demanded a cultural shift within nursing that required the use of evidence based practice in an effort to provide fiscally responsible care that remained patient focused.

Strong nursing leadership is necessary to implement effective management practices that create cultures of safety . . . With so much attention directed to creating healthier and safer practice environments for both nurses and patients, nursing leadership is called on to advance this agenda within organizations. (Wong & Cummings, p. 509)

Transformational Leadership

Transformational leadership is not the exertion of power over followers. It is defined as “leaders inducing followers to act for certain goals that represent the values and motivations of both leaders and followers” (Burns, 1978, p.19). Burns distinguished transactional from transformational leadership, suggesting that leaders are not born or made; leaders evolve from a structure of motivation, values, and goals (Stewart, 2006).

Bass’s (1985) research clarified the concept of transformational leadership. His empirical work stems largely from the documented inadequacies and deficiencies from Burns’ earlier work. Bass sought to differentiate between the transactional leader and the transformational

leader. Although both types of leadership are associated with effectiveness, transformational leadership practices tend to yield the most positive relationships with staff satisfaction and effectiveness (Bass; McKey, 2002; Taylor, 1996). Bass attributed this finding to transformational leaders' charismatic qualities and constant individual consideration.

Leadership practices and characteristics changed and turned away from the transactional leadership styles when Burns (1978) proposed a theory of transformational leadership. Although transactional leadership was successful at achieving first order changes in nursing practice, it was limited in that it could not affect cultural changes. Thus there was a thrust within nursing to establish a transformational leadership model from which to shape nursing administration and achieve cultural changes within the profession. This is evidenced by the Registered Nurses Association of Ontario's (2006) best practice guideline *Developing and Sustaining Nursing Leadership*, which uses Kouzes and Posners' (2002a) model of transformational leadership as a key component of its overall model of achieving healthy workplace environments. Kouzes and Posner (2002b) expand on the works of Burns and Bass to provide a model of transformational leadership from which leaders and leadership skills can be developed. Since the purpose of Kouzes and Posners' (2002b) model of transformational leadership is to cultivate and build leadership abilities and strengths amongst aspiring and established leaders, these authors have also developed a tool to measure such leadership. This tool is called the Leadership Practice Inventory or LPI. Its purpose is to measure leaders self perception of their leadership abilities (LPI-Self), and have followers measure their observations of leaders' fulfillment of transformational leadership behaviours (LPI-Observer). Kouzes and Posner (2002b) have developed an interactive workshop that aims at further developing the transformational leadership abilities of established and aspiring leaders across various business sectors and fields

of work. It is important that transformational leaders develop their skills, since transformational leadership is associated with greater job satisfaction, and productivity (Kouzes & Posner 2002b).

“Transformational leadership can protect against the adverse effects of stress; Transformational leadership behaviours are associated with a multiplicity of positive work attitudes amongst staff” (Murphy, 2005, p.131). These effects are achieved since the transformational leader assumes a proactive approach to management. Transformational leaders are visionary, future oriented, and as such become catalysts for positive change (Kouzes & Posner, 2002 b; Murphy). The nursing profession needs nurse leaders at the level of patient care who are visionary, support professional growth, and address current needs of patients and nurses.

Transformational leadership differs greatly from instructional leadership and transactional leadership. The process of transformational leadership is the cultivation and fostering of a mutual relationship between the leader and follower(s) that result in the transformation of followers to leaders, and leaders to moral agents (McArthur, 2006; Murphy, 2005; Stewart, 2006). The concept of moral leadership is important to this model of leadership since it means that transformational leaders must take responsibility for their leadership role, as they aspire to satisfy the needs of the followers. Also, the power within this model of leadership is shared – power and leadership are not things, but relationships (Bass, 1978; Murphy, 2005; Stewart). Burns defines transformational leaders as “inducing followers to act for certain goals that represent the values and the motivations – the wants and needs, the aspirations and expectations – of both leaders and followers” (p.19). Transformational leadership reflects characteristics of empowerment, shared leadership and organizational learning (Stewart). This model of leadership fits well within nursing since the concepts of empowerment, motivation,

inspiration, and collaboration are all integral to the practice of nursing, especially during times of change.

Positive leadership ratings are associated with positive attitudes toward adopting evidence-based practice and leaders who reflect transformational leadership behaviours yield higher scores on leadership questionnaires (Aaron, 2006). Although transformational leadership yields positive results within nursing groups, it is not a formula for all situations. Within the context of nursing, transformational leadership is postulated to provide the climate necessary to facilitate long-term positive change (such as meeting standards of practice), and achieving objectives. However, transactional leadership styles are still used to achieve short-term goals. For example, an incentive program to reduce absenteeism (Aaron).

Leadership and Management – Distinct or Overlapping

A plethora of literature on the topic of leadership exists. There are multiple perspectives about how leadership is conceptualized and defined (Stewart, 2006). Leadership is commonly described as the art and science of influencing a group toward the achievement of goals (McArthur, 2006). Management is defined as the control of resources to accomplish organizational goals that emphasize the functions of the organization (McArthur). Thus, leadership and management are different phenomena. The difference is that leader's do the "right things" while focusing on purpose and mission, having a futuristic outlook and engaging their followers. On the other hand manager's do the "right things" according to structures and procedures, with a short-range view, and not necessarily engaging their staff (McArthur). Kouzes and Posner (1988) recognized the difference between leaders and managers. According to Kouzes and Posner (2002b) leaders thrive on change, seize opportunities, empower others, create and share visions, and celebrate success. Managers focus on the short-term, assure tight control,

and encourage stability. NPs are in a position to act as front-line nursing leaders. By doing so, NPs' may influence the quality of nursing work environments and patient outcomes.

Gurka (1995) acknowledged the need for leadership within nursing, and explored the CNS role in the context of developing leadership qualities, providing leadership, and fostering the empowerment of front-line nurses. Gurka described the CNS role as a change agent. "The CNS can play a major role in transforming clinical practice and the system in which it takes place" (p.169). Gurka also focused on elements of transformational leadership as a vehicle to creating a "shared humanness that will invite others to participate in a shared vision and unified purpose" (p.169). Transformational leadership is a leadership style that stimulates followers to commit to shared values as they work together to achieve a common vision or goal (Burns, 1978).

This train of thought is extended by Langford (1995), who described the connection between leadership provided by the CNS and the process of empowerment of front-line staff that supports the growth of clinical and professional practice amongst teams of nurses. Laschinger and Finegan (2005), using Kanter's theory of organizational empowerment, found an important link between leadership and empowerment, stating that when staff nurses feel supported with adequate resources and appropriate leadership, they have a sense of increased power, and they display empowered behaviours that are reflected in decreased staff turnover, reduced absenteeism, greater organizational commitment, and greater job satisfaction.

It is not only through empowerment that change will occur. The concept of coherence is also explored in the context of team building and creating a supportive and healthy work environment (Ponte, Kruger & DeMarco, 2004). Coherence, described within the context of nursing team function, refers to a sense of shared responsibility within the group that leads the

group to achieve unity. Cohesion is a group function that is facilitated and supported by the group leader. A sense of coherence amongst staff creates a climate that ensures high quality care and continued professional development.

Developing a sense of coherence depends on the existence of mutual trust, a commitment to the process of working together, and a shared responsibility for practice and professional development. (Ponte et al., p. 174)

Inherent to the relationship between NP and staff nurse is working towards a common goal with a shared responsibility and commitment because they share a common vision – care of the patient. With a conscious effort toward team building, the NP is in a position to foster coherence and affect positive change within the workplace.

Effective organizations have leaders who empower employees to design innovative work methods to ensure efficiency, effectiveness, and productivity (Trofino, 1993). Leaders in effective organizations share their vision of professional nursing practice, and design models that meet the needs of patients, and address standards of practice, while at the same time achieving cost efficiency. A catalyst for an effective organization is leadership (Trofino, 1993).

Leadership and the Advanced Practice Nurse

The APN has been conceptualized in many different ways. Some include descriptions of roles, such as the clinical nurse specialist, primary care nurse practitioner, and nurse practitioner in the acute care environment, and depict advanced practice nursing as including advanced patient care (CNA, 2008; Hamric, Spross, & Hanson, 2005). Other conceptualizations are broader and incorporate specialized nursing roles such as the health policy analyst (Stimpson & Hanley, 1991; Hamric et al, 2005). The Canadian Nurses Association (2008) defines advanced nursing practice as

an umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise

in meeting the health needs of individuals and families, groups, communities and populations. (p. 9)

APN is an umbrella term that describes an advanced level of nursing practice. Advanced nursing practice is inclusive of the NP role. As such, the NP in the acute care environment is an advanced practice nurse. Therefore, the competencies of the APN apply to the NP.

The important common thread in these descriptions is the inclusion of *leadership* as a key *competency* of the NP (CNA, 2008; Hamric et al, 2005). In fact, the CNA (2008) identified leadership as a key element and area of competency of the NP role, suggesting that leadership is an integral role function. Leadership as a core competency means that the NP advocates for clients in relation to treatment, and health care policy that affects public access to care and quality of life (CNA). NPs also demonstrate leadership by

identifying the learning needs of nurses and other members of the health-care team, and finding or developing programs and resources to meet those needs; mentoring and coaching nursing colleagues, other members of the health-care team and students. (CNA 2008, p. 24)

The NP is expected to have knowledge and expertise including “the ability to motivate staff and create an environment conducive to team building” and “perform activities to further develop and strengthen the profession; act as a resource . . . provide functional supervision, provide on-going coaching, motivate, support, encourage, guide and influence staff, acts as a resource and a role model” (Anonymous, 1997, p. 2). These descriptions are consistent with the CNA Advanced Nursing Practice Position Statement. Two aspects apparent in the leadership competencies are the NP’s vision for nursing practice within the context of the healthcare system, and the NP’s ability to mentor nursing colleagues to improve and support nursing practice (CNA, 2008). The NPs have a strong foundation of clinical experience, graduate education that facilitates the development of expanded clinical skills, and an awareness of the position of nursing in the

greater health-care delivery system (Carryer, Gardner, Dunn, & Gardner, 2007). The NP role encompasses leadership components, including leading and fostering the development of practice. They have the clinical knowledge and education to act as leaders in the broader context of health-care delivery. NPs have comprehensive knowledge of legal and ethical considerations related to nursing practice, policies that guide practice, and best practice guidelines, all of which influence their own practice and potentially influence the practice of staff nurses with whom they work with. The NP is a potential clinical leader with a readiness and an obligation to advocate for their client base, their profession, and the system level of health care (Carryer et al.)

The Nurse Practitioner as a Leader

The acute care sector has utilized NPs for over a decade, and the research on these practitioners is largely focused on their technical skills. NPs are much more than care providers. They not only have specialized clinical competence, but they are also educated to fulfill leadership roles such as mentoring and educating their colleagues. Leadership within nursing is no longer exclusive to administrators. Leadership responsibilities also belong to others in the clinical setting; the NP is one position (Carryer, Gardner, Dunn, & Gardner, 2006).

In order to understand leadership practices in the current clinical environment, nursing research needs to focus on the role of NPs. Strong nursing leadership is imperative to sustaining the profession of nursing (Duffield, 1991). There is an opportunity to enhance and develop an understanding of leadership within the clinical setting. This could influence role implementation of the NP in the acute care environment. This is important because the acute care NP may be in a position to provide front-line leadership to nurses.

Research Literature

The following section offers an overview of current qualitative and quantitative studies of nursing manager leadership. Studies exploring APNs' own perceptions of their role and the perceptions that staff nurses and the multidisciplinary team have of the APN role are also reviewed.

Effects of Nursing Leadership on Staff Nurses

The study of the effect of managers' leadership style on nurse job satisfaction and nurse retention supports that managers' leadership styles influence nurse job satisfaction and turnover rates. Fisher's, Hinson's and Deet's (1994) longitudinal study found a weak, but positive relationship ($r = 0.20, p = 0.05$) between supervisors' communication and perceived management style and staff nurses' intent to stay in their current position. Nurse managers who communicated openly with staff, encouraged group problem solving and reflected a shared governance approach to leadership positively influenced the retention of staff. Volk and Lucas (1991) studied nurses' perceptions of current and desired management styles in hospitals using a descriptive-correlational design. The authors found a positive correlation ($r = 0.57, p = 0.05$) between participative management styles and low turnover. Other studies also found that front line managers who used a participative management styles, contributed to retaining professional nurses (Johnston, 1991; Taunton et al., 1989; Volk & Lucas; Taylor, 1996).

Wong and Cummings (2007) conducted a systematic review of studies that examined the relationship between nursing leadership styles and patient outcomes. Transformational leadership was found to share a positive relationship with patient satisfaction, patient safety outcomes, and an inverse relationship with adverse events and complications. In two of three studies that measured the relationship between transformational leadership and patient satisfaction, an

increase in patient satisfaction was significantly associated with transformational leadership behaviours. However there was no conclusive evidence that associated transformational leadership style with decreased mortality rates (Wong & Cummings). However, the strongest relationship between transformational leadership and patient outcomes was the reduced patient adverse events and complications. Thus, enhanced patient safety was associated with transformational leadership. The conclusion that was drawn from Wong and Cummings' systematic review was that "an emphasis on developing transformational nursing leadership is an important organizational strategy to improve patient outcomes" (Wong & Cummings, p. 508).

Pryer and Distefano (1971) used a correlational design to explore the relationship between individual nurses' perceptions of leadership behaviours of their immediate supervisors, and personal job satisfaction. They focused particularly on the leadership behaviour of consideration which includes properties of supportiveness, friendliness, openness of communication, and positive recognition of subordinates. From this small sample of staff nurses ($N = 20$), the findings supported that leadership behaviours, particularly the behaviour of consideration, are moderately positively correlated to job satisfaction ($r = 0.56, p = 0.01$).

McNeese-Smith (1996) investigated the impact of nurse managers' transformational leadership behaviors (as measured by the LPI) on job satisfaction and organizational commitment of 650 staff nurses in two acute care hospitals. Nurse managers were found to score highest on the subscale *enable others to act*, and lowest on the subscale *inspire a shared vision*. The results show a positive, significant correlation ($p = 0.001$) between managers' LPI scores (as rated by employees), and employees' productivity, job satisfaction, and organizational commitment. Positive correlations were also found between productivity and job satisfaction ($r = 0.25; p = 0.001$), productivity and organizational commitment ($r = 0.31; p = 0.001$), and job

satisfaction and organizational commitment ($r = 0.39$; $p = 0.001$). Thus, managers who attained a higher LPI score (reflective of stronger transformational leadership practices) had employees who were more productive, more satisfied with their job, and more likely to maintain their position in the current organization. The findings also suggested that employees found to be more productive were also found to be more satisfied with their job and had a higher organizational commitment. With the use of Kouzes and Posners' (1995) Leadership Practice Inventory, the results of this study support that nurse managers who display transformational leadership behaviours have staff nurses who are more satisfied and committed to work and to the organization.

Taylor (1996) conducted a descriptive-correlational study aimed at determining the relationship between staff nurses' perceptions of their manager's leadership behaviours and their job satisfaction and organizational commitment. The sample consisted of 200 staff nurses from medical-surgical intensive care, intermediate care, and specialty care units in a tertiary care medical center. The study findings demonstrate a moderately positive correlation ($r = 0.50$ to 0.58 , $p = <0.01$) between job satisfaction and Kouzes and Posners' (1988) five leadership behaviours (model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart). These findings support that there is a positive relationship between staff nurse job satisfaction, organizational commitment, and transformational leadership behaviours of the nurse manager. Using transformational leadership behaviours could improve job satisfaction and organizational commitment and decrease staff nurse turnover rates and improve productivity (Taylor, 1996).

Studies of Advanced Practice Nurses' Perceptions of their Leadership Role

Bramford and Gibson (2000) were interested in APNs' perceptions of their role development. The study design was exploratory-descriptive and used a grounded theory method. The sample consisted of 25 CNSs, all of whom answered structured questions about their role. The findings of this study revealed that APNs defined their role in terms of components. These components were: clinical, involvement in education (patient and staff nurse) and training, acting as a consultant, participating in and undertaking research, and performing administrative tasks. CNSs operationalized their role on a continuum from novice to expert practitioner. It is interesting to see that even the novice level CNS acknowledges that the role demands leadership qualities, and endeavors to meet this demand by supporting staff development with education. As practitioners develop along the continuum, their role evolves and more clearly defines their leadership capacity. This is demonstrated by the 'expert' ability to act as a mentor and role model, and influence practice by creating an environment that is analytical and ready for change (Bramford & Gibson).

Carver (1998) sought to identify acute care nurse practitioners' (now called Nurse Practitioners or NPs) perceptions of their role expansion, practising at a regional cardiology center in Ontario. Four randomly selected participants (of a larger self identified NP group) took part in the study. The number of participants for this study was appropriate for this phenomenological inquiry, since the objective was to seek out the lived experience of the NP role. Seven concepts were identified as influencing how nurses expand their roles. However there was no mention of leadership as a competency or role component. This is important because although national nursing organizations, such as the CNA, conceptualize the APN role as a leadership role, NP participants of this study did not acknowledge this aspect of the role.

Participants did acknowledge that role expansion is one important facet of advancing the profession of nursing. Since the lived experiences were sought, themes that were found may be unique to this group in this setting, and so the findings may not be generalizable (Carver, 1998).

Hoffman, Happ, Scharfenberg, DiVirgilio-Thomas, and Tasota (2004) examined the contributions of the NP to the healthcare team through qualitative inquiry. These authors used a comparative open-ended survey approach. The sample was comprised of medical doctors (MD), respiratory therapists (RT), and staff nurses ($N = 53$). The results from the MD and RT participants revealed that the NP is viewed as a member of the medical team. The open-ended survey elicited responses from the interdisciplinary team regarding NPs' competence and knowledge related to the care of acutely and critically ill patients. NPs' competence was evaluated in terms of clinical capability, more specifically tasks such as prescribing and the medical treatment of patients. Staff nurses valued NPs for their expertise, accessibility, and ability to meet patient and family needs. Nurse respondents emphasized the accessibility of the NP. Staff nurses also respected the NP's communication skills. Nurses felt that these skills were exemplified through teaching nursing staff. This study did not specifically speak to the NP's leadership role. Perhaps leadership could be considered inherent in their teaching of nursing staff and role modeling professionalism because these behaviours are reflective of the leadership practices enabling others to act and modeling the way.

Pauly et al. (2004) sought to identify APNs' perceptions of their role in comparison with the characteristics and key competencies identified by the CNA (2002) framework. The objectives of this study were to learn how APNs understand their role, and identify gaps in healthcare delivery that may be filled by the APN role. The research design of this three phase study was a descriptive and exploratory, using interview and quantitative data collection

methods. Telephone interviews ($N = 64$), email surveys ($N = 12$), and focus groups ($N = 55$) with self identified clinical nurse specialists were undertaken. The research study took place in British Columbia where, at the time, the only APN role was the CNS. Researchers found that two groups of APN existed within the large group: graduate prepared APNs and registered nurses prepared with basic (diploma or BScN) nursing education, but practising in an expanded role. The first group of APNs characterized themselves in terms of the CNA APN core competencies. This group of APNs were masters prepared and were familiar with the concept of advanced practice nursing as articulated in the CNA framework. They described their role as including patient care, research, coordination of care, education (of patients, families, and staff), policy and program development, administration, leadership, and consultation. These participants viewed advanced practice nursing as a combination of research, education, and knowledge of administrative responsibilities and skill that affect patient care and policy. They stressed the importance of leadership and mentoring of other nurses. In addition, all of these respondents identified that, in order to be an APN, graduate education was required.

The second group perceived themselves as APNs because they were performing duties outside the scope of traditional nursing and were acting in non-traditional nursing roles. They associated advanced practice with performing duties that traditionally belonged to medicine. Their view of advanced practice nursing was characterized by direct patient care, educating patients and families, and consulting with nurses and other health care providers with respect to individualized patient care. This group of nurses viewed themselves as experts with refined clinical skills. The defining role characteristic of the APN role for these participants was clinical competency.

The first group of APNs that identified themselves as fulfilling the APN role shared the same view of advanced practice nursing that the CNA (2008) put forth in the national framework. These participants attribute the underutilization of knowledge, and skills to factors such as organizational culture that does not promote full use of competencies, knowledge and skill. The other participants identified themselves as fulfilling the APN role because they perceived themselves as practicing beyond the basic level of nursing. They focused on clinical competency, but did not acknowledge the other APN competencies, such as leadership.

The findings from Pauley et al. (2004) revealed that there is substantial interest, but uncertainty, about advanced practice nursing, and there is a feeling amongst APNs that they are widely underutilized within the healthcare system. With respect to their education, clinical experience and broad expertise, they are a resource that has not fully been realized.

Allen (1998) explored 71 psychiatric nurse participants' perceptions of an appropriate NP role in the specialty of psychiatric nursing. This role was defined in terms of tasks, such as prescribing and conducting assessments. There was no exploration of this role in terms of the benefits of expanding nursing practice or advancing the profession of nursing by way of mentorship or leadership practices. Although keywords used to explore this issue included expansion and extension, the broader benefit of introducing an APN role within this facet of nursing was not identified. Allen's study (1998) illuminates that nurses understand APNs in terms of their ability to perform tasks. Although the concept of leadership is part of the advanced practice nursing role description, these APNs were perceived by staff nurses as being a part of the medical team.

Van Soeren and Micevski (2001) explored success indicators, barriers, and recommendations with respect to the implementation of the NP role. Their pilot study was

designed to investigate the multidisciplinary team's perception of the NP role with a self-administered questionnaire. The questionnaire was developed by the researchers and included fixed and open-ended questions. The sample consisted of NPs (14), physicians (12), administrators (8), and staff nurses (34) ($N = 68$). The analysis of NPs' responses generated three themes: *continuity of care*; *nursing leadership role*; and a *clinical focus*. NPs' perceived their role as influencing *continuity of care* by improving coordination between services, providing a global perspective, fostering positive relationships among the family, patient and team, and developing a more holistic plan of care. They perceived themselves as acting as *nursing leaders* by supporting nursing decision making, teaching staff and evaluating outcomes related to nursing activities. Analysis of physicians' responses resulted in two themes: *continuity of care* which consisted of providing a balanced perspective of patient care issues and a more comprehensive approach to patient care; and a *clinical focus* which consisted of developing links with families and other teams and services, and enabling physicians to focus on medical issues. Analysis of administrators' responses yielded two themes: *nursing leadership* which included acting as a role model and establishing standards for staff; and *continuity of care* which consisted of bridging physician-nurse gap and decreasing the readmission rate. Staff nurses results yielded three themes: *continuity of care* which consisted of improving access to team members, improving the quality of care of longer term patients and improving communication amongst teams; a *clinical focus* which included providing staff education, acting as a nursing consultant for the team and improving communication between nurses and physicians; and *role modeling* which consisted of providing a nursing focus on patient management supporting advanced nursing skills, and initiating care plans with a nursing perspective. Physicians were the only group that did not identify the NP as a leader. It is interesting to note that 70% of nurses found the role to be most

important as a clinical resource, with leadership, and mentorship being less frequently mentioned. Staff nurse participants wanted NPs to share knowledge with them about outcomes-based practice, and NPs wanted to provide this mentorship. Only one respondent identified that the NP role was not influential. The limitations of this study were its small sample size from a single Canadian province (Ontario) and a lack of homogeneity amongst participants due to a lack of credentialing, standards of practice and certification for NPs in Ontario. The latter is problematic since the understanding of the NP role may be influenced by personal interpretation. Additionally, the questionnaire that was piloted was not previously used, and the researchers did not describe the validity and reliability of the tool. However, an important strength of this study is that it reveals that staff nurses perceive the NP as a leader.

The findings of this literature review are important since they highlight gaps in the research and substantiate the need for further study of NPs as frontline leaders. Within the quantitative and qualitative literature leadership is not consistently described as a component of the APN role. Some studies found little emphasis on APN leadership and other studies found that APN leadership is a quality that is important to both nursing staff and the APN. There were no studies found that specifically addressed the NP's leadership role. Qualitative studies that were examined acknowledged the importance of APN leadership, however there was no deliberate exploration of staff nurses' perceptions of NPs in terms of leadership practices. From the literature reviewed, the major gap that exists within this body of knowledge is an understanding of staff nurses' perceptions of the NP leadership role.

It is important to explore the topic of NP's leadership role, from the perspective of staff nurses, because this will inform the utilization of the NPs. For example, if nurses perceive NPs

as leaders, perhaps this aspect of their role could be maximized in the clinical setting by creating more opportunities for NPs to offer direct clinical leadership.

Nursing Studies that Incorporate the Leadership Practice Inventory

The Leadership Practice Inventory (LPI) is a questionnaire developed by Kouzes and Posner (2002a) as a tool that measures transformational leadership behaviours and practices among individuals in leadership positions, such as managers and supervisors. The research conducted by Kouzes and Posner dates back to 1980, and is the foundation of the five leadership practices; model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart (Kouzes & Posner). The LPI has been used extensively in organizational settings, and is highly regarded (Kouzes & Posner). It is one of the most widely used leadership assessment instruments, recognized for its high validity and reliability. In fact, validation studies have been conducted by Kouzes and Posner and other researchers over a 15 year period and results consistently confirm the LPI's high validity and reliability in various settings including health care organizations. There are few nursing studies that have used the LPI to measure leadership practices, but in the nursing studies done, the LPI has been found to be a valid and reliable tool (McNeese-Smith, 1996; Taylor, 1996; Tourangeau, Lemonde, Luba, Dakers, & Alksnis, 2003; Tourangeau & McGilton, 2004). However, further application of the tool in healthcare, and more specifically within nursing, will broaden the use of the LPI.

McNeese-Smith (1996) examined the relationship between Kouzes and Posners' (1988) model of transformational leadership, employee productivity, job satisfaction, and organizational commitment. Nurse managers' ($n = 41$) completed the LPI-Self questionnaire, and staff nurses ($n = 471$) completed the LPI-Observer tool in addition to instruments that measured productivity, job satisfaction, and organizational commitment. The results of the study revealed that managers

consistently rated their leadership behaviours higher than staff nurses did. However, both the nurse managers and the staff nurses responses demonstrated that nurse managers performed behaviours consistent with *enabling others to act* most frequently, and behaviours consistent with *inspiring a shared vision* least frequently. Employee productivity, job satisfaction, and organizational commitment all showed a positive correlation with staff nurses evaluation of nurse managers' transformational leadership practices ($p = 0.001$). These findings support that there is a positive relationship between nurse managers' use of transformational leadership behaviours, and staff nurses productivity, job satisfaction, and organizational commitment.

Taylor (1996) investigated the relationship between leadership behaviours of the nurse manager as perceived by staff nurses, and staff nurse job satisfaction and organizational commitment. This was the only study that evaluated staff nurses' perceptions of nurse managers' leadership practices as operationalized by Kouzes and Posners' (2003) Leadership Practice Inventory. This study used a descriptive correlational design and the sample consisted of 200 full-time and part-time staff nurses representing a 40% response rate. The LPI was one of three questionnaires used. The Pearson r was used to determine the degree of relationship between the five leadership behaviours and staff nurses' job satisfaction and organizational commitment. There was a moderate significant relationship between job satisfaction and challenging the process ($r = 0.53, p = <0.01$), enabling others to act ($r = 0.58, p = <0.01$), encouraging the heart ($r = 0.53, p = <0.01$), inspiring a shared vision ($r = 0.50, p = <0.01$), and modeling the way ($r = 0.57, p = <0.01$). Organizational commitment was significantly positively correlated with the leadership behaviour enabling others to act ($r = 0.51, p = <0.01$) and there was a significant relationship between job satisfaction and organizational commitment ($r = 0.59, p = <0.01$). Taylor's (1996) study supports that transformational leadership behaviours are positively related

to job satisfaction of staff nurses. This suggests a need for strong front-line leadership since staff nurse job satisfaction has been correlated with nurse sensitive patient outcomes and staff nurse retention, both of which are becoming increasingly important with regards to the sustainability of healthcare and nursing (RNAO, 2006)

A study by Tourangeau et al. (2003) evaluated a transformational leadership development intervention. A one-group pre-test, post-test quasi-experimental design was used to measure leadership practices of nurses in order to establish the effectiveness of a leadership development intervention administered to a group of aspiring and established nurse leaders in Canada. The LPI-Self questionnaire and the LPI-Observer tool were used. The Cronbach's-alpha remained consistent as compared to previous studies (Tourangeau et al.; Tourangeau & McGilton, 2004). The intervention was a five day leadership residency program in Toronto, Ontario that was followed-up 3 months later with a 'booster' weekend. Participants were invited to participate in dyads, each consisting of an established nurse leader and an aspiring leader. A total of 67 nurses participated of the 73 individuals who were recruited. While the authors of the study hypothesized that self-reports of each of the five leadership practices would increase from pre-test to post-test, no significant increases in self-reports of leadership practices were found. The second hypothesis predicted observer reports of the five leadership practices for participants would increase from pre-test to post-test. Established nurse leader partners reported statistically significant increases in leadership behaviours of the aspiring nurse leaders from pre-test to post-test periods. A follow-up ANOVA revealed that the hypothesis was supported for all subscales ($p = <0.001$). The findings of this study provide support for a concentrated, residential leadership development intervention as an effective means of strengthening leadership behaviours exhibited by both aspiring and established nurse leaders, as perceived by established leaders and measured

by the LPI. The LPI is a valid and reliable measure of leadership practices as defined by Kouzes and Posner (2002b).

Tourangeau and McGilton (2004) investigated the psychometric properties of the LPI when used to measure the leadership practices of nurses engaged in a leadership educational experience. All 67 participants completed the LPI-self evaluation at the beginning of the study. The authors assessed the LPI's construct validity ($p = 0.01$) and reliability, Cronbach's-alpha, ($r = 0.88-0.99$) and this demonstrated that the instrument was a valid measurement of transformational leadership behaviours when used with this population. This study also identified that further research within the context of nursing must be undertaken in order to gather evidence of the LPI's applicability to nursing.

Summary

There were only four isolated research studies that used the LPI instrument with nurses (McNeese-Smith, 1996; Taylor, 1996; Tourangeau et al., 2003; Tourangeau & McGilton, 2004). No studies were found that investigated staff nurses' perceptions of the NPs leadership practices, as measured by the LPI. It was also noted that further research with the LPI tool in the healthcare environment is required before the tool can be considered to be a reliable and valid tool in the health care context (Tourangeau et al., 2003).

A review of relevant literature has established that nurse managers who practice transformational leadership behaviours have units associated with lower turnover rates and increased productivity (Taylor, 1996). The literature also revealed the vast change in responsibilities of the nurse manager as the role has changed to meet the increased demands of restructured hospital environments, diverse patient populations, workforce demographics, and

competing fiscal demands such that they are less available to provide frontline leadership. This has created a need for leadership at the front-line of the nursing profession.

Although the use of the NP is increasing, research into the NP leadership role has not been a focus of the nursing research. No studies have explored the leadership role of the NP as perceived by the NP or the staff RN. The importance of exploring the leadership role of the NP is particularly important to staff RNs since this group may benefit most from NP leadership competencies. If NPs practice leadership it may result in staff nurses having increased job satisfaction, decreased turnover, increased retention, and increased quality of care provision.

CHAPTER III: CONCEPTUAL FRAMEWORK

Introduction

The conceptual framework that was used in this study consisted of the Canadian Nurses Association (CNA) Framework for Advanced Practice Nursing (2008) and Kouzes and Posners' model of transformational leadership (2002b). The CNA (2008) offers a national framework that reflects the ongoing evolution of advanced practice nursing. Within the framework put forth by the CNA, Advanced practice nursing is defined, the roles are outlined, the education required to be an APN, and the regulation of practice is discussed, and the set of key competencies to be met within advanced nursing practice is clearly articulated. This framework was chosen as an appropriate component of this study's conceptual framework because the leadership role of the NP as articulated by the CNA, is conceptually consistent with Kouzes and Posners' (2002b) model of transformational leadership.

Kouzes and Posner's (2002a) model of transformational leadership was also used as a component of the framework for this study because it supports the definition of leadership as conceptualized by the CNA (2008), and offers a validated instrument that measures leadership behaviours, the Leadership Practice Inventory (LPI). Kouzes and Posner (1988) described leadership as an "art". They said that it is through the art of leadership that leaders' actions and practices mobilize others to achieve shared aspirations. Together the CNA national framework (2008) and Kouzes and Posners' (2002b) model of transformational leadership form the conceptual framework used in the current study.

CNA Framework for Advanced Practice Nursing

There are four key competencies outlined by the CNA (2008): clinical, research, leadership, and consultation and collaboration. The leadership competency is of key interest for this study. The CNA conceptualizes the APN as a leader. The leadership competency is operationalized as the NP or APN performing the following actions as articulated by the CNA (2008): advocate for individuals, groups or communities; identify the learning needs of nurses and other team members and develop programs or resources to meet those needs; mentor and coach nurse colleagues; contribute to an organizational culture that promotes professional growth and development; evaluate programs and develop approaches to approach complex issues; integrate principles of resource allocation; identify gaps in health care delivery and develop partnerships to facilitate change; develop and articulate a vision of nursing practice, influence organization's and health care system's vision, and implement strategies to realize the vision; identifying issues and initiating change at the individual, organizational and system level; and understand legislative and socio-political issues and influencing change to health care policy (p.25).

Leadership as articulated by the CNA (2008) is consistent with the process of transformational leadership outlined by Kouzes and Posner (2002a). There are elements of role modeling, for example mentoring nurse colleagues, inspiring a vision that can be shared, helping others to change practice and empowering them to create change themselves, and challenging the status quo with creating changes to policy. Since the expectations of NP practice is consistent with Kouzes & Posners' (2002a) theory of transformational leadership it is reasonable to evaluate NP leadership role fulfillment based on this framework.

Kouzes and Posners' Model of Transformational Leadership

Kouzes and Posner (1988, 1995) extended the work of Burns (1978) and Bass (1985) and focused on the development of a model of transformational leadership that included five leadership practices of extraordinary leaders. According to Kouzes and Posner, extraordinary leaders challenge, inspire, enable, model, and encourage followers and leadership is an observable set of practices that can be learned.

Conceptual Definitions

Kouzes and Posners' (2002b) theoretical definition of leadership states that "leadership is a relationship between those who inspire to lead and those who choose to follow . . . [it] is the art of mobilizing others towards shared aspirations" (p. 1). Transformational leaders cultivate group and personal improvement, share inspiring organizational visions, and foster commitment and motivation towards important goals (Kouzes & Posner, 1988). Transformational leadership theory proposes that an emotional attachment develops between transformational leaders and their followers to the extent that followers begin to identify with transformational leaders and feel inclined to go beyond the call of duty to achieve an organization's mission. The transformational leadership model established by Kouzes and Posner (2002b) includes five leadership principles. These principles represent the five subscales of the leadership practice inventory, and they are (a) model the way; (b) inspire a shared vision; (c) challenge the process; (d) enable others to act; and (e) encourage the heart (Appendix A).

Model the way.

Modeling the way means being a good role model. The most important quality that others look for and admire in a role model is personal credibility (Kouzes & Posner, 2002b). Leaders who stand up for their beliefs and clearly and authentically give voice to their values may earn

the respect of others and gain credibility. Two behaviours that support modeling the way are setting the example and planning small wins (Kouzes & Posner, 1988). Modeling the way begins with the clarification of personal values and involves building and affirming shared values that all can embrace (Kouzes & Posner, 2002b). The second aspect of modeling the way is planning for small wins so successes can be experienced by individuals and the entire team. When problems are too large, they become overwhelming. However, by planning for small success along the way, the leader creates an environment of excitement, potential, confidence, accomplishment, and commitment to continuing the journey (Kouzes & Posner, 1993). Successful leaders set high standards, lead by example, and demonstrate actions that are consistent with the stated values (McNeese-Smith, 1993). They convince followers that the impossible is possible and that the journey to success begins with one small step.

Inspire a shared vision.

Inspiring a shared vision begins with the leader conceptualizing an exciting and attractive future. A shared vision is achieved when leaders create bonds or common purposes with their followers (McKey, 2002). Leaders' motivation is their clear image of possibility and what their organization could become. Leaders inspire a shared vision by envisioning the future and enlisting others in a common vision (Kouzes & Posner, 2002b)

Envisioning the future is the process of creating a dream and getting others to buy into it with great passion and commitment (Kouzes & Posner, 1988). Kouzes and Posner articulated future orientation, image, ideal, and uniqueness as the four attributes that create vision. Future orientation is a statement of destination and the ideal end; image is the ability to know what the destination and the ideal end look like; ideal is defined as a vision that has the ultimate possibilities and standards of excellence; and uniqueness is the quality that makes a vision

distinct from everyone else's in order to facilitate the development of an atmosphere of pride and self-respect (Kouzes & Posner, 2002b).

Leaders passionately believe a difference can be made, and through motivation and inspiration, leaders create a common vision with followers. McNesse-Smith (1993) reports that nurse leaders use this approach to bring about change within their area of responsibility. They create a bond that supports the sharing of a vision for the delivery of patient care services by respecting diversity and building upon a common ground. "Leaders forge a unity of purpose . . . breathe life into visions [*and*] uplift people's spirits with an enabling perspective about why they should strive to be better" (Kouzes & Posner, 1993, p. 3). Kouzes and Posner identified that the leader must support the vision with competence, confidence, and experience – they must be credible.

Challenge the process.

Challenging the process involves leaders who are willing to be innovative, to experiment and to take risks. In turn they encourage and support their followers to do the same (McKey, 2002; Kouzes & Posner, 1993). Exemplary leaders seek and accept challenge. Transformational leaders are not satisfied with the status quo. Instead the leader looks for opportunities to innovate, grow, and improve. Leaders who challenge the process recognize and seize learning opportunities that come from disappointments (McKey, 2002). They support good ideas and are willing to challenge the system to change processes and services (Kouzes & Posner, 2002b).

Challenging the process consists of two strategies: searching for opportunities and experimenting and taking risks (Kouzes & Posner, 1988). Searching for opportunities involves bringing new ideas to an organization, being a change agent, constantly challenging the status quo, and looking for possibilities. Sometimes it is not the idea of the leader, but that of the

follower. A good leader is able to listen and encourage others' ideas into operation (Kouzes & Posner). Searching for opportunities means treating every job as an adventure, and seeing possibility and potential in change.

Experimenting and taking risks involves the leader being open to ideas and willing to listen. The leader encourages experimentation by collecting ideas and suggestions for change from followers and stakeholders. Experimentation and risk taking demands team renewal by providing educational offerings, refocusing on goals, and adding new members to enhance creativity and motivation (Kouzes & Posner, 1988).

The transformational leader accepts the challenge of change. Understanding that change can be stressful, the leader creates a climate in which people are psychologically hardy, and feel in charge of the change (McNeese-Smith, 1993).

Enable others to act.

Leaders enable followers to act through trust and teamwork. Through collaboration, leaders teach followers to succeed (McNesse-Smith, 1993). The transformational leader is aware that leadership is not an independent effort, and acknowledges the importance of the team. In a constant effort to team build "leaders enable others to act by fostering collaboration and strengthening others" (Kouzes & Posner, 1993, p. 5). Fostering collaboration and strengthening others are the two behavioral commitments of enabling others to act.

Fostering collaboration begins with creating and sustaining cooperative goals (Kouzes & Posner, 1988). This collaborative effort between the leader and followers is reinforced by sharing goals and successes as well as recognizing the efforts of others.

Through building trust and fostering empowerment, teamwork is continually reinforced and all team members' capacity to exceed their own expectations is strengthened (Kouzes &

Posner, 1993). By developing capacity in staff to contribute to the organization, leaders can successfully enable others to act in a manner that supports teamwork and the vision of the organization (McKey, 2002). The extraordinary leader recognizes that the key to success lies not in competition but in cooperation and collaboration.

Strengthening others to act includes strategies for building power for followers and leaders. These behaviours are; getting to know others; being sensitive to others; listening actively to what others have to say about themselves; developing interpersonal competence; giving power away by delegating and keeping others informed; using power to assist others in their goals; and making heroes of others (Cress, 1996). The extraordinary leader recognizes the importance of making others feel valued, and believes that human resources are the most important resource in an organization (Kouzes & Posner, 1988).

The transformational leader creates a climate of trust wherein people are involved and feel important. This is the beginning of changing followers into leaders themselves. The key to this leadership practice is that leaders use their power to enable others to act by sharing their power with followers, instead of hoarding their inherent power and using it as authority. Leaders foster collaboration by understanding that mutual respect is a key factor that drives and sustains the team's efforts (McKey, 2002).

Encourage the heart.

Encouraging the heart is visibly recognizing others' contributions to the common vision, expressing pride in the accomplishments of the team, and making hard work enjoyable (Cress, 1996). Leaders encourage the heart by performing two behaviours: recognizing the contributions of others and celebrating values and victories (Kouzes & Posner, 1993). Encouraging the heart occurs when leaders support followers, encourage them, and recognize and reward their

achievements (McNeese-Smith, 1996). Transformational leaders set high standards and have high expectations. They expect the best of people and create self-fulfilling prophecies about how ordinary people can produce extraordinary results (Kouzes & Posner). Leaders stimulate peoples' energies by paying attention, offering encouragement, personalizing appreciation, and maintaining a positive outlook. Encouragement is achieved by celebrating others' accomplishments visibly and in group settings, thereby sustaining a team spirit. Leaders need to recognize that small accomplishments are part of larger achievements and these small accomplishments need to be celebrated to help followers remain determined and continue with their hard work. "Encouraging the heart is how leaders visibly and behaviorally link rewards with performance and behaviour with values" (Kouzes & Posner, p. 7). Through this process of encouragement and acknowledgement a strong sense of a collective identity and community spirit is built – and this is what carries the group through turbulent and difficult times (Kouzes & Posner).

In addition the following conceptual definitions were used to define participants:

1. The NP is a registered nurse (RN) with graduate education who currently works in an acute care setting within an expanded nursing role performing practices that extend beyond traditional nursing roles.
2. Staff Nurse is a RN employed by an acute care hospital to provide nursing care to patients.

Summary

From the literature reviewed it has been ascertained that leadership is important to the function of an organization. Within the context of nursing, transformational leadership is important to achieving higher nurse job satisfaction, and better nurse sensitive patient outcomes

(Gipe, 1998; Hay, 2004; Houser, 2003; McNeese-Smith, 1996). By using transformational leadership practices the leader enables the follower through mentorship, inspiration, and encouragement to work towards team and greater organizational goals. Since nursing managers have increased span of control, they have become less available to provide needed clinical leadership. Due to the proximity and position of the NP with respect to the staff RN, and the NP's leadership capacity, it is worthwhile to investigate if staff nurses perceive the NP as a leader. In this study, NP leadership was evaluated by staff nurses using the LPI-Observer tool. The LPI-Observer tool is a valid and reliable 30-item questionnaire developed by Kouzes and Posner (2002a) that measures the transformational leadership behaviours of a leader by a peer, co-worker or subordinate. A detailed explanation of this tool will follow in the next chapter.

Problem Statement and Purpose

The problem identified is the lack of empirical knowledge of staff nurses' perceptions of leadership characteristics of NPs in the acute care environment. Knowledge of the NP leadership role may offer a baseline understanding of NP leadership capacity and direct further development of strategies to optimize NPs' leadership role in the clinical setting.

The purpose of this study is to determine staff nurses' perceptions of NPs' leadership role in an acute care setting, and to compare these findings with the normative percentile values of leadership as described by Kouzes and Posner's (2002a) Leadership Practice Inventory (LPI).

Research Questions

1. What are staff nurses' perceptions of the fulfillment of the transformational leadership role by the NP, as measured by the LPI-Observer tool?
2. How do the participant scores of the LPI-Observer tool compare with the normative percentile values?

CHAPTER IV: METHODS AND PROCEDURES

The following chapter describes the methods and procedures used in this descriptive pilot study. First, the design and instruments of measurement are described. The demographic questionnaire was used to elicit meaningful information about the participants of this study. The Leadership Practice Inventory – Observer was used to measure leadership practices of the NP as observed by the staff nurse participants. Next, the sample and sampling strategies, including inclusion and exclusion criteria are discussed. This is followed by a review of the ethical aspects and considerations of this study. Finally, the methods used for data collection and analysis are identified.

Design

This pilot study was a non-experimental, quantitative-descriptive design that investigated the perceptions of staff nurses' regarding their perceptions of the NP leadership role. Registered nurses, who work in a staff nurse capacity within an acute care setting, and have experience working with a NP within the last year, for at least one year, were asked to participate. These participants completed the LPI Observer Report questionnaire based upon their work experience with an NP. Staff nurse LPI scores were compared to the normative values of the LPI-Observer tool, and are reported as a mean and percentile value.

Measurement

Demographic data were collected in order to describe the sample in a meaningful way. The demographic sheet (Appendix B) for participants elicited information about their:

1. Age
2. Gender
3. Level of education

4. Years of nursing experience
5. Years of nursing on the unit
6. Type of acute care setting
7. Number of years working with an NP.
8. How recently the staff RN has worked with the NP

The variables, leadership practices, were collected and measured using the LPI-Observer tool. Thirty eligible participants were recruited to complete the LPI-Observer tool.

Age, years of nursing on current unit, years of staff nurse experience, and the length of time working with an NP were treated as ratio level measurements; gender, type of nursing unit, and how recently the staff RN worked with an NP were treated as nominal level measurements; and level of education was treated as an ordinal level measurement.

Instruments and Measurement of Key Study Variables: The LPI-Observer

The key study variables were leadership practices, and were measured using the LPI-Observer tool. There is a “Self” and “Observer” version which allows for 360-degree feedback from managers, co-workers, colleagues, and others. The purpose of the LPI-Observer and LPI-Self tools is to assist with self-evaluation and guide leadership building activities. For the purpose of this study, the LPI-Observer tool was used. It was not the intent of this research to evaluate individual NPs. Additionally, there were ethical and feasibility issues that would have prevented the inclusion of NPs’ and their self evaluation. Since this study was aimed at eliciting staff nurses’ perceptions of the NPs fulfillment of the leadership role, the use of the LPI-Self tool was not necessary.

The LPI-observer tool consists of 30 statements, or items, that address five leadership practices: model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. The 30 items are divided into five subscales which are all weighted equally

and each scored with six items. The actions that make up the five leadership practices are translated into statements that describe the essential leadership behaviours. The mean value of the six behaviours belonging to each subscale reflects the overall performance of each of the five leadership practices, otherwise called subscales. Therefore, each of the five subscales is scored with a group of six items within the 30-item LPI-Observer tool.

Each of the thirty statements is cast on a 10-point Likert-scale. Each likert score is associated with a semantic frequency ranging from “*almost never*” to “*almost always*”. Thus the likert score and associated semantic frequency reflect how often the leadership behaviours are being observed. A higher value represents more frequent use of the leadership behaviour. For example; 1 (Almost never) do what is described in the statement; 2 (Rarely); 3 (Seldom); 4 (Once in a while); 5 (Occasionally); 6 (Sometimes); 7 (Fairly Often); 8 (Usually); 9 (Very Frequently); and, 10 (Almost always) do what is described in the statement (Kouzes & Posner, 2002a). Therefore each item can have a minimum score of 1, and a maximum score of 10; each subscale can have a minimum score of 10 and a maximum score of 60; and the total inventory can have a minimum score 30 and a maximum score of 300.

For each item the respondents of this study considered the frequency of that particular behaviour in the observed NP and then they assigned a value from 1 to 10. The rankings represent interval level data. The scale can be used as both interval and ordinal levels of measure. The scores as a continuous variable are interval level data, from 1 to 10. The items per subscale are calculated as an average subscale score for the corresponding leadership dimension. The semantics associated with each item’s score on that scale are ordinal levels of measure. The corresponding average from the interval data can be interpreted as per the semantics associated with that numeric value.

The LPI-Observer was developed and refined using a triangulation of qualitative and quantitative research methods and studies. The LPI-Observer tool has been administered to over 350,000 managers and non-managers across a variety of organizations, disciplines, and demographic backgrounds (Kouzes & Posner, 2002a). Validation studies have been conducted over a 15-year period, and they consistently confirm the validity and reliability of the Leadership Practice Inventory. The reliability coefficients of the five subscales within the LPI-Observer tool range between 0.88 and 0.92 (Kouzes & Posner). This is considered good since $\alpha = 0.70$ is considered acceptable for most social science studies (Salkind, 2005). These reliability scores remain consistent across industries and disciplines, within public and nonprofit organizations as well as private sector businesses, despite possible individual differences such as culture, ethnicity, and age (Kouzes & Posner, 2002).

Tourangeau and McGilton (2004) identified that Kouzes and Posner's (2003) LPI-Observer and LPI-Self tools have not been tested for reliability and validity within the healthcare sector, and more specifically nursing. Therefore more nursing research using the LPI is required in order to validate the use of this tool within the discipline of nursing. The purpose of Tourangeau and McGilton's (2004) study was to report LPI psychometric properties when the tool was used in an evaluation study investigating the effectiveness of a leadership development intervention administered to a group of aspiring and established nurse leaders. Multiple regression analyses have revealed that LPI scores are unrelated to various demographic characteristics such as age, marital status, years of experience, and educational level, as well as organizational features such as size, functional area, and line versus staff position (Tourangeau & McGilton, 2004). Tourangeau and McGilton's (2004) analyses focused on testing dimensionality, reliability, and construct validity of the LPI. This study established that test-retest reliability for the five leadership practices remains consistent, generally at 0.88 to 0.93

(Tourangeau & McGilton, 2004). Therefore, this study established that the traditional LPI questionnaire remains a reliable and valid tool when used within nursing.

In terms of the validity of the LPI “respondents have found the LPI to have excellent face validity” (Kouzes & Posner, 2002a, p.14). Factor analysis has been used to determine the empirical validity of the LPI. The results from various analyses reveal that the LPI contains five factors consistent with the five subscales of the LPI (Kouzes & Posner). Additionally the LPI is reported to have excellent concurrent validity, and leadership scores are consistently associated with important aspects of managerial and organizational effectiveness such as work-group performance, team cohesiveness, commitment, satisfaction, and credibility (Kouzes & Posner).

Although the LPI received moderate to high psychometric scores, its validity and reliability is unknown within nursing. Only two nursing research studies were found that tested the LPI (Tourangeau et al., 2003; Tourangeau & McGilton, 2004). Both of these studies used the LPI tool with nursing administrators and identified leaders in the field. Neither study tested the LPI-Observer or LPI-Self tools with staff nurses, or advanced practice nurses who practice in the clinical setting. This supports the need for the use of the LPI amongst the population of clinically practicing nurses and advanced practice nurses.

The high reliability coefficients provide reasonable evidence that the tool is a reliable measure of transformational leadership practices. The reliability coefficient was greater than 0.70 in all studies, thereby offering support that the instrument is appropriate. The investigator of this study will offer information about this tool’s reliability and validity with the study sample and target population of staff nurses.

Sample

Target and Accessible Population

The target population of this study is full-time, part-time, and casual registered nurses who are employed in an acute care setting and work regularly (more than 1 day per week) with a NP. The accessible population consisted of registered nurses enrolled in a Master of Nursing and a Post-Diploma Nursing program at a metropolitan university.

Sample Size

The investigator aimed to recruit as many participants as possible, using a purposive convenience sampling method. Since this study is descriptive in nature, inferential statistics will not be used thus a small convenience sample is appropriate. Kouzes and Posner (2002b) stated that the tool's feedback is valid and reliable when used with a group as small as one self-reporter and five observer reporters. Since this study was concerned only with observer reports, a sample size similar to previous research within nursing was used, since these studies obtained results that were valid and reliable.

After the recruitment phase a convenience sample size of 30 registered nurses was used. This sample was obtained from a Master of Nursing student population and Post-Diploma Bachelor of Science of Nursing student population of a metropolitan university.

Sampling

A convenience sample of 30 participants was obtained. This is considered adequate for the purpose descriptive pilot study (Burns & Grove, 2005). Thirty registered nurses participated in this study. Approximately 100-150 individuals were approached. The majority of those approached did not meet the inclusion criteria, most commonly because the individual was not a staff RN. Many of the individuals who were approached to participate did not practice bedside

nursing, thus were not eligible. Those who refused participation stated time constraints as the reason.

Method

Purposive sampling was employed since specific inclusion and exclusion criteria were followed to purposefully select participants.

Inclusion Criteria

Inclusion criteria included:

1. Current employment as an RN by an acute care hospital
2. Work full-time, part-time, or casual (working at least one shift per week).
3. Work in the setting regularly, with an NP in the past year, for at least 1 year.

The rationale for these inclusion criteria was to investigate the views of a participant population who had current experience working with NPs in an acute care environment, and who could offer a fair assessment of the NP's fulfillment of the leadership role. It was important to ensure that all of the participants had a consistent experience with NPs since this would increase the homogeneity of the sample, decrease the opportunity for the interference of extraneous variables, and improve the study's internal validity.

Exclusion Criteria

Exclusion criteria included:

1. Working night shift and/or weekends exclusively (since NPs do not typically work during these hours)
2. Casual nurses who work less than one shift a week
3. Employed by an agency
4. Experience with NP was prior to the past year

5. Experience with NP was less than 1 year
6. Working experience with an NP was other than in a staff nurse role
(i.e. manager, or educator role)
7. Registered practical nurses
8. Internationally educated nursing students in the post diploma program

The rationale for these exclusion criteria was to control for extraneous variables. Establishing criteria was an attempt to prevent participation of those who did not have a current, ongoing experience working and collaborating with a NP. This was important since such individuals could not fairly comment on the NP's leadership role, and their participation would increase error. Additionally, exclusion and inclusion criteria were used as an effort to decrease skewed results and establish as much homogeneity within the sample as possible thereby increasing the internal and external validity.

Setting

The study was conducted at a large metropolitan university.

Data Collection and Sampling Strategies

Upon approval from the University's Research Ethics Board (REB) a convenience sample of 30 staff nurse participants was recruited for the study using the following steps:

1. Faculty members were sent an email from the investigator introducing the study (Appendix D). An information sheet explaining the study in detail was provided (Appendix E) and faculty were asked for permission for the researcher to attend a class at a day and time of their convenience, for 15 minutes prior to, or at the end of class. The investigator requested permission to access Master of Nursing and Post-Diploma RN nursing students from each applicable nursing professor who was instructing classes.

2. Upon receiving permission, the investigator attended the class at the agreed upon day and time. The faculty member left the room, the researcher provided each nursing class with a brief description of the study objectives and an information sheet explaining the research;

3. Students self-identified if they worked in an acute care setting in the capacity of a staff nurse and had at least 1 year of experience, within the past year, working in collaboration with a NP. These individuals were given two consent forms (one copy for the participant, the other for the researcher), one questionnaire (LPI-Observer), and one demographic questionnaire. Students who did not meet inclusion criteria left the room. Those who met the inclusion criteria and provided informed consent completed the survey in the classroom after class. The questionnaires were completed independently by students and returned to the investigator in an envelope marked with the investigator's name.

Each potential participant was afforded the opportunity to learn about the study's aims and process, and ask questions and voice concerns. The researcher discussed the consent form with the potential participants. The discussion included:

1. The purpose of the study;
2. An explanation of the demographic and LPI-Observer tool;
3. An explanation that participation in this study was voluntary and if participants agreed to participate, they would be considered research participants;
4. Expected duration of participation (the length of time it takes to fill out the consent form, demographic sheet and questionnaire);
5. The right of the participant to withdraw at any time without repercussions;
6. Potential risks and benefits to participants;
7. Assurance of anonymity and confidentiality.

Ethics

Informed Consent and Right to Withdraw

Informed consent was obtained from each participant prior to data collection (See Appendix C – Consent Form). The rights of the participants of this study were protected. Individual participants had the right to make free and informed decisions. The researcher informed participants that there was no penalty or recourse of any kind if they refused to take part in the study, or if they decided that they no longer wanted to be a part of the study. The participants also understood that their participation in the study would not affect their status as a student in their respective programs or their grades. Faculty was not aware of students' participation in the study or of their study responses. There was no instance of a participant deciding to withdraw.

Participants' rights to self determination were maintained since all participants were given the opportunity to voluntarily choose to participate in the study, withdraw from the study or not participate at all, with no adverse outcomes. The research study only included adults who had the capacity to give informed consent, and by virtue of the research question, the research did not include vulnerable populations, from the perspective of capacity to consent.

The researcher was a full time student at the academic institution in which the study was completed. However, the researcher had completed all course work as of the spring of 2007. Therefore the researcher had no established relationships or experience with any students who were currently enrolled in the Masters of Nursing courses at the time of study completion.

Potential Risks

There was minimal risk associated with the study. Prior to the commencement of this study the investigator trialed the questionnaire with five individuals who were unfamiliar with the tool. The questionnaire took approximately 5-10 minutes to complete. The investigator communicated this to prospective study participants.

Three committee members were faculty for either or both the Masters and Post Diploma programs. As such there may be a perception of coercion by faculty to participate, and a student concern of penalty either refusing to participate or withdrawal from the study. No faculty or committee members saw the signed participant consent forms. Consents remained with the student investigator. Participants were approached and data were collected without faculty being present.

Potential Benefits

One benefit of this study to staff nurse participants was that they were able to apply their participation in this study to their annual performance appraisal. It could contribute to their leadership competency since it is evidence of the individual acting to “support the development of, and participate in, clinically relevant research” (CNO, 2008, p.15).

Another benefit that was associated with participation in this study was the contribution to increasing nursing knowledge. This may create personal and professional satisfaction. Participation in data collection for this research project may have also supported or reinforced the student’s learning about research. Compensation was not a benefit of participation. Participants of this study did not receive compensation for their participation in the study, as that could have been viewed as coercion.

Privacy and Confidentiality

Participants’ rights to privacy were protected since their demographic data sheets and completed LPI-Observer tools were identified with a unique number, not their name; consent forms were kept separate from the demographic sheets and LPI questionnaires.

The participants’ rights to anonymity and confidentiality were maintained since anonymity existed by virtue of the researcher being unable to link the participant to his or her responses. Confidentiality was maintained since private information shared by the participant

was not shared with faculty or persons other than committee members. All participants had the right to fair treatment, and the researcher and the participants had an agreement about their respective roles. Finally the participants' rights to protection from discomfort and harm were respected since the participants were informed of the research study's process and the time required for completion of the questionnaires. Privacy and confidentiality will be maintained by the investigator by keeping all data in a secured office at the University for 3 years, and then it will be destroyed. Participants were informed of this and ensured that the only individuals who will see the data are those who are directly involved with supervising the research (i.e. thesis supervisor and thesis committee). The data that participants provided via the LPI questionnaire and the demographic sheet were only used for the purpose of this study.

Faculty members were not present during data collection to ensure privacy of student rights to participate or withdraw without faculty awareness. Additionally, anonymity was maintained since the only time the participants recorded their name was at the time of giving informed consent. The researcher kept the consent forms separate from the questionnaires and demographic sheets.

Data Analysis

The data analyzed from this study were the demographic data and LPI-Observer scores. The LPI-Observer results from this study were compared to the Kouzes and Posners' (2002a) normative values. The normative values are the calculation of the mean of all observers' scores from a meta-analysis performed by Kouzes and Posner (2002a). Statistical Package for the Social Sciences (SPSS) version 16 was used to analyze demographic data, to perform psychometric testing of the instrument and conduct descriptive analyses of the LPI based on demographics. Descriptive analyses, specifically frequency distribution, measures of central tendency, and variability were conducted on the demographic data and the LPI observer scores. In order to

perform the percentile data analysis of the LPI-Observer scores the investigator purchased the *Leadership Challenge* (3rd ed.) starter kit which includes the normative values as published by the creators of the tool, Kouzes and Posner (2002a), as well as the appropriate scoring software.

Alpha

The level of significance, or the probability of making a type I error, was set at $p = 0.05$, which is common for nursing studies (Burns & Grove, 2005). The alpha was set at 0.05 instead of a more rigorous significance level (e.g. 0.001) in order to detect statistically significant results (Burns & Grove, 2005).

Psychometric Testing

SPSS version 16 was used in order to perform psychometric testing of the tool. Internal reliability testing of each subscale was performed by calculating the Cronbach's alpha. The validity of the instrument was tested by testing the LPI subscale correlations with a one-tailed Pearson Correlation.

Descriptive Statistics

Demographic Data

The demographic data were analyzed using SPSS served to describe the sample. The demographic variables were the participants' age, gender, level of education, total years of nursing experience, total years of nursing with the NP, and the nursing unit specialty. Gender and level of education were both ordinal level data and were analyzed to determine frequency distribution, percent and range. Total years of nursing experience, total years of nursing with a NP, and age represented ratio level data and were analyzed for measures of central tendency, specifically mean, *SD*, and range.

In order to describe the sample more broadly, responses on the LPI-Observer tool were explored in relation to the demographic variables. Independent-sample t-tests were performed to compare for differences in LPI subscale scores based on gender and level of education type (degree/diploma). Pearson correlations were performed to assess if there was a relationship between the leadership subscales and demographic variables of age, total years of nursing experience, or total years working with the NP.

Leadership Practice Inventory

Using SPSS each participant's questionnaire was individually scored. The mean scores, standard deviations, and ranges were calculated for each subscale. The data from the 30 participants' LPI-Observer tools of this study were entered into the LPI software provided by Kouzes and Posner (2002a). The software then calculated the mean value of each subscale and plotted this mean value against the normative values of each subscale, which resulted in a percentile value ascribed to each of the five leadership behaviours. These values are presented in the results section.

The scoring software provided by Kouzes and Posner (2002a) plots the researcher's data against the normative values, and ranks each mean subscale score as a percentile. The normative data reflect the mean values of each subscale of the LPI-Self and LPI-Observer (manager, direct report, peer, others, and all observers) established from a meta-analysis of published studies that used the LPI-self and LPI-observer. The total sample size used in the analysis was 17,908 (Kouzes & Posner, 2002a). The normative values for each subscale serve as a baseline that is used to compare the LPI-Observer results from the sample. The results are reported as percentiles and occur automatically with the scoring software provided by Kouzes and Posner (2002a). The value of each LPI subscale result is measured in relation to the overall distribution

(normative values), and represents the smallest score that is greater than or equal to that of the overall distribution. For example, the 65th percentile is the score at which 65% of all scores fall below.

As noted, the descriptive statistics of the demographic characteristics of the study sample, and the individual LPI-Observer results. The LPI-Observer results are presented for each subscale of the instrument, and are compared to the normative data and percentiles established by Kouzes and Posner (2002a).

Reliability Testing

Reliability testing was performed by using the instrument's internal consistency by computing Cronbach's Alpha for the total subscale and the inventory (Table 3). The subscale reliability scores ranged from $\alpha = 0.85$ - 0.96 , and the inventory's reliability score was $\alpha = 0.93$. These results demonstrated the total scale and subscales had adequate internal consistency reliability. This is consistent with Kouzes and Posner's (2002a) reliability testing of the psychometric properties of the LPI. The results demonstrated that the tool is adequate for measuring the dimension of transformational leadership as defined by Kouzes and Posner (2002a) with this study's sample.

Table 3:
LPI-Observer Tool Reliability Testing for this Study's Sample

LPI	Cronbach's Alpha (α)
Subscale	
Model	$\alpha = 0.96$
Inspire	$\alpha = 0.95$
Challenge	$\alpha = 0.94$
Enable	$\alpha = 0.85$
Encourage	$\alpha = 0.94$
Inventory	
LPI-Observer	$\alpha = 0.93$

CHAPTER V: RESULTS

The following chapter describes the results of the psychometric testing of the LPI-Observer tool, the descriptive statistics of the demographic characteristics of the study sample, and the statistical analyses of the LPI-Observer results. The LPI –Observer results are presented for each subscale of the inventory, and for the comparisons to the normative data and percentiles established by Kouzes and Posner (2002b).

Psychometric Testing

Reliability testing was performed by testing the instrument's internal consistency by computing Cronbach's Alpha (α) for each subscale and the inventory (Table 1). The subscales' reliability scores ranged from $\alpha = 0.85$ - 0.96 , and the inventory's reliability score was $\alpha = 0.98$. These results demonstrated the total scale and subscales had adequate internal consistency reliability. This is consistent with Kouzes and Posners (2002a) reliability testing of the psychometric properties of the LPI. The results demonstrated that the tool is adequate for measuring the dimension of transformational leadership as defined by Kouzes and Posner (2002a) with this study's sample.

Table 1:
LPI-Observer Tool Reliability Testing for this Study's Sample

LPI	Cronbach's Alpha (α)
<u>Subscale</u>	
Model	$\alpha = 0.85$
Inspire	$\alpha = 0.96$
Challenge	$\alpha = 0.94$
Enable	$\alpha = 0.88$
Encourage	$\alpha = 0.94$
<u>Inventory</u>	
LPI- Observer	$\alpha = 0.98$

The validity of the instrument was tested by testing the LPI subscale correlations. In order to test the LPI subscale correlations, a one-tailed Pearson Correlation was conducted (Table 2). The investigator chose to perform a one-tailed Pearson Correlation test since Kouzes and Posner's (2002a) model of transformational leadership and previous research using this theory as a framework do not support that an inverse relationship amongst leadership subscales exists. The correlation coefficients were moderate to strong ($r = 0.5-0.9$), and were statistically significant. The subscales were all highly correlated (Table 2). These results also provided further evidence that the tool was a valid and reliable measure of transformational leadership, as measured by these five domain subscales.

Table 2:
Pearson Correlation Results for LPI Subscale Correlations (One-tailed)

Subscale	Model the Way	Inspire a Shared Vision	Challenge the Process	Enable others to Act	Encourage the Heart
Model the Way	-	0.94**	0.90**	0.89**	0.79**
Inspire a Shared Vision		-	0.88**	0.80**	0.78**
Challenge the Process			-	0.79**	0.59**
Enable others to Act				-	0.78**
Encourage the Heart					-

Note. Subscale correlations are significant **: $p \leq 0.05$

Demographics

Measures of central tendency were used to report the mean, *SD*, and range of the variables age, years of nursing experience, and number of years working with a NP. Frequency distributions were used to describe and report gender and level of education. The results of the descriptive statistics are presented in Tables 3, 4, and 5. The sample consisted of 5 men and 25 women ($N = 30$). A degree in nursing was the highest level of education achieved by 83% of participants. This represented the participants who were enrolled in the Master of Nursing program. The remaining 17% of participants had achieved a diploma in nursing, and were currently pursuing their degree in nursing. The mean age amongst the participants was 35 years ($SD = 10.85$) (Table 4). This sample had a mean of 11 years ($SD = 10.93$) of nursing experience (range = 44 years, minimum = 1, maximum = 45 years) (Table 4). The mean total years of nursing that participants worked with a nurse practitioner was 5 years, (range = 10, min = 1 year, maximum = 11 years) (Table 4). While participants worked in a variety of institutions, across several different types of units, the most frequent were from acute care pediatrics setting ($n=3$) and cardiovascular surgery units ($n= 3$) (Table 5).

Table 3:

Demographic Characteristics of Sample: Gender and Level of Education

Variable	Frequency	Percent (%)
<u>Gender</u>		
Male	5	16.7
Female	25	83.3
<u>Level of Education:</u>		
Degree	25	83.3
Diploma	5	16.7

Table 4:

Demographic Characteristics of Sample: Age, Total years of Nursing Experience and Total years of Nursing with an NP

Variable	Mean (years)	Standard deviation (SD)	Range	
			Min.	Max.
Age	34.7	10.8	22.0	65.0
Total Years of Nursing experience	11.1	10.9	1.0	11.0
Total Years Nursing with NP	5	3.4	1.0	10.1

Table 5:
Demographic Characteristics of Sample: Current Nursing Practice Setting

Unit Type	Frequency	Percent (%)
Acute Care	10	33.3
Spinal/Neuro Surgery	1	3.3
Gyne	1	3.3
Acute Care Pediatrics	3	10.0
High Risk Pregnancy	1	3.3
CV/Vascular Surgery	1	3.3
Pediatric Acute Care MOT	1	3.3
Labour & Delivery	1	3.3
General Pediatrics	1	3.3
Cardiovascular	1	3.3
Pediatric Acute Care Cardiology	1	3.3
Acute Care: Trauma/Neuro surgery	1	3.3
Post-Operative Care	1	3.3
Acute Care MOT	1	3.3
Cardiovascular Surgery	3	10.0
Surgical	1	3.3
Post-Operative Cardiac	1	3.3

Leadership Practice Inventory

The following section describes the results of the five leadership subscales: model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. The mean scores, standard deviations, and ranges were calculated for each subscale (Table 6). The scores were compared to the normative data, and given a percentile ranking relative to the leadership scores across various industries (Kouzes & Posner, 2002a) (Table 7).

Table 6:
LPI Mean Subscale Scores

Leadership Subscale	Study Score Result: Mean Subscale Total Observer (<i>SD</i>)	Mode of Leadership Behaviour	Total Possible Score	Range	Min.	Max.
Model the Way	$M = 38.63$ ($SD\ 12.07$)	Usually	60	50	6	56
Inspire a Shared Vision	$M = 32.57$ ($SD\ 15.96$)	Seldom	60	53	6	59
Challenge the Process	$M = 35.23$ ($SD\ 14.94$)	Usually	60	53	6	59
Enable others to Act	$M = 42.17$ ($SD\ 11.14$)	Usually	60	47	13	60
Encourage the Heart	$M = 33.27$ ($SD\ 15.27$)	Sometimes	60	52	6	58

Table 7:
Mean Subscale Scores as compared to Normative Values

Leadership Subscale	Study Score Result: Mean Subscale Total Observer(SD)	Percentile	Normative Mean Subscale Total (SD): Observer (all)
Model the Way	$M = 38.63$ (SD 12.07)	10 th -15 th	47.5 (SD 8.5)
Inspire a Shared Vision	$M = 32.57$ (SD 15.96)	10 th	42.0 (SD 10.6)
Challenge the Process	$M = 35.23$ (SD 14.94)	10 th	44.1 (SD 9.1)
Enable others to Act	$M = 42.17$ (SD 11.14)	15 th	47.8 (SD 8.4)
Encourage the Heart	$M = 33.27$ (SD 15.27)	5 th	44.9 (SD 10.2)

Model the Way

For all of the items combined on the subscale model the way, the mean was 38.63 ($SD = 12.07$; which is between the 10th and 15th percentile). At the subscale level, which has a possible range of frequency of scores from 6 to 60, for the semantic categories from “almost never” to “almost always”, staff nurses reported most frequently that NPs performed the behaviours associated with model the way “usually” ($n = 36$). The total scores from the items on this subscale ranged from 6 to 56. At the item level for a possible range of frequency of scores from 1 to 10 for the semantic categories from “almost never” to “almost always”, the NPs were most frequently scored as “usually” with regards to performing the specific behaviour “following through on promises and commitments she makes” ($n = 10$) (Kouzes & Posner, 2003). At the item level, which has a range of frequency of scores from 1 to 10 for the semantic categories from “almost never” to “almost always”, staff nurses most frequently scored NPs as “almost

never” performing the specific behaviour of “ask[ing] for feedback on how her actions affect other peoples’ performance” ($n = 7$) (Kouzes & Posner, 2003).

Inspire a Shared Vision

For all of the items combined on the subscale inspire a shared vision, the mean was 32.57 ($SD = 16.0$; which is within the 10th percentile). At the subscale level, which has a possible range of frequency of scores from 6-60, for the semantic categories from “*almost never*” to “*almost always*”, staff nurses’ most frequently reported that NPs performed leadership behaviours associated with inspire a shared vision “*seldom*” ($n = 27$). The total scores from the items on this subscale ranged from 6 to 59. At the item level, which has a possible range of frequency of scores from 1 to 10 for the semantic categories from “*almost never*” to “*almost always*”, NPs were perceived as “*occasionally*” performing the specific behaviour “paints the ‘big picture’ of what we aspire to accomplish” ($n = 5$), and “*almost never*” performing the act of “show[ing] others how their long-term interests can be realized by enlisting in a common vision” ($n = 5$) (Kouzes & Posner, 2003).

Challenge the Process

For all of the items combined on the subscale challenge the process, the mean was 35.23 ($SD = 14.94$; which is within the 10th percentile). At the subscale level, which has a possible range of frequency of scores from 6-60, for the semantic categories from “*almost never*” to “*almost always*”, staff nurses perceived that NPs most frequently perform the leadership behaviours of challenging the process “*usually*” ($n = 29$). The total scores from the items on this subscale ranged from 6 to 59. At the item level, which has a possible range of frequency of scores from 1 to 10 for the semantic categories from “*almost never*” to “*almost always*”, staff nurses’ measures indicated that NPs “*occasionally*” performs the specific leadership behaviour

“seeks out challenging new opportunities that test her own skills and abilities” ($n = 5$), and “occasionally” performs the behaviour “experiments and takes risks, even when there is a chance of failure” ($n = 5$) (Kouzes & Posner, 2003).

Enable Others to Act

For all of the items combined on the subscale enable others to act, the mean was 42.17 ($SD = 11.14$; which is within the 15th percentile). At the subscale level, which has a possible range of frequency of scores from 6-60, for the semantic categories from “almost never” to “almost always”, NPs were perceived by staff nurses as most frequently performing the leadership behaviours of enable others to act “usually” ($n = 34$). The total scores from the items on this subscale ranged from 13 to 60. At the item level, which has a possible range of frequency of scores from 1 to 10 for the semantic categories from “almost never” to “almost always”, staff nurses’ measures indicated that NPs “almost always” perform the specific leadership behaviours “treats others with respect” ($n = 12$), and “fairly often” performs the specific behaviour “giv[ing] people a great deal of freedom and choice in deciding how to do their work” ($n = 11$) (Kouzes & Posner, 2003).

Encourage the Heart

For all of the items on the subscale encourage the heart, the mean was 33.27 ($SD = 15.27$; which is within the 5th percentile). At the subscale level, which has a possible range of frequency of scores from 6-60, for the semantic categories from “almost never” to “almost always”, staff nurses’ most frequently perceived NPs as performing behaviours associated with the subscale encourage the heart “sometimes” ($n = 29$). The total scores from the items on this subscale ranged from 6 to 58. At the item level, which has a possible range of frequency of scores from 1 to 10 for the semantic categories from “almost never” to “almost always”, staff nurses’ measures

indicated that NPs “*almost always*” perform the specific leadership behaviour “praises people for a job well done” ($n = 5$), and “*almost never*” performs the behaviour “finds ways celebrate accomplishments” least frequently ($n = 5$) (Kouzes & Posner, 2003).

Performance on LPI Subscales according to Demographics

In order to identify trends amongst participants’ scores, the LPI-Observer scores were examined according to the participant sample’s age, gender, and level of education, total years of nursing experience, and total years nursing with a NP. Since gender and education were both nominal level data, independent-sample t-tests were performed using each variable, the mean values of the participant totals, and each subscale total (Table 8). There were no significant differences in means associated with the demographic variables.

The Pearson correlation coefficient was calculated on the interval level data (age, total nursing experience and total years nursing with NP) to examine if any correlations existed between the variables and subscale total, and participant total (Table 9). No significant correlations were identified.

Table 8:

T-test Results of Demographic Variables and LPI subscales

Subscale	Gender	Education
Model the Way	$t = 0.14$ $df = 28$ $p = 0.49$	$t = 0.09$ $df = 28$ $p = 0.63$
Inspire a Shared Vision	$t = 0.24$ $df = 28$ $p = 0.19$	$t = 0.21$ $df = 28$ $p = 0.27$
Challenge the Process	$t = 0.21$ $df = 28$ $p = 0.26$	$t = 0.16$ $df = 28$ $p = 0.39$
Enable others to Act	$t = 0.04$ $df = 28$ $p = 0.82$	$t = 0.01$ $df = 28$ $p = 0.95$
Encourage the Heart	$t = 0.01$ $df = 28$ $p = 0.96$	$t = -0.18$ $df = 28$ $p = 0.93$
LPI Participant Total	$t = 0.13$ $df = 28$ $p = 0.48$	$t = 0.09$ $df = 28$ $p = 0.62$

Table 9:
Pearson Correlation Coefficient Results of Demographic Variables and LPI subscales

Subscale	Age	Total Nursing Experience	Total Nursing Experience with NP
Model the Way	$r = 0.14$ $df = 28$ $p = 0.48$	$r = 0.09$ $df = 28$ $p = 0.62$	$r = 0.18$ $df = 28$ $p = 0.34$
Inspire a Shared Vision	$r = 0.24$ $df = 28$ $p = 0.19$	$r = 0.21$ $df = 28$ $p = 0.27$	$r = 0.23$ $df = 28$ $p = 0.34$
Challenge the Process	$r = 0.21$ $df = 28$ $p = 0.26$	$r = 0.16$ $df = 28$ $p = 0.39$	$r = 0.22$ $df = 28$ $p = 0.26$
Enable others to Act	$r = 0.04$ $df = 28$ $p = 0.82$	$r = 0.01$ $df = 28$ $p = 0.95$	$r = 0.03$ $df = 28$ $p = 0.86$
Encourage the Heart	$r = 0.01$ $df = 28$ $p = 0.96$	$r = -0.02$ $df = 28$ $p = 0.93$	$r = -0.12$ $df = 28$ $p = 0.57$

It is important to note that because the sample size was small ($N = 30$) and a power analysis was not conducted, there was a risk of a type II error occurring. The sample size may have been too small to detect statistically significant differences. However, if the sample was larger perhaps meaningful differences may have been identified.

Summary

The psychometric properties of the LPI-Observer tool were tested. The tool was found to be reliable since the internal reliability was found to be $\alpha = 0.85-0.96$. The instrument's validity

was tested by testing the correlation of the subscales with each other, and these were found to range from $r = 0.59-0.94$, which means that the subscales share a moderate to very strong relationship with each other. This is consistent with the results of Kouzes and Posner (2002a).

The demographics of this study's sample were tested and found to be relatively homogeneous in terms of level of education and gender. However, there was a great range observed with regards to this sample's years of nursing experience, years working with a NP. The sample was quite heterogeneous in terms of the acute care setting in which each individual reported working.

The LPI results from this study demonstrated that staff nurses perceive NPs as performing transformational leadership behaviours across the five subscales ranging from "sometimes" to "usually". The leadership behaviours associated with *enabling others to act* yielded the highest mean, and *encouraging others to act* yielded the lowest mean. Overall, NP's scored below the 20th percentile, which is considered low, in terms of transformational leadership practices. This means that 80% of all LPI-Observer scores are above the 20th percentile, and only 20% of all the LPI-Observer scores fall below the 20th percentile.

The results from the LPI-Observer tool when compared to the demographic characteristics of this study's sample yielded non-significant results. There was no correlation between total years of nursing experience, total years of nursing with an NP, and age with the LPI subscales. Gender and level of education were also found to have no correlation with the LPI study results. Therefore, no significant differences were observed between the sample's demographic characteristics and the NPs perceived leadership.

CHAPTER VI: DISCUSSION

The purpose of this study was to explore staff nurses' perceptions of the NP leadership role within the context of Kouzes and Posners' (2002a) model of transformational leadership, and measured by the LPI-Observer tool. The convenience sample used was small, and may not be representative of the greater nursing population. This study was descriptive in nature and the results yielded are not generalizable.

The LPI-Observer tool was intended for analysis at the subscale level. The LPI-Observer was found to be a reliable tool in this study (Cronbach's alpha 0.85-0.98). This is consistent with the findings of McNeese-Smith (1996), Tourangeau et al. (2003), Tourangeau and McGilton (2004), and Taylor (1996) who used the LPI with nurses and reported the Cronbach's alpha at 0.79-0.95. Although these studies used the tool with nurses, Tourangeau et al. (2003) and Tourangeau and McGilton (2004) used the tool with aspiring and established nurse leaders, not frontline nurses. McNeese-Smith (1996) measured the impact of nurse managers' transformational leadership behaviours on the job satisfaction and organizational commitment of staff nurses. They found that nurse managers' yielded the highest mean score for *enabling others to act* and the lowest mean score for *inspiring a shared vision*. Like McNeese-Smith (1996) Taylor (1996) used the LPI with frontline staff nurses, and measured perceived leadership behaviours of the nurse manager. Taylor (1996) reported that staff nurses scored nurse managers on behaviours associated with the leadership practice *enable others to act* with the highest mean ($M = 21.98$), and on behaviours associated with *inspire a shared vision* with the lowest mean ($M = 20.41$). The findings of McNeese-Smith (1996) and Taylor (1996) are consistent with the findings of this study. The nurse leaders who were assessed with the LPI were found to perform highest at *enabling others to act* and lowest at *inspiring a shared vision*. This differs from the

findings of Tourangeau et al. (2003) who reported that established nurse leaders found that aspiring nurse leaders scored highest on behaviours associated with *inspire a shared vision* ($M = 41.8$), and lowest on behaviours associated with *model the way* ($M = 34.8$). Established nurse leaders were found to score consistently higher than aspiring nurse leaders (Tourangeau et al., 2003). This study found that, overall participants perceived NPs as performing transformational leadership practice below the 20th percentile. This was less than the normative values reported by Kouzes and Posner (2002a), which means that staff nurses in this study perceive that NPs practice transformational leadership practices less frequently than the average leader across business sectors and various industries. However, the results of this study are greater than the mean subscale values reported by Taylor (1996) (20.41-21.67, SD 5.66-6.98), which supports that staff nurses in this study perceived NPs to practice transformational leadership behaviours slightly more frequently than nurse managers evaluated by Taylor (1996). Placed within this context, the leadership practices of the NP are not vastly different from the leadership practices measured amongst leaders across varying business sectors, and are comparable to those practices of the nurse manager (McNeese-Smith, 1996; Taylor, 1996). However, the results yielded from this study do highlight that NPs score lower on leadership behaviours compared to leaders in the business sector, and even executive nurse leaders whose mean subscale scores ranged from 50.76-51.91 (SD 4.65-8.07) across the five LPI subscales (Tourangeau et al., 2003).

NPs were perceived by staff nurses to perform leadership behaviours consistent with Model the Way “usually”, scoring between the 10th and 15th percentile; Inspire a Shared Vision “seldom”, scoring in the 10th percentile; Challenge the Process “usually”, scoring within the 10th percentile; Enable Others to Act “usually”, scoring within the 15th percentile; and Encourage the Heart “sometimes”, scoring in the 5th percentile. It was observed that the highest mean was

associated with the subscale enabling others to act ($M = 42.17$). The subscale *enabling others to act* was found to have the highest mean by Tourangeau et al. (2003) and Taylor (1996) who reported that aspiring nurse leaders and the nurse manager performed behaviours associated with enabling others to act more frequently than leadership behaviours associated with the other subscales. In descending order of frequency of behaviours, staff nurses perceived NPs as performing leadership behaviours consistent with model the way, challenge the process, encourage the heart and inspire a shared vision. Taylor's (1996) findings of most to least frequent behaviours are consistent with this study's findings: *enabling others to act*, *model the way*, and *encourage the heart*. Tourangeau et al. (2003) found that aspiring nurse leaders scored, from most to least frequent: *enable others to act*, *model the way*, and *inspire a shared vision*. Established nurse leaders scored in descending order of frequency: *model the way*, *encourage the heart*, and *inspire a shared vision* (Tourangeau et al., 2003). These findings suggest that although NPs are perceived by staff nurses to perform transformational leadership behaviours across the five subscales, NPs like other nurse leaders were found to perform similarly with respect to the practice of transformational leadership behaviours. Although NPs scored below the 20th percentile, when considered with the other nursing studies that used the LPI to evaluate nursing leaders, NPs performed similarly to other nursing leaders (Taylor, 1996). This could mean that although NPs are not positioned in a formal leadership role, such as a nurse manager or executive, they are still perceived by their nurse colleagues to act as leaders.

The subscale Enabling Others to Act is associated with collaboration, team work, building trust, and creating a climate where people feel involved and important, thereby strengthening others and eventually helping followers to become leaders themselves (Kouzes & Posner, 2002b). It is interesting to observe that across different facets of nursing, nurse leaders

consistently performed better at Enabling Others to Act (Taylor, 1996; Tourangeau et al., 2003). Perhaps the reason that nurse leaders perform best at enabling others to act is because effective patient care is achieved through a collaborative effort, thus team work is integral to the practice of nursing.

In this study it was found that staff nurses perceived NPs' to perform behaviours associated with inspire a shared vision least frequently. To inspiring a shared vision means that the transformational leader imagines and articulates an exciting, and attractive future for their organization and its constituents (Kouzes and Posner, 2002b). The results of this study suggests that staff nurses do not perceive NPs as performing behaviours associated with *inspiring a shared vision* frequently. Although NPs may not exude behaviours as articulated by Kouzes and Posner (2003) that are characteristics of inspiring a shared vision, one should not draw the conclusion that NPs do not inspire change and goal attainment. Perhaps they do perform behaviours that are associated with inspiring a shared vision, but these practices may not be captured by the LPI-Observer. The NP, unlike the leader in the business sector, focuses on their client's attainment of health and well-being. For the NP, inspiring a shared vision may mean "contributing to and advocating for an organizational culture that supports professional growth, continuous learning and collaborative practice" (CNA, 2008, p. 25). Similarly, behaviours associated with the other subscales may not be adequately captured by the LPI-Observer tool since the role of the NP differs so greatly from the role of a leader in the business sector. For example, a goal that an NP and nursing colleagues may be working towards could be assisting a long term client to achieve independent living in the community. To achieve such a goal, a vision for the future must be shared, it could also mean that innovative and creative problem solving is used to overcome system challenges that obscure the attainment of the overall goal; and of

course that the group working towards the goal feel motivated to contribute to the achievement of the goal. Therefore, although the LPI-Observer tool may not capture the elements of transformational leadership with respect to the NP role, that is not to say that these elements of leadership do not exist, but perhaps they are not reflected in the statements of the LPI since the role of the NP is so different than that of a leader in the business sector. Whereas in the business sector the achievement of a long-term goal may be tangible, for example money, the achievement of a long-term goal of an NP and his/her nursing colleagues may be ensuring the psycho-social well-being of a client.

Although the literature supports that transformational leadership behaviours are positively correlated with nurse job satisfaction, this has only been examined amongst nurse managers and staff nurses (Taylor, 1996). The role of the nurse manager and NP are fundamentally different. There were no studies that used the LPI to measure leadership at the clinical level. This pilot study is the first of its kind, and its results highlight an important distinction that must be made between nurse managers and NPs. In an attempt to account for such differences and explain staff nurses' perceptions of NPs' leadership role the researcher looks toward the theory of Congruent Leadership (Stanley, 2008) to provide some insight.

The underlying assumption of this study was that NPs have the education, knowledge and expertise to provide frontline nursing staff with transformational leadership, which would in effect compensate for the decreased availability of the nurse manager at the frontline. Although the results of this study suggest that NPs are not perceived as performing all of the behaviours consistent with transformational leadership as measured by the LPI-Observer, the researcher believes that perhaps staff nurses do in fact perceive NPs as leaders, but it is possible that they do not conceptualize leadership in the same manner that leadership is conceptualized and

operationalized by Kouzes and Posners' (2002a) model of transformational leadership. Thus the leadership practices of the NP are not adequately captured by the LPI questionnaire.

This study focused on the use of Kouzes and Posner (2002b) model of transformational leadership as a foundation for supporting frontline nurses through charismatic and visionary leadership. Transformational leadership is strongly connected to meeting the needs of followers through a process of interaction that increases motivation, thereby creating a process of changing and transforming others. These changes contribute to the attainment of shared goals. Stanley (2008) suggests that frontline nursing leadership is not conceptualized or operationalized in a manner that is congruent with transformational leadership theory. He proposes the middle range theory of congruent leadership theory, which is focused on clinical leadership. The term clinical leadership and clinical leader is used to reflect the leadership provided by the nurse at the level of patient care, as opposed to nursing leadership that is provided at the administrative level of nursing. Stanley (2008) provides an alternative perspective with regard to frontline nursing leadership, and he proposes that congruent leadership theory helps nurses understand and develop clinical leadership practices. Stanley (2008) believes that conventional leadership theories may not offer a conceptual framework that enables the recognition of the unique qualities and attributes of clinical leadership. He suggests that transformational leadership may be a limited model since it was developed in a business paradigm, unlike congruent leadership theory that was developed within a nursing paradigm. Transformational leadership has been cited as a theory that supports nurses' leadership development and overall goal attainment (Murphy, 2005). Kouzes and Posner's (2002b) model of transformational leadership has been used widely in research that is focused within the business sector, not healthcare or within nursing, and not at the clinical level of nursing.

Stanley (2006) investigated the attributes and characteristics of clinical leadership and found that the characteristics cited as foundational to the transformational leader are not the characteristics that are identified by nurses as being central to a clinical leader. This provides a rationale for the LPI-Observer scores in this study falling below the 20th percentile. It also lends support to the possibility that Kouzes and Posners' (2002a) model of transformational leadership may not be contextually suited to front line nursing in their relationships with the NP. Perhaps frontline nurses do not expect transformational leadership from the NP, therefore do not look for it or recognize it.

According to Stanley (2006) clinical leaders were recognized and valued because they remained "hands-on" and, when faced with a crisis or challenge, their actions were directed and grounded in their values and beliefs. Some parallels can be drawn to Kouzes and Posners' (2002a) model of transformational Leadership. However, a major difference between the clinical leader and the transformational leader is that the clinical leader is seen as doing whereas the transformational leader is seen as creating.

Some of the attributes that are central to the concept of the clinical leader and the theory of congruent leadership are similar to those described in Kouzes and Posners' (2002a) model of transformational leadership. For example, clinical leaders were recognized, in part, because they display behaviours that are valued by their colleagues and act as a positive role model. This is reflective of the transformational leadership behaviour model the way. Nurses from Stanley's' (2008) study stated that their clinical leader was credible because they were hands-on and still identified with frontline nursing staff. This was reflected in the findings from this study in that staff nurses reported that NPs acted as role models "*usually*".

Another parallel that can be drawn between the two theories is that they both value teamwork. Teamwork is central to nursing, and important in the clinical leader. Likewise, the transformational practice of enabling others to act is based on team work. Participants in the current study rated NPs as performing behaviours associated with the subscale *enabling others to act* most frequently, albeit below the 20th percentile. These behaviours were consistent across nursing studies evaluating different nurse leaders (Tourangeau et al. 2003; Taylor, 1996). Perhaps leadership behaviours associated with *enabling others to act* are fundamental to nursing, since all nurse leaders performed well at supporting others, collaborating, and strengthening leadership qualities in others. This is congruent with Stanley's (2008) theory of clinical leadership. Clinical leaders perform well at building relationships and strengthening leadership qualities on others.

According to Stanley (2008) followers are influenced by the leaders' actions, not vision. Because vision is a foundation of transformational leadership, this could explain why NPs leadership behaviours are perceived as occurring at a low percentile by their staff nurse colleagues. It does not mean that NPs are not perceived as leaders. It could mean that this study defined and measured leadership in a manner that was not congruent with staff nurse values and beliefs about what they expect from NPs.

The results obtained from this study could also reflect that perhaps staff nurses do not perceive NPs as leaders in terms of the behaviours listed in the LPI-Observer tool. Hoffman et al. (2004) stated that staff nurses perceive the NP as fulfilling a role focused on the medical management of patients, and associate the role as being aligned with medicine more so than nursing. This could be a result of the NP role implementation. In fact, in another study NPs themselves did not acknowledge leadership and mentorship as an element of their role. Their

focus was also placed upon the medical management of patients (Carver, 1998). The CNA (2008) clearly defined leadership as a role competency that the NP is responsible for fulfilling. The APN, including the NP, fulfills the leadership role by advocating for clients' needs, identifying learning needs of nursing staff, and mentoring and coaching nurses to meet these needs, and developing strategies with the organization to overcome system issues. The LPI-Observer tool does not list behaviours such as these which perhaps affected what leadership behaviours staff nurses recognized NPs as performing. Although leadership is a part of the NP role, in this study it appears that this competency is not highly recognized by staff nurses. The results of the current study identifies that staff nurses recognize elements of transformational leadership in the behaviours of the NPs with whom they work, but the results also highlight the vast range in their perceptions.

Perhaps the manner in which the NP role has been implemented has affected staff nurses' expectations of the NP. When the NP role was implemented within the acute care sector, it was used to bridge a service gap. Thus, the manner in which the system itself has driven this role may not have placed (transformational) leadership practices as a priority. The study undertaken by Tourangeau et al. (2003) described a leadership intervention that was created to help aspiring nurse leaders understand what leadership theory is, and how it translates into practice. Although NPs are expected to act as leaders and mentors, they may not be mentored or coached to fit into the leadership role themselves.

Summary

The results from this study are encouraging since they highlight that NPs are perceived by their nurse colleagues as leaders, as defined by Kouzes and Posners' (2002a) model of Transformational Leadership. NPs' were perceived to perform leadership behaviours associated with *enabling others to act* most frequently. NPs' were considered to perform best at fostering teamwork, and trust while empowering members of their team. NPs were found to *model the way* usually, specifically scoring the highest on the following through with her commitments (Kouzes & Posner, 2003). This helps to affirm shared values and cultivate a trusting environment. Staff nurses observed NPs to perform behaviours associated with *challenging the process* usually. NPs were found to seek out challenging opportunities that promoted professional growth. NPs were perceived by their nurse colleagues as performing similarly with respect to *inspire a shared vision* and *encourage the heart*. Although NPs scored the lowest with respect to these two subscales, they were found to be able to paint the big picture, which provided inspiration and motivation. With respect to *encouraging the heart* NPs praised their colleagues for a job well done most frequently, however they could improve on celebrating individual accomplishments. Although NPs were perceived as performing behaviours that were inspirational and motivational, they did not frequently recognize others contributions or celebrate values and victories.

The findings of this study can be viewed from different perspectives. One suggests that NPs did not achieve high scores on the LPI because they do not exhibit transformational leadership behaviours consistently, or as described by Kouzes and Posner (2003) in the LPI-Observer tool. Another possible explanation is that NPs do not demonstrate behaviours consistent with transformational leadership because perhaps the leadership they do demonstrate is consistent with congruent leadership. This explanation supports the use of congruent

leadership at nursing's frontline because it addresses the expectations of the front line nursing team. This explanation discounts the value of transformational leadership with respect to clinical nursing leadership, yet there are many parallels that can be drawn between the two theories. Another perspective takes the implementation of the NP role into consideration. Perhaps NPs are not perceived as leaders because they have not developed this aspect of their role and require additional education and support to do so.

CHAPTER VII: LIMITATIONS, IMPLICATIONS, AND CONCLUSION

Limitations

Although this study drew on a small convenience sample, it was most appropriate for a pilot study. Since this study was descriptive in nature, the aim was not to attain generalizable results, but to explore how staff nurses perceive NPs' leadership practices within the context of Kouzes and Posners' (2002a) model of transformational leadership, and to test the LPI-Observer tool with this particular population, which previously had not been done. The setting of the study was a large metropolitan university, and the participants were employed at metropolitan teaching hospitals. This added to the heterogeneity of the sample with regards to the range of the nursing practice settings, age, and years of nursing experience, which was in fact a benefit since the greater nursing population is quite heterogeneous. However, there were some important differences between the sample used and the greater nursing population that affect the external validity of the study findings: the average age of Ontario's nursing population is 46.1 years (CNO, 2007) and the mean age of the participants was lower (34.7). It was also observed that the level of education of participants was not representative of nurses in Ontario since 83% of the participants had achieved a degree in nursing and in the target population the proportion of nurses who have achieved a Baccalaureate degree is lower (33.09%) (CNA, 2008). Additionally, because participants came from various practice settings, this made the sample less homogeneous. Participants may have varying perceptions of leadership because their experiences vary due to differing philosophies that underpin the care and leadership principles at these various hospitals. For example, individuals that are guided by a model of transactional leadership may have a very different interpretation of what leadership practices are, as compared to individuals who employ transformational leadership as a guiding framework. Inclusion and

exclusion criteria were used to create the most homogeneous sample possible with respect to level of education, exposure to working with an NP, and practice area (i.e. acute care setting). That is why individuals such as nurse educators and managers did not qualify to participate – their experience working with NPs is different than the experience of a staff nurse because the nature of the working relationship is different. Staff nurses who did not work on their respective units for at least a year did not qualify to participate because these individuals may not be able to fairly evaluate the NP since their work experience with them is limited. Agency nurses and nurses working less than one shift a week were excluded for the same reason.

The participant RNs' personal feelings toward the NPs with whom they work may affect how they evaluate the NPs' leadership performance, thus contributing to bias. For example, an individual who has a very positive experience with a NP may rate that NP very high on the LPI, whereas another individual may have a different experience with that NP, and would have rated him/her lower. In addition, the participants may also be more aware of leadership practices than those nurses who are diploma prepared since those participants in the MN program are exposed to leadership theories and leadership practices as they relate to advanced nursing practice. This may have affected how they interpreted the practices of the NPs who they were evaluating. The researcher could not control for this. However, had the sample size been larger, this factor would be less important because there would be a greater range of responses.

Another limitation of the study was its small convenience sample size. Participants were recruited based on availability and accessibility. These participants were all enrolled in education programs and have been exposed to leadership theory and education. This may shape the manner in which they perceive the behaviours of the NP. A random sampling strategy would have made

this limitation less important. The findings of this study have implications for nursing practice, research and education.

Implications for Nursing Practice

The results of this study demonstrated that staff nurses perceive NPs to perform leadership practices associated with enabling others to act most frequently. In light of current challenges affecting nursing units, such as budget constraints, and increasing patient acuity (Hay, 2004; Wong, 2004), building on the leadership practice enabling others to act, could help to facilitate team work, and build trust amongst NPs and staff nurses, and improve or sustain morale amongst staff. This is important since a trusting climate, and mutual respect builds the foundation for creating change and strengthening others, while helping to keep team members connected with one and other (Kouzes & Posner, 2003).

Within nursing practice changes may need to occur regarding the implementation of the NP role. Although initially implemented to bridge a service gap in the acute care sector, the potential for the NP to affect nursing practice extends far beyond that. Perhaps specific guidelines for acting as clinical leader could be built in to NP job descriptions, or time should be allowed for peer-peer mentorship to occur. The Tourangeau et al. (2003) study is an example of how leadership mentorship in nursing practice can support the development of leadership practices.

The results of this study also demonstrated that compared to normative values, NPs performed behaviours related to *encouraging the heart* least frequently amongst the leadership practices. This highlights the need for nurses in leadership positions, such as the NP, to recognize others' contributions and accomplishments, and to celebrate these victories. This is important because these genuine acts of caring boost morale and draw team members together and facilitate a collective push forward to achieve goals (Kouzes & Posner, 2003).

Another perception of staff nurses from this study was that NPs do not frequently fulfill behaviours associated with *inspiring a shared vision*. NPs are in a unique position to offer inspiration and create a motivational working environment. Perhaps this can be fulfilled by the NP by identifying shared goals with staff, and articulating these goals in a manner that creates a feeling amongst team members of shared values. This is important because when people believe that leaders understand their needs and have their interests at heart, shared values become visions that create inspiration and motivation (Kouzes & Posner, 2003).

Implications for Nursing Research

Past nursing leadership research demonstrates an association between transformational leadership and decreased nurse burnout, increased nursing team cohesion, and better patient outcomes (Hay, 2004). However, Hay's (2004) research was focused on leadership stemming from the nurse manager. Current research suggests that frontline nurses perceive clinical leadership as differing from transformational leadership. In order to understand the leadership potential of the NP, future research needs to focus on leadership that stems from the NP.

Although this study suggests that nurse practitioners in the acute care setting are perceived by staff nurses as fulfilling a leadership role at the 20th percentile, the tool that was used is based on Kouzes and Posners' (2002b) model of transformational leadership. This highlights another area for research – to better understand how staff nurses recognize and understand leadership. Perhaps staff nurses' definition of leadership differs from the definition of leadership provided by Kouzes and Posners' (2002b) model of transformational leadership. Future research could explore how the role of the NP is perceived by staff nurses in terms of leadership, and how this role may be optimally utilized.

Based upon the clinical expertise, educational preparation, and guiding principles of practice of the nurse practitioner in the acute care setting, NP's seem to be a logical and complementary source of leadership. NPs' can help to guide clinical nursing practice, and achieve goals that are important to the nursing team, and their presence on the unit can become a source of motivation and inspiration which could facilitate the function of the nursing team as a cohesive unit. First, a better grasp on the concept of what leadership means to the staff nurse and NP is needed. A qualitative study that explores how NPs in the acute care environment conceptualize leadership and how they enact leadership is needed.

Implications for Nursing Education

The NP is expected to uphold a set of key competencies in practice. One competency is that of leadership. A review of academic curricular is recommended to evaluate the leadership content included. It may be advantageous to ensure there is an emphasis placed on the implementation of leadership theory in practice graduate and NP programs. At the masters' level of education the understanding of leadership theory is facilitated, however students could benefit from learning how to actualize leadership theory by learning how to specifically integrate leadership into their own practice. One way that this may be achieved is by having students translate leadership theory into practice goals in their own specific learning plans. In the same manner, NPs could benefit by defining their leadership competency in terms of actual practice goals. This may help to prepare them to not only understand the theory of leadership, but also understand how to practice leadership. This could support NPs in their role, and it could further prepare them to understand the importance of recognizing the values and beliefs of frontline nurses, in order to facilitate the development of positive relationships that support the growth and development of clinical leadership. Another opportunity for developing transformational

leadership practices amongst NPs could be the use of a leadership workshop intervention, such as the one described by Tourangeau et al. (2003). The outcome from the leadership intervention described by Tourangeau et al. (2003) was that aspiring nurse leaders were evaluated as developing leadership practices that were greater than what they practiced prior to the intervention. If NPs are to fulfill a leadership role, further effort should be placed upon supporting them in developing this aspect of their role.

Conclusion

This study postulated that the NP was in the optimal position to provide frontline nursing staff leadership using Kouzes and Posners' (2002b) model of transformational leadership. However, upon investigating staff nurses' perceptions of the NP transformational leadership role within the acute care setting it was found that the NP is strongest at enabling others to act. Taking the normative values into consideration there is room for NPs to develop leadership behaviours with respect to each leadership subscale. The results must be interpreted with caution due to the small sample size, lack of homogeneity, and lack of control over extraneous variables. Although this study was small and the findings are limited, it represents the first study that attempted to explore the staff nurse's perception of the NP's transformational leadership role. This study's findings point to the need to better understand how the staff nurse perceives NP leadership in the acute care setting. Understanding the concept of leadership is important to nursing in order to contend with the various challenges in today's health care environment. Fostering leadership is an important strategy for creating a workplace culture that supports continuing nursing professional growth and satisfaction while enhancing their leadership potential. Leadership remains an asset within nursing, especially at the frontline, where patient safety and outcomes, as well as nurse job satisfaction can be affected. The nurse manager's span

of control will likely remain broad, and demands upon staff nurses will likely increase. Having a leader such as the NP at the clinical level available for frontline nursing staff would be most beneficial.

Leadership Practices

1. *Model the way* means setting high standards and providing an example from which others can follow. Modeling the way consists of a person's actions or behaviours that are imitated and recognized as valued. Kouzes and Posner (1987) operationalized the definition to mirror the requirements of an individual to set a good example for others, which allows others to relate to the organization's vision. This leads not only to the support the leader's vision, but also to congruence between the leader's vision and that of the followers'. Modeling the way is measured with questions 4, 9, 14, 19, 24, and 29 of the Leadership Practice Inventory. (McKey, 2002, p. 17; Kouzes & Posner, 2002, 3rd ed.).
2. *Inspire a shared vision* means helping others to share the mission and goals of the organization. It is a process that occurs when the leader influences followers to embrace a common goal. Kouzes and Posner (2002) operationalize the definition to reflect the role of the leader that includes sharing a bond with followers. This creates a sought after and desirable future for the organization. Inspire a shared vision is measured by the LPI with questions 2, 7, 12, 17, 22, and 27. (McKey, 2002, p.16; Kouzes & Posner 2002; Kouzes & Posner 1987).
3. *Challenging the process* means taking risks, experimenting and questioning the status quo. It is a course of activities that presents followers with opportunities to achieve a result. This fosters a sense of ambition and motivation amongst followers. Kouzes and Posner's (2002) operational definition refers to leaders who are willing to be innovative, to experiment, to take risks, and to encourage their followers to do the same as a means of achieving organizational goals. The LPI measures this variable with questions 1, 6, 11, 16, 21, and 26. (McKey 2002, p.13; Kouzes & Posner, 2002; Kouzes & Posner, 1987).
4. *Enabling others to act* encourages team work and empowers others to feel strong and capable. Leaders enable others to act by fostering collaboration, strengthening others, and create a climate of trust and confidence. It creates an environment that empowers followers and makes it possible for them to achieve a goal. Enabling others to act is measured by the LPI with questions 3, 8, 13, 18, 23, and 28. (McKey, 2002, p.15; Kouzes & Posner, 2002, Kouzes & Posner, 1987).
5. *Encouraging the heart* supports followers by praising and celebrating individual and group accomplishments. It is a process of increasing the hope and confidence of others so they can have the courage to achieve their goals. The LPI measures this variable with questions 5, 10, 15, 20, 25, and 30.
(Kouzes & Posner 2002, p.1-7; Kouzes & Posner 1987; McKey,

DEMOGRAPHIC QUESTIONNAIRE

Staff Nurse Perception of the Leadership role of the ACNP

Dear Participant,

The following is an anonymous and confidential questionnaire. In order to describe this study population, the investigator would like to collect some personal information from you.

This information will be collected from all participants. The information collected will be used to describe the group of nurses participating in the study. Please do NOT include your name or student number.

1. What is your AGE? _____
2. What is your GENDER? _____
3. What is the highest LEVEL OF EDUCATION you have received (e.g. diploma, degree)?

4. What is your total number of YEARS OF NURSING EXPERIENCE
(As an RN)? _____
5. What is your total number of YEARS OF EXPERIENCE
working with an ACNP? _____
6. How recently have you worked with an ACNP? _____
7. How many years have you worked on THIS UNIT? _____
8. What type of unit do you work on (acute care setting)? _____

The Staff Nurse Perception of the ACNP Leadership Role

CONSENT:

I acknowledge that the research study described above has been explained to me, and all questions that I have asked have been answered to my satisfaction.

I have been advised of my right not to participate and the right to withdraw at any time without compromising my role at my place of employment or status as a student.

The potential risks have been explained to me and I understand the benefits if any, of participating in the research study.

I understand that I may ask now, or in the future and questions I may have about the study or the research procedures.

I have been assured that my right to confidentiality, privacy and anonymity will be respected.

I have been given sufficient time to read and understand the above information.

I hereby consent to participate, and a copy will be given to me of this consent form.

Date:

Research Participant:

(Print)

(Sign):

Witness (to signature and consent process):

(Print):

(Sign):

(Investigator's copy of participant consent)

I hereby consent to participate, and a copy will be given to me of this consent form.

Date:

Research Participant:

(Print)

(Sign):

Witness (to signature and consent process):

(Print):

(Sign):

Dear Faculty Member,

My name is Shamila Ali. I am a full time Masters of Nursing Student at Ryerson University, and I am currently working toward the completion of my thesis.

The title of my study is 'The Staff Nurse Perception of the ACNP Leadership Role'. I am recruiting 60 participants from Ryerson's Masters of Nursing program and Ryerson's Post-Diploma program.

I will be asking the participants who meet the inclusion criteria to complete one Leadership Practice Inventory (Observer), and one demographic questionnaire.

The time it will take to introduce the research topic, distribute the questionnaires and collect completed questionnaires (and consent) should not exceed 15 minutes.

I am asking your permission to attend one of your classes, either during the first 15 minutes or the last 15 minutes of class in order to recruit participants from your class.

For your convenience I have attached a copy of the information package.

If you have any questions or concerns please contact me directly at (647)343-5242.

My email address is: s8ali@ryerson.ca

Or, if you prefer you may contact my Thesis Supervisor
Elaine Santa Mina at (416)979-8993 Extension 4559
Email: esantami@ryerson.ca

Thank-you for your time and consideration.

Sincerely,

Shamila Ali RN, BScN, MN(c)

Letter Head

Contact Information

The Staff Nurse Perception of the ACNP Leadership Role

My name is Shamila Ali and I am a student in the Masters of Nursing Program at Ryerson University School of Nursing. My thesis supervisor is Elaine Santa Mina.

I am conducting a research study on staff nurses perceptions of the ACNP leadership role. You have been invited to participate in this study because you are a Registered Nurse who has worked directly with an ACNP(s) in the same clinical setting for at least one year.

Before agreeing to participate in this research study, it is important that you read and understand this research consent form in order to make an informed choice to participate in the following study.

The following forms provide all the information pertinent to this study. If you have any questions after you read this form, I will be present to address any questions or concerns.

DESCRIPTION OF RESEARCH

Investigators:

Shamila Ali R.N., BScN, MN (candidate)
Masters of Nursing Student, Faculty of Nursing, Ryerson University;
Staff Nurse, Inpatient Cardiovascular Surgery Unit, Toronto General Hospital
Telephone: Monday to Friday 8 AM to 4 PM, (416)888-8575

Supervisor: Elaine Santa Mina R.N., B.A., B.A.A.N., M.Sc., Ph.D.
Professor, Faculty of Nursing, Ryerson University

Participant Information Sheet

Name of Study: The Staff Nurse Perception of the ACNP Leadership Role

PURPOSE OF RESEARCH STUDY

Since the restructuring of our health care system the role of the Nurse Manager has changed. Nurse Managers have increased administrative responsibilities. Their role is no longer exclusive to their nursing unit but has extended to a broader nursing and organizational leadership role.

During this time of reorganization ACNPs have become an important role on many nursing units extending beyond patient care. One such role is acting as a leader.

Past research concerning nursing leadership has typically focused on the role of the Nurse Manager. Evidence from such research highlighted that a certain leadership style exhibited by the nurse manager shares a relationship with greater nurse job satisfaction, less staff nurse turnover and improved quality of patient care.

There has been no research exploring the potential leadership role of the acute care nurse practitioner. This is an important gap within this body of nursing knowledge since ACNPs could potentially be perceived by staff nurses as nursing leaders. Thus, strong nursing leadership provided by the ACNP could potentially yield outcomes similar to that of strong nurse managers.

This research is interested in beginning to understand staff nurses perception of ACNPs leadership role.

DESCRIPTION OF RESEARCH

This study is concerned with identifying staff nurses perception of the ACNP leadership role. The tool that will be used is Kouzes and Posner's Leadership Practice Inventory (Observer). This tool has been deemed a reliable and valid tool in past research assessing leadership characteristics.

IF YOU ARE A REGISTERED NURSE:

You will be asked to think of an ACNP you have worked the closest with (i.e. you have the most experience working with) over the last year. You are NOT to identify this practitioner or yourself in ANY way. With the practitioner in mind you are to fill out the Leadership Practice Inventory Questionnaire (about 5 minutes). The end of data collection will be marked when a total of 60 questionnaires have been collected from Masters of Nursing students from this institution. At this time the researcher will analyze the data and present the results as a percentile ranking representing the leadership role perceived by staff nurses.

Participants will also be asked to fill out a demographic questionnaire (about 2 minutes). This questionnaire will ask questions like your age, gender years of experience etc. This questionnaire is being collected so the researcher can describe the characteristics of the sample that participated (for example: The sample consisted of 10% males and 90% females; 60% of the RNs that participated have worked as an RN for 20 years).

PARTICIPATION AND WITHDRAWAL

Your participation in this study is completely voluntary. You can refuse to answer specific questions, and you can withdraw from the study at any time. Your decision to participate or withdraw will not impact your status as a student in any way.

PUBLICATION OF RESULTS

Your name will not appear on any of the questionnaires, and your responses will remain confidential. Your name will not be identified in any report or presentation that may arise from this study.

POTENTIAL HARM

None

POTENTIAL BENEFITS

Although there is no direct benefit to you, your responses may provide a broader understanding of the Acute Care Nurse Practitioner leadership role. This may in the future lead to further research.

CONFIDENTIALITY AND PRIVACY

Confidentiality will be respected and no information that discloses the identity of the participant (e.g. place of employment) will be published. Your name will not be used on any questionnaire. All documents will be coded with an anonymous number. No member of the research team will be able to correspond the individual to their completed questionnaire

Thank-you for your time and consideration.

Shamila Ali

Table 1:

Internal reliability of the LPI

RELIABILITY. Internal reliability, as measured by Cronbach's Alpha, continues to be strong, with all scales above the .75 level. This is true for the Self version as well as for all Observers and for each Observer category.

Leadership Practice	Self	Observers (All)	Manager	Direct Report	Co-Worker or Peer	Others
Challenge	.80	.89	.89	.90	.88	.88
Inspire	.87	.92	.92	.92	.91	.91
Enable	.75	.88	.86	.89	.87	.88
Model	.77	.88	.86	.90	.87	.87
Encourage	.87	.92	.92	.93	.92	.93

(Kouzes & Posner, 2002, Appendix, 1-19)

Table 2:

Normative values: Comparisons between self and observer

Leadership Practice		Self	Observers (All)	Manager	Direct Report	Co-Worker or Peer	Others
Challenge	Mean	43.9	44.4	44.0	44.3	44.5	44.4
	Std Deviation	6.8	9.1	8.5	9.9	8.5	9.0
Inspire	Mean	40.6	42.0	40.4	42.4	41.6	42.7
	Std Deviation	8.8	10.6	10.1	11.4	9.9	10.2
Enable	Mean	48.7	47.8	48.0	48.2	47.6	47.5
	Std Deviation	5.4	8.4	6.9	9.3	7.8	8.5
Model	Mean	47.0	47.5	47.6	47.2	47.5	47.6
	Std Deviation	6.0	8.5	7.4	9.5	7.8	8.3
Encourage	Mean	43.8	44.9	45.4	44.5	45.0	45.0
	Std Deviation	8.0	10.2	8.3	11.5	9.4	10.2

(Kouzes & Posner, 2002, Appendix, 1-19)

Leadership Practices Inventory Percentile Ranking

This page compares this study's Observer scores to the scores of several thousand people who have taken this version of the LPI.

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