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Connective Leadership: The Chief Nursing Officers' Relationship with Staff Nurses

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CONNECTIVE LEADERSHIP: THE CHIEF NURSING OFFICERS'
RELATIONSHIP WITH STAFF NURSES

BY

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DEDICATION

With much love, I dedicate this dissertation to Gerard, my husband who played, “Mr. Mom” so that I could pursue my scholarly journey. He encouraged me to put myself first to complete this dissertation and he would take care of everything else. I would also like to dedicate this to my children, Patrick, Jeffrey, and Morgan, who loved me unconditionally throughout this journey. Also, I would like to dedicate this to my sister, Ann and her family, as well as my extended family, Ron and Maddy. Finally, I would also like to dedicate this dissertation to my deceased grandparents, my mother, and my in laws, who always encouraged me to pursue my education.

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ABSTRACT

“CONNECTIVE LEADERSHIP: THE CHIEF NURSING OFFICERS’ RELATIONSHIP WITH STAFF NURSES”

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2011

Background: According to the Health Care Advisory Board (2006), forty six percent of staff nurses (SNs) from the acute care hospital setting are not satisfied with their Chief Nursing Officer (CNO). Additionally, SNs were found to have the lowest employee satisfaction scores compared to all health care workers from an acute care hospital. The study findings indicated that SNs felt the CNO was removed from the reality of the SNs work day; in addition, the CNO did not care about things that were of concern to the SNs; and the CNO was not a visible advocate for nursing in the organization. The SNs also reported that hospital administration does not respect the contributions of nursing in their Health Care Organizations. There is no research regarding the nature of the CNOs relationship with SNs from an acute care hospital setting.

Objectives: The aim of this study was to describe and understand the nature of the CNOs relationship with SNs from an acute care hospital setting.

Method: The method of inquiry utilized for this study was phenomenology. Six CNOs participated in the study. Interviews with each participant were conducted and each interview was recorded, transcribed, and analyzed by utilizing qualitative techniques as described by Ely (1991). Patterns and themes emerged from the lived experience of each participant. Each theme was identified and described.

Results: Four main themes were identified: *developing and sustaining the relationship, creating a positive work environment, brave leadership, and return on the investment in the relationship.* One metatheme was discovered: *connective leadership.* *Connectivity leadership* captured the essence of the relationship between the CNO and SNs.

Conclusions: Seven research-based recommendations are presented for the practice of nursing administration.

Key Words: Chief Nursing Officer, Staff Nurses, relationship, connective leadership, phenomenology, nursing leadership, qualitative.

Chapter I

INTRODUCTION

Personal Recollection

An interesting experience transpired as I mentored graduate students whose course work required observing and interviewing a CNO. In our time together, the graduate nursing students recalled that their experience with me was not typical of their own personal experiences of nursing leadership from their acute care hospital setting.

I have experienced the joy and good fortune of being able to establish positive working relationships with the SNs in my hospital setting, where I am a CNO. I have made it a point to be a visible and accessible leader who demonstrates caring behaviors toward the SNs. I value the SNs' thoughts, feelings, and the concerns about their patients, their work environment, and them as individuals. I ensure that I "close the loop" on any commitments I make with them and I follow up as appropriate.

In my role as a CNO, I take great pride in connecting with SNs. I believe it is important to be truly present in my face to face interactions with the SNs. It has always been my goal to understand, from the SNs perspective, how the organization was in the past, how the work environment is situated for them currently, and how we can work together to provide the best possible care to those we serve as we move forward in the future together. Ultimately, my goal is to continue to further enhance their professional growth and development, as well as assuring that their work environment will support existing goals.

Soon after listening to the students' remarks, I realized that while I knew many of the CNOs throughout the state, I had assumed the relationships they had with their SNs were similar to mine. It was then that I realized that I needed to know more about these relationships.

Aim of Study

The aim of this study was to describe and understand the nature of the Chief Nursing Officers' (CNOs') relationship with staff nurses (SNs) within an acute care hospital setting.

Perceived Justification for Studying the Phenomenon

In 2006, the Health Care Advisory Board (HCAB) announced results of a qualitative study that examined acute care SNs satisfaction with nursing leadership and with their work environment. The Health Care Advisory Board (2006) reported that 46% of acute care staff nurses are dissatisfied with their CNO and compared to acute care ancillary health care workers, the acute care staff nurses are the most dissatisfied group of employees in a hospital setting. The study findings indicated that SNs felt the CNO was removed from the reality of the SNs' workday, that the CNO did not care about things that were of concern to the SNs, and that the CNO was not a visible advocate for nursing in the organization. Additionally, the SNs reported that hospital administration does not respect the contributions of nursing in their Health Care Organizations (Health Care Advisory Board, 2006). Research suggests that the CNO is a critical conduit for employee engagement and enhancement of relationships (Covey, 1991; Kane-Urrabazo, 2006; Abbasi, Hollman, and Hayes, 2008; and Taulbert, 2008); however, there is little research that describes the CNOs'

relationship with acute care SNs. Understanding this relationship may potentially provide the necessary insight that may serve as the basis for interventions in nursing administrative practices.

Research Question

What is the nature of the Chief Nursing Officers' (CNOs') relationship with Staff Nurses (SNs) within an acute care hospital setting?

Chapter II

REVIEW OF THE LITERATURE

Introduction

The current work environment for nursing and nursing leaders presents unique challenges related to the nursing shortage (Cox, 2002; HRSA, 2005; Flynn, 2007). Research demonstrates the nursing shortage will be exacerbated by several factors including; aging of the United States (US) population coupled with the large number of aging Registered Nurses (RNs) who are expected to reach retirement age within the next 15-20 years (Buerhaus and Straiger, 1999; HRSA, 2005). It is estimated by the Bureau of Labor Statistics that the United States will require more than one million nurses to meet the needs of its people by 2020 (Cox, 2002; HRSA, 2005).

Although recruitment efforts are important and underway to assist in solving the nursing shortage, efforts must be made to retain those RNs currently in the workforce (Cox, 2002). It is important that nursing leaders understand and address the issues facing the nursing staff so that the CNOs can ameliorate the factors other than aging and retirement which are driving RNs away from the bedside and retain the current workforce (Cox, 2002).

Cummings, et al. (2008), Decter and Villeneuve (2001) posit that an occupational reality facing RNs is that they are among the most overworked, stressed, and absent (sick) workers in the United States (US) workforce. RNs have endured an increase in their workload related to the nursing shortage which has added to the ongoing work related stress. Other stressors also negatively impact the SNs such as negative aspects

of their work setting, lack of autonomous practice when not warranted and a perception of being treated unfairly and not in charge of the delivery of the care they provide to patients (Cummings, et. al., 2008). Focus on problems in the current work environment is essential in acute care settings since hospitals are the largest employers of RNs in the US and will be most directly and negatively affected by a decline in working nurses (HRSA, 2005).

CNOs must ensure that SNs will have a forum to enhance communication, provide opportunities for future growth, encourage various levels of participation so that the SNs can be part of the decision making process, and seek ways to improve the work environment (Jehn, 1997; Aiken, Clarke, Sloane, Sochalski, Busse, and Clarke, 2001; Laschinger, Finegan, Shamian, and Wilk, 2003; Kane-Urrabazo, 2006; Leiter and Laschinger, 2006). Through these opportunities, the SNs may feel a stronger sense of organizational commitment and trust (D'Amour, Ferrada-Videla, San Martin Rodriguez, and Beaulieu, 2005; Kane-Urrabazo, 2006). There is some evidence that successful CNOs engage their staff in a meaningful way and stay connected to them (Lundrigan, 1992).

We have a limited understanding of the complexity of relationships between and among SNs and other health care professionals, including CNOs (Klakovich, 1994; Schofield and Amodeo, 1999; Drinka and Clark, 2000; D'Amour, et al., 2005; Duddle and Boughton, 2007). According to D'Amour, et al. (2005), the working lives of health care professionals in the acute care hospital setting occur in collective environments where everyone is constantly interacting. For health care workers, these group interactions, when they occur in the spirit of harmony and trust, can take

on various forms and can generate positive outcomes such as sharing of ideas and the creation of a common goal (D'Amour, et al., 2005). Adding to the complexity of this phenomenon is that health care leaders and health care professionals must find better and more effective ways to work together (D'Amour, et al., 2005; Kane-Urrabazo, 2006; Duddle and Boughton, 2007).

A review of the literature suggests that workplace relationships of SNs with other health care professionals are problematic, in general (Duffy, 1995; Jehn, 1995; Farrell, 2001; Taylor, 2001; Duddle and Boughton, 2007). Studies suggest that several things happen when there are poor working relationships, including escalating conflict, employee dissatisfaction, decline in morale, increased patient errors, and a lack of cohesiveness with others (Jehn, 1995; Rayner, 1997; Farrell, 1999; Quine, 1999; Duddle and Boughton, 2007). Ultimately, SNs are choosing to leave the Health Care Organization (HCO) (Jehn, 1995; Rayner, 1997; Farrell, 1999; Quine, 1999; Duddle and Boughton, 2007). During times of the nursing shortage, poor working relationships are even more damaging to SNs and the organization as a whole (Aiken, et al., 2001; Aiken, Clarke, Sloane, Sochalski, and Silber, 2002; Kane-Urrabazo, 2006; Duddle and Boughton, 2007).

The combination of poor relationships and conflict in the workplace can interfere with the SNs' work performance, productivity, diligent workplace presence, and patient outcomes (Jehn, 1995; Farrell, 1997 and 2001; Aiken, et al., 2002; Bowles and Candela, 2005). Additionally, SNs also experience an inability to concentrate and focus on the direct patient care when there is conflict and poor relationships in their

work environment (Jehn, 1995; Farrell, 1997 and 2001; Aiken, et al., 2002; Bowles and Candela, 2005).

The literature suggests that when a positive work environment exists, patients are more satisfied with the care provided by the SNs, and enhanced quality patient outcomes are evident (Kangas, Kee, and McKee-Waddle, 1999; Aiken, 2002; Duddle and Boughton, 2007). While the literature suggests that positive interactions are important, there is a lack of knowledge as to how to achieve this.

Klakovich (1994) suggests that both nursing leaders and SNs experience stress because of ongoing political and financial turmoil in the current health care environment. Stress promotes a mutual lack of support and can negatively influence the behaviors of the CNO and SNs (Klakovich, 1994). CNOs are perceived as being elite, by not being visible to the SNs, and not appreciating the value of SN involvement (Simms, 1991; Klakovich, 1994). Klakovich (1994) posits that there is a need for a new paradigm to improve the synergy between nurse leaders and SNs, one that she calls connective leadership. Connective leadership could successfully diminish the SNs' perception of being abandoned by their CNO (Klakovich, 1994; Mauksch, 1990). Klakovich (1994) suggests that the connective leadership "will allow nursing leaders to function effectively within the organizations culture while empowering nursing staff through the provision of a caring professional practice environment" (Klakovich, 1994, p. 50).

Summary

The literature focuses on the work environment of SNs (Kangas, Kee, and McKee-Waddle, 1999; Aiken, 2002; Duddle and Boughton, 2007), working relationships of

SNs with other health care team members (Jehn, 1995; Farrell, 1997 and 2001; Aiken, et al., 2002; Bowles and Candela, 2005), leadership studies regarding the nurse managers behaviors/styles and effects on the SNs (Klakovich, 1994), but it fails to describe in any depth the nature of the specific relationship that exists between the CNO and the SNs. Therefore, in order to understand and describe this relationship, it is important to evaluate what transpires between the CNO and the SNs from the perspective of the CNO having the experience.

Chapter III

METHODOLOGY

Introduction

Phenomenology is a philosophical approach to enhance our understanding of human experiences (Husserl, 1964; Parse, 1985; van Manen, 2002). It does not make assumptions as to what is real or not real (van Manen, 2002). According to Spiegelberg (1972), phenomenology is an attempt to expand the world view of our experience by raising to the surface previously neglected components of the specific experience being studied.

In phenomenology, the true essence of the phenomenon that we strive to comprehend is uncovered (Merleau-Ponty, 1962; Parse, 1985; van Manen, 2002). The focus of phenomenology is to describe our human experiences as they are lived or experienced (Husserl, 1965; van Manen, 1984). Phenomenology rejects quantitative methods of natural science (Husserl, 1964) because it excludes the human experience (Colaizzi, 1978).

Design and Approach

Phenomenology, specifically, van Manen's approach was used to answer the research question, "What is the nature of the CNOs' relationship with acute care SNs?" Van Manen's method is hermeneutic in nature and thus combines both descriptive and interpretive styles. Van Manen (2002) developed and utilized this method in the study of professional practice. A comprehensive description of van Manen's approach is outlined in Appendix A.

Because the literature is silent on the nature of the CNOs' relationship with SNs from an acute care hospital setting, and little is known about this experience, the method of phenomenology was an appropriate approach to answer the research question (Colaizzi, 1978; van Manen, 2002). Using van Manen's (1984; 1990; 2002) approach, I turned to the nature of the lived experience (van Manen, 1997, p. 5); I investigated the experience of the CNO's relationship with their acute care SNs by utilizing their stories and words; I uncovered themes from the CNOs' lifeworld descriptions. Additionally, I utilized specific guidelines for analyzing and "writing up" the data as provided by Ely, Vinz, Dowing, and Anzul (1997; 2006).

Assumptions, Biases, and Beliefs

In phenomenology, it is imperative for the researcher to be aware of their personal biases and how that could potentially influence the research process. The researcher must be cognizant of his/her worldview and preconceived notions regarding the phenomenon of interest. According to van Manen (1984), the identification of such assumptions, biases, experiences, intuitions, and perceptions must be noted. In doing so, the researcher then has the ability to think about those beliefs and break free from or understand the ways in which they may be influencing the research process.

Van Manen (1990; 2002) and Ely (1991) recommend that the researcher use the technique known as bracketing. Bracketing allows the researcher to concede and identify their predetermined beliefs and assumptions before data collection.

According to Munhall (2007), the identification by the researcher of assumptions, biases, experiences, intuitions, and perceptions prior to data collection is called decentering. Decentering is a way for the researcher to keep an open mind about

what is being revealed by the participants or in this case, the CNOs. It allows the researcher to actually hear what the participants are saying without bringing in their own notions about the experience. In this study, I used both bracketing and decentering. Additionally, my predetermined assumptions and notions were examined against the results of the study in accordance with the audit process by my dissertation chair (Lincoln and Guba, 1985).

Researcher stance.

There were several assumptions about the nature of the CNOs' relationship with SNs that had the potential to influence the research process. These assumptions evolved over time based on my life experiences and were the lens through which I viewed professional interactions. Some of my life experiences provided for the development of my personal and professional values that were refined over years of being a SN and later as a nurse leader. In a parallel way, my assumptions and beliefs were also influenced by my ongoing academic journey.

Growing up, I was usually attentive to the needs of other people. I felt an inner desire to lend a helping hand to those I believed were in need. I felt connected to the people with whom I surrounded myself and for whom I had concern. While engaged in such caring interactions, my sense of being connected seemed reciprocal and, thus, provided personal rewards for being actively involved in such a relationship. Later, the choice to become a nurse was a natural fit for me. I have consistently maintained a sense of value for demonstrating caring and concern from my early years as a SN and now as a nursing leader.

Over the past 25 years, I have sought to broaden my perspective on how to best activate my ideas about nursing. Through education, I have gained a theoretical perspective of nursing and most especially, an area of ongoing interest to me, nursing leadership. I am aware that in my professional role as a CNO, I was deliberately and perhaps even unconsciously, profoundly influenced by my worldview of leadership behaviors that has been developing over the course of my life.

Generally, I believe, that a CNO needs to recognize the importance of creating an environment that fosters a positive, caring, and compassionate work setting for SNs. I believe that when a CNO listens very carefully to what the SNs are saying, they are able to keep their finger on the pulse of the organization, based on the evidence provided by the SNs. The CNO has to be brave enough to act in the best interest of the SNs and thus, generate and maintain the much sought after positive, caring, and compassionate work setting where both the CNO and SNs will thrive.

When I began this study, I did not know if other CNOs believe as I do about interactions with SNs. While my worldview has guided me to formulate meaningful and professional productive relationships with my SNs, there is little in the literature that describes the relationship.

As a qualitative researcher, I was cognizant of my worldview and worked to make sure that it did not cause a bias for me when entering the field. It was imperative for me to acknowledge where I came from as a nursing leader but more importantly that as a nurse researcher my goal was to capture the essence of my participants' experience, not my own. In an effort to prevent any kind of bias, I took the

opportunity to bracket and write how my beliefs were potentially influencing what I saw and what I was interpreting.

Trustworthiness

I established and maintained trustworthiness by adhering to the criteria for rigor in qualitative inquiry as outlined by Lincoln and Guba (1985), Guba (1981), and Sandelowski (1986). The four criteria are *credibility, transferability, auditability, and confirmability*.

Credibility. According to Lincoln and Guba (1985), credibility is one of the most important elements in establishing trustworthiness. Specifically, credibility allows the researcher to demonstrate that the findings are based in reality and when reality is upheld, it demonstrates internal validity which is similar to the criteria set by quantitative researchers (Guba, 1981). Additionally, a qualitative study is deemed credible when the study presents rich descriptions and or interpretations of the phenomenon under study whereby those who are having the experience would recognize the experience as their own as well as others who can identify with the study just by reading it (Lincoln and Guba, 1985; Sandelowski, 1986; Beck, 1993). Truth is subject oriented and not researcher oriented (Lincoln and Guba, 1985; Sandelowski, 1986). The researcher must ensure a separation from the experience to allow for truth to come forth as they describe or interpret the experience under study to enhance credibility (Lincoln and Guba, 1985; Sandelowski, 1986). Therefore, credibility is the truth value of study data (Lincoln and Guba, 1985).

Lincoln and Guba (1985) describe three elements to enhance the credibility of a study: prolonged engagement, persistent observation, and triangulation of the data.

Prolonged engagement. Prolonged engagement is not to be confused with the actual time spent in the field, but rather it is the time spent by the researcher to establish trust, understand the culture, and clarify information (Lincoln and Guba, 1985). Prolonged engagement between the participant and the researcher is to gain deeper understanding and to build a sense of trust between the researcher and participant (Lincoln and Guba, 1985).

I focused on establishing trust with each participant in the study by taking time to allow them to feel comfortable with me, by assuring them that confidentiality of the interview data would be maintained, and how that would be accomplished. Each interview session took approximately 1-2 hours. Two interviews were conducted with each CNO and I continued to interview CNOs until the data were saturated. The multiple sessions enhanced truth value and credibility of data. Of note, the CNOs were very enthusiastic about sharing their experience with rich descriptions. Michele, Shelly, and Donna share their sentiments about participating in this study which captured the general essence of all the participants.

Michele: I am so thrilled to be a part of this.

Shelly: It is my pleasure...this is great, I'm energized, I'm going to go upstairs and tell them (the SNs) how great they are, because they are!

Donna: I am happy to assist you.

Upon each encounter with the CNOs, I was cognizant to thank them for participating in this study. I told them that I appreciated their willingness to assist me in my research endeavor, as they would be assisting me in a phenomenon which has

not yet been explored. This was done in an effort to ensure a trusting relationship with one another.

Persistent observation. Lincoln and Guba (1985) encourage the researcher to identify and code meaningful observations. I made persistent observations and documented both typical and atypical events which were captured as field notes. There was a comparison between the observations made and the spoken words by the CNO.

Triangulation. Triangulation refers to the combination of two or more data sources such as observations, focus groups, and individual interviews, which when put together, form the essential data elements of qualitative research (Lincoln and Guba, 1985). It is through the process of triangulation that the researcher can in fact verify the experiences and viewpoints against others who share similar backgrounds or experiences (Lincoln and Guba, 1985). Therefore, triangulation confirms the truth of the research findings (Lincoln and Guba, 1985).

To enhance credibility, this study assessed congruence of data across all data sources including all data recorded in the form of field notes, memos, and transcriptions from all interviews and returning to the literature as themes emerge.

Transferability. Transferability is sometimes compared to external validity or generalizability in quantitative research which suggests results can be applied to another situation (Guba, 1981; Lincoln and Guba, 1985). In qualitative research, generalizability is not the goal and there is little threat to external validity because qualitative research is done in the natural setting (Lincoln and Guba, 1985). Guba (1981) posits that qualitative research is focused on the degree of similarity between

two contexts and does not attempt to develop generalizations. According to Lincoln and Guba (1985), and Sandelowski (1986), the researcher is to provide the reader with a broad, rich descriptive data about the experience, and it is the judgment of the reader to determine if the description is transferable to other situations, and if the findings are meaningful and applicable to their own experiences. The descriptions are formulated by exploration, clarifying, and analyzing the data (Lincoln and Guba, 1985).

I collected and provided rich descriptions of data as described by the spoken words of the CNOs. These rich descriptions of their experience allow the reader to determine if the findings are transferable. Although the number of participants was relatively small, the intensive and prolonged contacts with the participants supported transferability in this study (Lincoln and Guba, 1985). Six CNOs were interviewed, two times each, and until there was saturation of the data. The CNOs were encouraged to speak freely about their experiences in order to capture the true essence of the nature of the relationship they had with their acute care SNs.

From this study, the findings demonstrated rich descriptions of the nature of the CNOs' relationship with their acute care SNs. These descriptions are represented by way of the themes which emerged and the metatheme which was revealed as illustrated by the spoken words (quotes) from the CNOs. The actual spoken words by the CNOs demonstrate fittingness of the findings (Sandelowski, 1986). Fittingness allows the reader to determine whether or not the findings are transferable (Lincoln and Guba, 1985).

Auditability. Auditability in qualitative research relates to consistency of qualitative findings and is sometimes described as the qualitative equivalent of reliability in quantitative research (Lincoln and Guba, 1985; Sandelowski, 1986). In quantitative research, an instrument/tool is utilized to gather data but in qualitative research, the researcher is considered the instrument (Guba, 1981; Lincoln and Guba, 1985). Auditability is achieved when another researcher can draw the same or similar but not contradictory conclusions from the findings (Lincoln and Guba, 1985; Sandelowski, 1986). When another researcher can follow the audit trail used by the investigator from its beginning to its end, follow the progression of events in the study, and has comprehension of the logic by the researcher, then according to Lincoln and Guba (1985) and Sandelowski (1986), auditability is achieved. The audit trail is deemed as the most significant technique that provides for trustworthiness (Lincoln and Guba, 1985).

In this study, auditability was achieved by meticulously developing an audit trail, i.e., securing all memos, audio tapes, data and transcriptions, coding process, and process for category development so that other researchers can follow the decision trail. The decision trail related to ongoing data collection and analysis remains completely transparent, including bracketing where I consider how my research stance was influencing what I saw and how I interpreted it.

Confirmability. Confirmability is sometimes compared to neutrality in quantitative research (Guba, 1981; Lincoln and Guba, 1985). According to Sandelowski (1986, p. 33), “neutrality refers to maintaining freedom from bias in the research process and product.” According to Lincoln and Guba (1985),

confirmability is achieved when the findings of the study accurately describe the experience and ideas of the participants and not the objective or subjective stance of the researcher. Specifically, when truth value, plus auditability, and transferability are established, then confirmability is achieved (Lincoln and Guba, 1985; Sandelowski, 1986).

For this study, I ensured that ongoing member checks were conducted to provide clarification and validation so that the participants can “see” themselves in the transcribed data collected. Additionally, I would circle back to the CNOs for further clarification for example, I would ask them, “Did I understand you correctly when you said...?” The CNOs were able to agree, disagree, or clarify my understanding and correct my interpretation of their spoken words. Ensuring the validation of the data through member checks, the data are more credible. An audit trail was provided and I was aware of my stance as a researcher; bracketing and writing about how my beliefs may be influencing how I saw and interpreted the voice and expressions of the interviewees were given careful scrutiny. I was very careful to ensure that I kept my own personal beliefs and biases bracketed.

In an effort to ensure the trustworthiness of the data as it relates to the validity of the findings, I also utilized the technique known as decentering (Munhall, 2007). Decentering allowed me truly listen and hear what the CNOs were saying during their interview. This specifically fostered my ability to remain as objective as I could so that I would not bring my own thoughts, beliefs, and worldview into the findings of this study.

I reviewed my data collection and analysis with my dissertation chair who reviewed the audit trail. Triangulation of the data also provided for confirmability.

Participants

When conducting a phenomenological research study, it is imperative that the participants have knowledge and expertise of the phenomenon under investigation (Field & Morse, 1985). Since this was a study of the nature of the CNO-SNs interaction in the acute care hospital setting, the participants were recruited from a purposeful sample. The participants were to have responsibility for SNs in acute care hospitals, with at least three consecutive years of experience prior to this study. CNOs from the Organization of Nurse Executives/NJ (ONE/NJ) and the New Jersey Hospital Association, Chief Nursing Officers Constituency Group (NJHA-CNOCG) were invited to participate based on their experience and expertise as nurse executives, and because they were willing to describe the nature of their relationship with SNs working in the CNO's hospital. CNOs who meet the inclusion criteria were asked to volunteer for this study without limitations for age, gender, race, education, or type of acute hospital setting. I excluded any CNO with whom I had a friendship and or social relationship over and above my professional relationships.

Six CNOs from the state of New Jersey participated in this study. From the six CNOs who responded to this study, it was their perspective that they felt positive about their relationship with their SNs. Additionally, the six CNOs valued the relationship they had with their SNs. Foundational to understanding the CNOs' relationships with the acute care SNs, it was helpful to become acquainted with the CNOs career background, education, and their personal stories related to becoming a

nurse and becoming a CNO, as well as, knowing the characteristics of the acute care hospital setting in which they worked.

Data saturation was achieved after interviewing six CNOs. This was achieved when consistent patterns and themes emerged from the data and no new information could be gleaned from the data collected (Polit & Beck, 2004, p. 57).

Gaining Access

Because I have worked as a CNO in acute care hospitals for the past 13 years, I have had the opportunity to develop relationships with other CNOs through my professional nursing associations. These professional working relationships enhanced my credibility and were a valuable asset for gaining access to CNO participants for this study. Specifically, being a member of two professional organizations facilitated my networking with other CNOs from ONE/NJ and NJHA-CNOCG. The professional relationships I maintained through these organizations provided access to CNOs locally.

The purpose of the research was explained to CNO professional organizations including, the ONE/NJ and the NJHA-CNOCG, in order to gain access to potential volunteers for this study. Specifically, I interacted with the Executive Director of ONE/NJ and the Vice President of the NJHA-CNOCG whereby I reviewed all materials that would be sent to their membership. I obtained permission from the professional organizations to invite potential participants for this study. I submitted a letter, to each organization, requesting permission to invite CNO volunteers from the professional organization's membership through the organization's email/list serve (see Appendix B). In gaining access, I asked each organization to provide me with a

letter of support for this research study with access to their members through the organization's list serve (see Appendix C). Although, I did not have direct access to the email/list serve for the CNO members, each organization emailed all materials to CNO members via their list serve, including an Introductory Cover Letter (see Appendix G), Letter of Invitation (see Appendix E), and the Consent Form (see Appendix F).

I scheduled a time to speak with each potential participant who responded with an interest in participating in the study. The invitational script (see Appendix D) was read to potential participants. I also reviewed the Letter of Invitation, described the inclusion and exclusion criteria, the approximate amount of time for each interview, the number of anticipated interview sessions, information related to data collection, and confidentiality. Additionally, I answered any questions the potential participants had about the study and participation. I closed the conversation by arranging a time to conduct the first interview. Individuals who participated in the study returned the Consent Form to me.

Protection of Human Subjects.

This study did not commence until Institutional Review Board (IRB) approval from Seton Hall University was granted. Each CNO in this study received a letter of invitation, outlining the study and a request for their participation (see Appendix F). Each CNO who participated was asked to sign an Informed Consent that included, consent for audio taping of conversations and interviews (see Appendix G). The CNOs had the right to withdraw from the study at any time, for any reason, without reprisal. There were no known physical risks to the CNOs and there were no direct

benefits but, there may be a benefit to CNOs for the potential of fostering further research in the future. Additionally, there were no supervisory or collegial relationships between the researcher and the CNOs.

The identities of the CNOs in this study were never revealed (Munhall & Chenail, 2008). The CNOs were anonymous to all but me and their names were changed (Munhall & Chenail, 2008). Audiotapes were coded for each CNO to maintain anonymity, and I transcribed the audiotapes verbatim. Each CNO was informed and reassured that the field notes, transcripts and other notes would be stored and secured on a thumb drive which would be placed in a locked desk drawer whereby only the researcher will have access to the key. No data was stored on a hard drive. The data will be stored for at least three years. The CNOs were informed that the findings would be reported in the aggregate and their true identity would never be revealed.

Formal Acceptance and Initial Contact.

Once the CNO agreed to participate in the study by returning the signed Consent Form, I made an initial telephone contact with each participant at a convenient time, to answer any final questions regarding the study, review participant responsibilities, and to arrange for an appointment with the individual to conduct the first interview. Specifically, I asked the CNO to select a setting or location that would be conducive for a private, one on one interview with no interruptions. At the end of each interview session, I made arrangements with each participant to schedule a follow up meeting, as appropriate. This process was continued until there was saturation of data and member checks were completed.

Data Collection

Data were collected through interviews with each participant. A semi formal interview was conducted with the CNOs. An interview outline (see Appendix H), was used initially. Specifically, the outline contained general questions that were utilized as a guide.

I spoke with each CNO twice, over a one to three week period of time. The CNOs provided me with their perception regarding the nature of their relationship with their acute care SN's. Initially, I asked CNOs to tell me about their acute care hospital and the story about how they became a CNO. This allowed the participant to become more comfortable, provide background information, and assisted in the facilitation of developing trust. Additionally, other open-ended questions were posed to each participant including, "Tell me what it is like for you to be a CNO," "Share with me how you interact with your staff nurses," "Describe your relationship with your staff nurses," and " Describe a specific example that illustrates your interaction/relationship with your staff nurses." At the end of each interview session, participants were asked if there was anything else they would like to add.

All interviews were conducted in each CNO's office with the door shut for privacy, with one exception; one interview was conducted in a public place but it was conducive to the interview process. The interviews took place on weekdays and during normal business hours.

I audio recorded each participant during our interview via a digital recorder. The digital recorder was placed on the table between me and the participant. A letter was assigned to each participant and each session was noted. To ensure anonymity, the

real names of the participants were changed. The average time for each interview ranged from 45 minutes to 75 minutes. Field notes, memos, audio tapes, and verbatim transcriptions of interviews with each participant provided rich data for analysis. Observations were described in written field notes. I simultaneously reviewed the audio tape and the transcription for accuracy. Any discrepancies were noted on the transcription. Additionally, I read and re-read each transcription before initial analysis of data began. Based on the preliminary analysis, additional questions were identified prior to the next interview, including any questions related to content needing further clarification.

At the time of the final interview session, I thanked the CNO for her participation and asked permission to contact her if further clarification of data was necessary, during the analysis phase of this study. The data collection phase took approximately 6 months. At that time data saturation had occurred.

During the interview process, I was aware of my biases and constantly worked to insure that my beliefs were not leading the participants. Bracketing was an effective tool which I utilized to keep me grounded (Ely, 1991). Following each interview, I wrote many comments about what I was hearing from each participant and I questioned myself constantly to make sure I was hearing their words and not inserting my own thoughts and beliefs into what the participants said. Additionally, bracketing ensured that my research stance was not unduly influencing what I was hearing and interpreting from the participants. It was imperative for me to acknowledge my own experiences as a nursing leader but more importantly that I stayed in the role of nurse researcher capturing the essence of my participant's experience, not my own.

Data Analysis

I read and reread the transcribed interviews, developing codes, categories, sub themes, themes, and a metatheme. The codes were grouped and put into analytical categories. Van Manen's (1997, p. 5) methodological outline was utilized for data analysis and can be found in Appendix A.

The mechanics of data analysis as outlined by Ely et al. (1991) provided a guide as the detailed work of the data analysis took place. Logs were my data repository and they were put in chronological order. "The log is the place where each qualitative researcher faces the self as instrument through a personal dialogue about moments of victory and disheartenment, hunches, feelings, insights, assumptions, biases, and ongoing ideas about method" (Ely et al., 1991, p. 70). Specifically, the "log is the data" (Ely et al., 1991, p. 70). The logs commenced with my initial feelings about the journey upon which I am embarking. All my interactions with each participant were recorded, including any telephone calls, visits, conversations regarding gaining entrée, and any responses. In writing the logs, my margins were wide enough for me to write comments, make categories, note my hunches, and determine what needed to be clarified. The log was established to accommodate sequential pagination so that I could easily refer to the log when I developed my analytic memos as part of the process. Specifically, the analytic memos were my personal reflections on the logs as well as an incorporation of my observer comments.

In an effort to establish categories, I followed the guidelines provided by Ely et al. (1991), which are as follows,

1. I reacquainted myself with what I was about to categorize. Specifically, I selected one entry from my log, read and pondered it several times until I felt I have captured the essence of it.
2. I wrote comments in the margins of the log about my thoughts related to the entry. This allowed me to capture why the remarks were interesting to me, what my insights were relative to the entry, and any topics that came to mind as a result of my thoughts about the topic.
3. I created “meaning units” by reading the narrative and divided it in a way that made sense to me. That transpired as I found meaning throughout the log. For example, I noted, “There is something going on here.”
4. Once the meaning unit was identified, I designated a label for it, in the margin of the log. The label was descriptive, with only one, or a few words to describe it and a code was assigned.
5. A list was made of all labels. Then, I assessed the list for any similarity between labels and put similar labels into groups that seemed to fit together. If the labels did not seem to fit into a group, the label was maintained as a single item. Groups of labels were compared and contrasted to assess for links across label groups. I continued this process until I could find a descriptive meaning, as opposed to looking for reoccurrence.
6. I continued to analyze the data and applied the labeling, grouping, and across group comparisons process while reflecting upon the previous labels as I worked through the next log entries. I was cautious and aware, so as to not to force fit labels

into these new meaning units. Once the labels fit, they were considered as a temporary title for categories.

7. I wrote the analytic memos as I went along to prepare for the final analysis.

8. The final analysis was focused on the search for themes.

According to Ely et al. (1991), a theme is defined as meaning which consistently runs through the pertinent data. Additionally, a theme can also be a meaning that carries a heavy emotional or factual impact (Ely et al., 1991). The data analysis resulted in the identification of four themes specific to the phenomenon with eight subthemes, and one metatheme which emerged; I went back to review the literature following the emergence of each theme and the one metatheme.

Chapter IV

FINDINGS

Participant Profile

As shown in Table 1, all six participants were female and the CNOs ranged in age from forty eight to sixty seven years with an average age of fifty seven years. Three of the CNOs' held a doctorate degree (one CNO had a Ph.D. and two CNOs' had a DNP) and the remaining three CNOs' held a master's degree (two CNOs' had a MSN and one had a MA). One CNO who held a MSN degree was enrolled for her doctorate degree. All six CNOs obtained national board certification in their area of specialty, Nurse Executive, Advanced (NEA-BC). All the CNOs in this study belonged to ONE/NJ, their professional organization. Four of the six CNOs are Johnson & Johnson Wharton Fellows from the Nursing Executive Program.

Table 1

Participant Profile by Gender, Age, Race, Education, National Certification Held, Professional Associations, & Other Education

Participant (n=6)	Gender F= Female M= Male	Age	Ethnicity Race	Educational Level	National Cert held	Professional Associations	Other Education
Judy	F	61	Caucasian	MA	NEA-BC	ONE/NJ	J&J FELLOW
Donna	F	55	Caucasian	DNP	NEA-BC	ONE/NJ	
Michele	F	67	Caucasian	DNP	NEA-BC	ONE/NJ	J&J FELLOW
Lea	F	48	Caucasian	MSN	NEA-BC	ONE/NJ	J&J FELLOW
Margaret	F	57	Caucasian	MSN	NEA-BC	ONE/NJ	J&J FELLOW
Shelly	F	55	Caucasian	Ph.D.	NEA-BC	ONE/NJ	

The CNOs had been Registered Nurses (RNs), from twenty-eight to forty-six years, with an average of thirty-five and a half years as a RN. The CNOs possessed on average twenty-nine years of experience in Nursing Administration. The average length of time the participants held the position of CNO was thirteen and half years. The average numbers of years experience as a CNO in their current acute care hospital was eight years. This information is depicted in Table 2.

Table 2

Participant Profile by RN Experience, Nursing Administration Experience, CNO Experience, and Length of Time as CNO in Current Acute Care Hospital Setting, Prior CNO Experience

Participant (n=6)	Total Years As An RN	Total Years Experience in Nursing Administration	Total years experience as a CNO	Length of Time as CNO in Current Acute Care Hospital Setting	Prior CNO Experience
Judy	40	38	25	3	Yes
Donna	33	25	13	13	No
Michele	46	32	14	14	No
Lea	28	26	13	3	Yes
Margaret	35	32	25	10	Yes
Shelly	32	25	7	7	No

All participants began their career as staff nurses. The six participants held various administrative positions along their career path such as a nurse manager, director, and eventually progressed to the CNO role. Three of the participants also had previous experience in nursing education. There were three participants who shared that their current position as a CNO was their first. The remaining three participants had prior CNO experience.

The CNOs were well read and current with both leadership and nursing administrative literature. Comments from Judy, Donna, and Michele illustrate this commitment to staying current.

Judy: It is a very short article, yes, the article was written by Dana Blexo and Catherine Robinson-Walker and it is called, "Investing in Leadership; an unwavering priority." What she talks about in order for a nurse exec to be successful, you have to be a coach, a mentor, you have to lead by example, you have to share your vision, support the teamwork, teach, inspire, and motivate, all at the same time. I look at this and I say, this is what I live and breath. This is from Nurse Leader, this just came out, I think I got it this week.

Donna: Let's help them (the RN's) to get where they need to be. So, we've really engendered that kind of thinking in the organization and there's also a book, I don't know if you've ever read it, *From Good to Great* by Jim Collins. So, um, I really think that has helped us with our journey.

Michele: We were able to work with the staff (RN's) and help them understand where we were going all going and giving them opportunities to meet with the staff and see what their needs were, type of model, and I kept hearing about Magnet, Tim Porter-O'Grady, Shared Governance, and I was thinking, why couldn't we do that here...So, we brought Tim Porter-O'Grady here, which was such a big deal for the hospital, I'll never forget that day. We were so nervous, we had about thirty nurses in the room. That's when we started our Shared Governance journey.

Acute Care Hospital Setting Profile

All six acute care hospitals were community based and one hospital was a designated trauma center. Five of the acute care hospitals were not for profit and one acute care hospital was a for profit hospital. Only one of the acute care hospitals had their SNs represented by a nurses union. Two hospitals achieved Magnet status and

the remaining four hospitals were on the Magnet Journey. Table 3 depicts the acute care hospital setting profile by each participant.

Table 3

Acute Care Hospital Setting Profile by Participants- Type of Hospital Setting, Profit vs. Not for Profit, SN's represented by Union vs. Non Union, and Magnet vs. Non Magnet/Magnet Journey

Participant (n=6)	Type of Hospital Setting	Profit vs. Non Profit	SN's Represented by Union Vs. Non Union	Magnet Vs. Non Magnet/ Magnet Journey
Judy	Community Hospital	For Profit	SN's Non Unionized	Non Magnet- On the Journey
Donna	Community Hospital & Trauma Center	Not For Profit	SN's Non Unionized	Magnet
Michele	Community Hospital	Not For Profit	SN's Non Unionized	Non Magnet On the Journey
Lea	Community Hospital	Not For Profit	SN's Unionized	Non Magnet On the Journey
Margaret	Community Hospital	Not For Profit	SN's Non Unionized	Magnet
Shelly	Community Hospital	Not For Profit	SN's Non Unionized	Non Magnet On the Journey

Vignettes

I created a vignette of each CNO in this study. The purpose of creating the vignette was to assist the reader in gaining a better understanding of each CNO who participated in this study. The goal was to bring to life the CNO and demonstrate that although they have different relationships with their SNs, they have a commonality relative to their lived experience regarding this phenomenon of interest.

Lea.

Hello, I'm Lea. I did not always want to be a nurse but the career I wanted to go into was not an option. So, I spoke with my mother and she encouraged me to go into nursing. My mom was a Chief Nursing Officer. I knew that someday I would be a nursing administrator. My mom always offered me so many wonderful insights from her experience as a nursing leader. She was very well respected in the nursing profession. I came up through the ranks quickly from a staff nurse, to a charge nurse, to a head nurse, to director, then a CNO. I continued on in my education over the years. I am currently enrolled in school for my doctoral degree (Ph.D.). I previously worked at several different hospitals in the Philadelphia area. Before I came here, I thought I worked in "Mecca", and then I came here. I have to tell you, I love it here, and I love the staff. Coming from such a big academic hospital setting, I really didn't get as much time with the staff that I would have liked. Here, I can take time to be with the staff nurses. The best part of my job is interacting with the staff nurses. I am out on the floors and I watch what is going on and I have to tell you, I am so proud of the staff nurses here. The staff nurses here just amaze me. I created a professional practice council and I will tell you, this meeting is the best meeting I

have. I look so forward to working with the staff through the professional practice council. I want the staff nurses here to be able to make the decisions about patient care and their practice. They are on the front lines of patient care and they have the answers. You know, when you invest in the staff nurses you get it back in patient care and patient outcomes. I have so many incredible stories about how my staff nurses have made such a wonderful impact with the patients here. I think it is so important to recognize the staff nurses. I want to make sure the staff nurses have access to me. As a matter of fact, I was asked to move my office to the executive suites but I told my boss that I didn't want to move. I want to stay right here in the thick of it all. I want to know what is going on. Even though my staff nurses are unionized, I have been able to decrease the grievances by 80% and I am proud of that. I feel it shows the staff nurses that I care about them, I want to understand their concerns and I will be responsive to them. I take great pride and satisfaction in mentoring and coaching the staff nurses and nurse externs. I will never forget what it was like to be a new nurse and I never want to leave the staff nurses with the negative experience I had with my Chief Nursing Officer. Therefore, I have learned from those past experiences and know what type of leader I want to be. I appreciate the staff nurses and they appreciate being appreciated. Most of all, I want the staff nurses to know that I am human.

Michele.

Hi, I'm Michele. I have been around for a long time. I have been in this hospital for my entire professional nursing career. You could say that I grew up here. I actually grew up in this community. My nursing background was that of an OR

nurse. I worked for a wonderful CNO who was so warm and compassionate. She encouraged me to go back to school to advance my education. I started out as a diploma RN. I went back for my BSN, my masters, and I just recently completed my DNP. As I went back to school, I was provided the opportunity to assume various nursing leadership positions at this hospital. I went from being the director to the CNO. The CNO position became vacant when my CNO retired. I really admired her. She also encouraged me to get involved in our Professional Organization for Nurse Executives and I joined the Organization for Nurse Executives of New Jersey. I was very active on many of ONE/NJ committees. I would go there to learn and see what was going on outside the four walls of this hospital. I was so impressed by what others were doing, I would think, why can't we do that here? So, when I would come back from those meetings, I spoke to my team and I said, "Let's try this." I kept hearing about Tim Porter O'Grady and shared governance, and you know what? I got Tim to come here and he told us what shared governance was all about. Although we are in a rural setting, there is no reason we couldn't do innovative things with our nursing staff. I was so excited. We created a shared governance model and a professional practice council. I wanted the staff nurses to be empowered to drive change in their practice. I have the nursing staff run the professional practice council meetings. We work together to identify problems and issues. I help to facilitate the resolution of the issues. I have an open door policy and the staff nurses know they can come to me for anything they need. I have all kinds of forums to communicate with the nursing staff. What I love to do most is to go up on the floors and make rounds with the staff nurses. I like to talk to them about what is going on with their

patients and most of all what is going on with them. I really take a personal interest in them. I know everyone by name. I will do anything for them and I will always help them. I even push patients on stretchers from the Emergency Department (ED) to the floor if the ED is too busy. We are always celebrating something around here. The staff nurses really do a great job with the quality of care they provide to the patients. I am so proud of them. You know, we were number one in the state for our core measures. It is about making sure the staff nurses are happy. If they are happy then the patients will be happy. It is that simple. I think I have the best staff nurses in the state. I think the staff nurses know that I care about them. I do love my staff and they love me back.

Margaret.

Hi, I'm Margaret. I have been at this hospital for several years now. I came here with previous CNO experience from out of state. I had a passion for wanting to be a nursing administrator. I held several leadership positions but I went into education before I assumed the CNO role. I have a master's degree and I am currently enrolling in school for my doctorate degree. My previous role in education has really helped me in this role as CNO. I offer many educational sessions to the nursing staff and nursing management team here. I believe in transformational leadership and that guides me in what I do here. It is all about the nurses. I believe that they are the key and drivers to making positive changes for patient care and in the organization. When an issue arises, I form a task force and have the nurses at the bedside work on the problem because they know best. They can tell me what needs to change, so we can make things better-they are the experts. We just built a new ICU and I had the

staff nurses work on the design, the work flow, and they determined the aesthetic interior design for the unit via evidence-based practice and a literature review. I was really so proud of them. We were pioneers for a new electronic medical record and I had the staff nurses involved in this as well. Our hospital has achieved Magnet status and I am so proud of the nursing staff here. I take the time to be visible and accessible with the staff nurses. I am here for them. I appreciate all that they do. I know it isn't easy on the floor but I am here to make things better for them. I care about the nursing staff. I am also involved in my professional association, the Organization of Nurse Executives/New Jersey.

Donna.

Hi, I'm Donna. I always knew that I wanted to be a nurse. I have been at this hospital for many years. I previously worked as a nurse in the New England area and then came out to New Jersey. I have been here at this hospital ever since I moved to New Jersey. My clinical nursing background was in Maternity. When I started out in this hospital, I was a nursing supervisor and then went into a nurse educator role. I was able to work my way up to the position as the CNO for this hospital because the previous CNO just didn't fit here. Her leadership was very authoritative and that didn't sit well with the staff nurses. I was given the opportunity to be the acting CNO. I was eventually given the CNO and it was nice because the staff knew me. The staff nurses knew what kind of a leader I was, down to earth, calm, and I had a deep understanding of what the nurses day to day challenges were from working with them as a nursing supervisor. The former Chief Executive Officer of the hospital was a great mentor to me. He believed in my ability to further pursue my career

advancement as well as my education. I had my BSN but he encouraged me to get my Master's degree. I recently completed by DNP. I am active in the Organization of Nurse Executives of New Jersey. We are a Magnet hospital. I like to make rounds and see the staff nurses. I created a professional practice council and I really enjoy networking with the staff nurses on the committee. The management team here has adopted the philosophy of servant leadership. It has really helped me to connect with the staff nurses here. I want to truly understand their needs. I like to recognize the nursing staff for a job well done. A regret I have is that, I wish I could be out on the floors more with the staff but the staff know that I am available to them for whatever they need. My secretary knows that if a staff nurse calls me, she gets me right away so I can speak to him or her. The staff nurses have my email so if they want to ask me a question, they can reach me by email and I will follow up. I am an advocate for the nursing staff. I also advocate for the nurses when I am in my senior management meetings and at the board meetings. I feel it is so important to recognize the staff nurses.

Shelly.

Hi, I'm Shelly. I knew I wanted to be a nurse when I was young. It was because of my best friend. She had cancer and unfortunately she died, but I was always there for her. I watched her in a lot of pain and I was there to comfort her. I will never forget her. I went to school for nursing and eventually ended up with my Ph.D. in nursing. I have worked for this hospital for quite some time now. I previously worked as a director in another health care facility and I came here in the late 1980's. I really enjoy working here. I was hired as a director of nursing and then worked my

way up to the CNO position. I did not have any aspirations to become a CNO but the previous CNO had left and my Chief Executive Officer asked me to think about it. I did and the next thing I knew, I was given the position. I had a great rapport with the staff nurses and when it was announced, during nurse's week, that I got the CNO position, the staff nurses cheered and clapped for me. I will never forget that day. I have been involved in the Organization of Nurse Executives in New Jersey for many years. We are on the Magnet Journey. The staff nurses here really deserve that recognition. They work hard. I really try to understand from the staff nurses point of view, what is happening on the patient care units. I am frequently in the ED. We have a very busy ED and I want to do what I can to help them. Very often, I get them pizza because they are so busy, they never have time to eat and I tell them, "You have to eat, you can't keep working like this without food." The ED staff nurses call me the "Pizza Lady." The bottom line is the staff nurses know that I care about them. I do come in on the weekends and make rounds. I treasure that time because it is my time with the staff nurses. I take my time doing the rounds and I am not rushed. I really feel it is the best time of the whole week. I want the staff to know they can come to me with anything. I will not tolerate any bad mouthing from the doctors about the nurses. I will stand up for the nursing staff, whether it is with a physician or even a family member. I am their advocate. I am the voice of reason. The staff has access to me. We have a great professional practice council. The staff nurses at the hospital are involved in making decisions here and they are empowered. I try to be very down to earth with the staff nurses. I want them to be comfortable with me. I hold round the clock meetings with the staff nurses on each shift. I show them that I

am human and I have a sense of humor. You have to be able to laugh at yourself and not take yourself too seriously. It is important to have that connection with the staff nurses. You have to get to know them. I would do anything for them and I they would do anything for me.

Judy.

Hi, I'm Judy. I have been a CNO and Chief Operating Officer before this hospital position. I have worked in the Mid West before coming to work in New Jersey and I held various nursing administrative position along the way. I did want to be a Chief Nursing Officer and I had a wonderful mentor who I am still in touch with today. I am an active member of the Organization of Nurse Executives in New Jersey. I have obtained my Master's degree. I always wanted to be a nurse as far back as I can remember. My expertise was in Maternal Child Nursing. At this facility, I am working hard to regain trust between the staff nurses and administration. The hospital has been through a lot and I want to support them through this new leadership transition. The staff nurses here have my cell phone number and they know they can call me anytime. I do get calls from them in the middle of the night and that is fine. I come in early on the night shift to make rounds. In the beginning the staff nurses were so surprised to see me, but now, they are used to me. I keep every Friday open with no meetings scheduled because that is my day to round on all the patient care units and see the staff nurses. I am encouraging the staff nurses to obtain their national certification as well as getting them to go back to school to further their education. I try to reward and recognize the staff as much as possible. I write personal thank you notes to them on a job well done. I will say I was very touched by

the outpouring of support I got from the staff nurses when my father died. I didn't expect anything and so many of the staff nurses came to see me and sent me cards to express their sympathy. I was truly touched.

Chapter V

THEMATIC FINDINGS

Themes

Four themes and eight subthemes (see Table 4) emerged as the data were analyzed. The four themes (see Figure 1) were:

- Developing and Sustaining the Relationship
- Creating a Positive Work Environment
- Brave Leadership
- Return on the Investment-Investing in the Relationship with SNs

Figure 1

Themes- *Developing and Sustaining the Relationship, Creating a Positive Work Environment, Brave Leadership, and Return of the Investment of the Relationship with the SNs.*

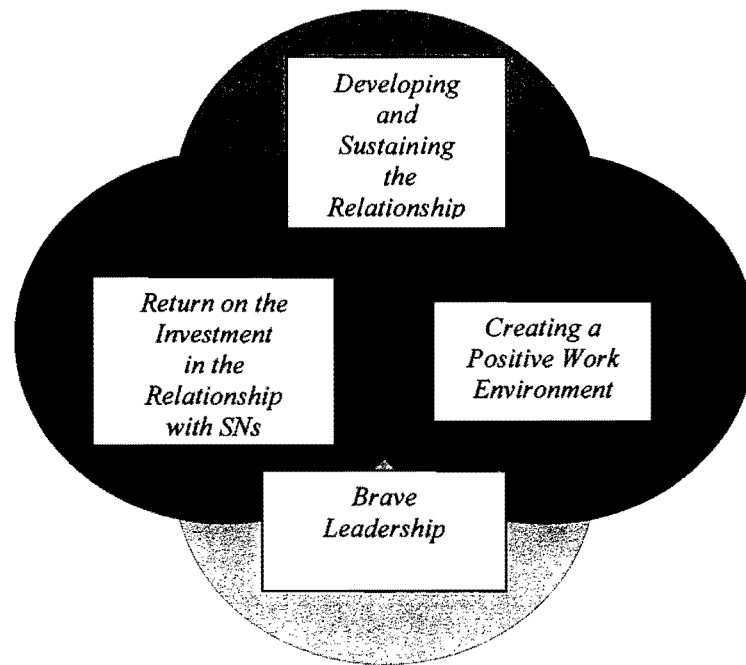


Table 4

Themes, Subthemes, and Categories

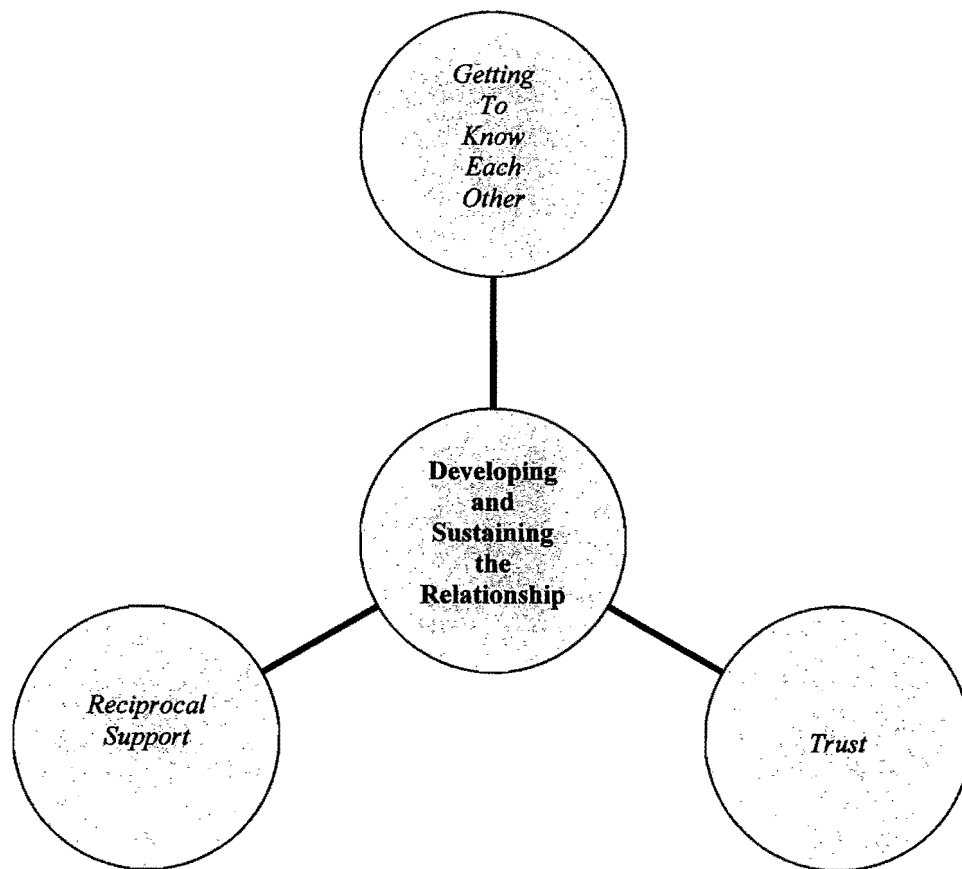
Theme	Sub Theme	Category
Theme # 1-Developing and Sustaining the Relationship	Sub Theme # 1 A-Getting to know each other	Being Human Caring & Compassion Presence by Rounding/Management by Walking Around
	Sub Theme # 1 B-Trust	Transparency Integrity Fairness Autonomy Respect Non-Threatening Protection
	Sub Theme # 1 C- Reciprocal Support	Support Appreciation Thankful Recognition
Theme # 2- Creating a Positive Work Environment	Sub Theme- Shared Governance	SN Satisfaction SN Voice/SN Decision Maker Teamwork Inclusiveness
Theme # 3-Brave Leadership	Sub Theme # 3 A- Advocates for Nursing	Pride In Nursing Visionary Promotes Nursing
	Sub Theme # 3B- Agility	Adaptable & Flexible Takes Action Change Agent
	Sub Theme# 3 C- Coach and Mentor	Shares Knowledge
Theme # 4-Return on Investment in the Relationship with SNs	Sub Theme- Positive Patient Outcomes	Patient Centered

Developing & Sustaining the Relationship

Developing and sustaining the relationship was the first theme to emerge from the data analysis. The CNOs participating in this study described the evolution of and the importance of their relationship with their SNs. *Developing and sustaining the relationship* was the strongest and most common theme discovered in the analysis of the data, and was comprised of several subthemes: *Getting to know each other, trust, and reciprocal support* (see Figure 2).

Figure 2

Theme # 1- **Developing and Sustaining the Relationship** and Subthemes: *Getting to Know Each Other, Trust, and Reciprocal Support*



Getting to know each other.

The CNOs expressed throughout the interviews how important it was for them to get to know the SNs and for the SNs to get to know them. They felt this was the first step in the formulation of the relationship. When asked what would be their advice to a new CNO coming into this position, all the CNOs made the statement that the new CNO had to take the time to get to know the SNs. It was also interesting to note that the majority of the CNOs made the statement that when they were SNs, they did not know their own CNO. Every CNO verbalized that they made a concerted effort to ensure that they knew their SNs.

Donna sums up what all the CNOs stated about getting to know each other.

Donna: You need to really get to know them (SNs) and have them get to know you.

Three categories describe the process of getting to know each other: *being human, caring and compassion; and presence by rounding/management by walking around.*

They are discussed below.

Being human.

The CNOs felt it was very important for the SNs to see them as human beings. All of the CNOs wanted to relate to the SNs on a human level. They were proud to be able to say that they knew the staff by name. Consistently, the CNOs felt that by getting to know the SNs by name, it made a difference in the sense of allowing for ease in developing the relationship.

Lea: I do think it is incredibly important to call everyone by name.

Judy: It is my goal...I have 450 nurses to eventually know all them by name, to get to know them personally, uh, I think that

personal relationship, finding out who they are...So, you know, I try to have a personal relationship with all my staff but that takes a lot of time.

Donna: I had a couple of BSN students...they are actually our employees but they did their clinical time here and they said to me, "Oh my god, we can't believe you know everybody's name."

The CNOs wanted the SNs to call them by their first name. If the SNs called them by their last name, the CNOs would show their sense of humor by saying, "Mrs. Smith is my mother in law."

Margaret: Everybody knows me as Margaret.

Judy: We are on a first name basis... Some of the staff even have a hard time calling me Judy, but you know when they say, "Mrs. Jones," I say, "that is my mother in law," but I think I have developed a very strong relationship with them and I think I am very approachable.

All the CNOs verbalized how important it was for the SNs to view them as human beings. They were passionate in sharing stories about how much it means to them as being perceived as human and that CNOs are not perfect. Being human was significant for the CNOs in developing and sustaining the relationship with the SNs.

Lea: They get to see you are a human being, you make mistakes, um, you are not going to bite their head off because they made an error or something like that.

Margaret: I am on the bio ethics and so, I am out there doing the bio ethics consults and stuff. I think they see the human side of me.

Shelly: Well, they know I'm human. I mean, at yesterday's meeting, first meeting, well, I unfortunately, the slide, we were using a proxima and it set to then ten second flip time, so my slides kept flipping and they were watching me...it was comedy of errors. It makes you look human and I usually laugh if I make a mistake... let them know you're a real person, don't be haughty, don't be haughty...let them see you as a person.

Caring and compassion.

As part of the development of the personal relationships with the SNs, the CNOs were interested in understanding the SNs on both a professional and social level. The CNOs conveyed caring and compassion to the SNs.

Lea: Before they (SNs) start, all the directors send them a little packet, and in the packet it is a free meal ticket, free lunch, for the first day they are here we allow them to valet park so they don't have to worry or be confused on where to park...So, they don't even have to worry about the car on the first day. They get a welcome card before they start...it's really, you know as a new employee, what flusters you the first day you were there, so it's trying to take all those concerns away when they start.

Michele: I think that knowing them (SNs) as people, you know, if a staff member comes down, I just had one this morning whose husband has um a brain tumor and he's been two years clear and she came in this morning to tell me that it's not, um, it's come back. It's like grapes, it's not really that big but just to sit there, I mean, my heart just went out to her. I'm like, ok, now, what can we do for you? Do you need time off? Do the manager and I need to sit down so that you're free to be able to support your husband, because your family comes first now. Um, those types of things...I had a nurse who was going through a real bad divorce, if my husband ever knew, he would kill me...but he took the car, he took so much, she didn't even have transportation to work. She went to look for a car in one of the those second hand lots that she thought she could afford but she didn't have the down payment. So, I said to her, "I will help you with the down payment but you gotta promise me that you'll pay me back." It is that type of stuff because people don't have other resources and yet what do we get from when we had these snow storms, they didn't even, it wasn't a matter of how to get them in, they know the snow was coming, so they packed their bags and they were ready to stay overnight. You can't pay people enough for that...you can't and I am looking and the place is so small, I know them all on that type of personal level.

Donna: I love them (referring to the SNs), I really do.

Presence by rounding/management by walking around.

All of the CNO engaged in management by walking around. Each CNO expressed a high level of satisfaction when being out and about on the nursing units, interacting with their SNs. It was obvious that this brought them a strong sense of joy and happiness in their day. The CNOs absolutely wanted to be visible and by making rounds the CNOs were able to increase their visibility, accessibility, and presence.

Lea: So, I do think it is really, really, important for me to be present and I say that to the staff.

Margaret: I was present with them, right there with them, to hear, listen, take it in, respond and make things happen.

Judy: I think people see that I care, it is that presence, and it's that front line presence, and it's valuing what we are asking them to do, being in the front lines, being available.

Rounding was conducted by the CNOs on both a formal and informal basis.

Several of the CNO maintained a consistent time they rounded and others chose to round on an unscheduled basis. If there was free time, the CNOs would opt to run up to the nursing units to conduct spontaneous rounds.

Michele: If you asked my boss, the CEO, he would say, "She hasn't evolved enough because she is still up there on the units and she's late for meetings because she gets involved in talking to the staff (giggles)," you know, if I have to be here until seven at night so I can see the staff, it's just those little-how's it going, what's the best thing that happened today...that has always been my style.

The CNOs demonstrated their presence not only during the rounding process but also by the way in which they engaged the SNs while making rounds. Of utmost importance to the CNOs was the fact that they wanted to relate to the SNs in the

moment of their interaction. Specifically, they wanted to take the time to listen and understand what the nurses were facing at the bedside, how they could be of assistance and to come across as being genuine towards them during the interaction.

Lea: The first week I was here, um, I was rounding and no one really knew who I was, I was walking around in my lab coat, looking through charts, trying to get a sense of the issues and what systems they used, and things like that and I was standing at one of the nurses station and the nurse was on the phone and she was talking to a patient who had just been discharged, he was elderly and his wife had come to pick him up but it was a struggle to get him home, the two of them were needy, the patient got home and realized that he left his glasses...so he called and he was talking to the nurse and again, I am standing in the background listening to her, and she was talking as sweet as a pumpkin, and then she goes, look, you live in ***name of a nearby town and I live in the town right past ***name of the nearby town, I get off work at 7 pm I will drop them off for you and I just stopped dead in my tracks, and I'm like, I don't think I have ever hear a story like that even in Philadelphia, I...I was so overwhelmed, I came down here and we give cards and gift cards, things like that and I wrote a little thank you to her, she didn't know me, and I walked up to her about 2 hours later to meet her and I said, Hi, my name is Lea, she said Hi, I'm Amy, and I said, Amy, you just validated for me that I made the right decision in coming here. I was just blown away.

Michele: I think, first and foremost, you have to be a good listener and you have to be really present. I don't think it's the amount of time, it's the, it's the touch on the shoulder, it's looking them right in the eye when they are trying to tell you something about a patient care issue, a physician issue, or just about how their day is going. You can't be too harried and you've got to be very centered and focused on them and I think that says it all. You gotta get out of your office, and that's hard for us, right?

Donna: We get a scouting report. First of all, we have a very formal process for a senior leader has to visit every area including the nursing units, once a month; at least once a month... We have a formal schedule, they know we're coming. We get a scouting report...and it basically goes over some of the personal things that manager might want you to know. For example, a staff member

recently returned after a long leave that was public...and she's back, her husband had cardiac surgery, and that was disclosed, I mean anything you wouldn't want to be disclosed wouldn't be on the form, one of the radiologist has a first grandchild. So, it's the little things that are on there as well as, um, anything hot, there having an American College of Surgeons visit to the Cancer Center in May...So, any little tidbit you need to know and any issue, any hot issue as well as any congratulations...So, the manager is responsible for giving us that, the week or a couple of days before and then I basically go and make rounds...it is kind of open ended but it gives you some things to talk about and then you can follow up.

Trust.

Establishing trust is the second phase of the CNO relationship with the SNs. Each CNO expressed how important it was for them to establish a trusting relationship with the SNs. The CNO ensured a level of trust with the SNs by being transparent with the SNs during their interactions and various types of communication. Without such trust, the relationship would be strained and a lack of support would be evident. Trust developed over time and captured the essence of seven categories. There were seven categories that describe the beliefs and behaviors of the CNOs that contributed to the development of trust, they were as follows: *transparency, integrity, fairness, autonomy, respect, non-threatening, and protection.*

Transparency.

The CNOs expressed the need to be transparent when interacting with the SNs. They felt transparency would have a positive impact upon furthering the development of their relationship with the SNs. All the CNOs described ways in which they demonstrated transparency to their SNs as well as the importance of being transparent.

Lea: I say what I mean and mean what I say, I am a stickler...but being consistent for staff, it is incredibly important, that um, once you say something it's not going to change somewhere else, um and if you say it, then you're going to do it and you get back to them or do whatever you say, that is crucial.

Shelly: I think you just have to be very, very, transparent. I think you have to tell them the good, the bad, and the ugly...I don't think there is any other way to talk to a professional nurse, except to be straight with them. I think it gets you more ground then trying to spin...I'm not a spinner.

Donna: It's about honest conversations...they understand the realities.

Integrity.

Also important to the CNOs was integrity. They expressed how significant integrity was for establishing a relationship. Many of the CNOs described examples of how they demonstrated their sense of integrity to the SNs.

Margaret: It takes time, you have to prove yourself...trust has to be earned. It's that we believe in...and one of them is trust and integrity...So, we live it.

Shelly: I don't share anything confidential, because I can't. I have to maintain all that stuff but, I'll answer any question, with, you know, complete candor and truth. I think the truth will set you free.

Judy: I think overall they, over time, you know, they've trusted me. They see that my commitment to them is strong.

Fairness.

Hands down, the CNOs were all in agreement; they had to be fair in their decision making, when it comes to the SNs. The CNOs understand that things are not always black and white but at the end of the day, they had to be fair. They felt fairness was one way the SNs would judge them and they did not want the SNs to perceive that they were unfair in their approach. Ultimately, if the CNO was perceived as being

fair to the SNs, this fostered positive relationships with the SNs. Margaret shared how important it was for her SNs to perceive her as fair. The other CNOs described examples of how they demonstrated their sense of fairness to the SNs.

Lea: I have a nurse who came through our extern program, who we hired as a RN and she really thought she wanted surgical services and we put her in surgical services, which was rare. We don't usually put GNs (graduate nurses) in the OR (operating room) but she really thought that was what she wanted to do and I was like, let's give it a shot. We worked with her all summer. She was great, gave her a shot and I think the first week she was there she was like, oh my god, what a huge mistake but she was afraid to tell me and um, the nurse who precepted her for her externship, I was doing rounds one day and she goes, have you talked to Dawn, she was going to come to talk to you and I said, no, what's wrong and she said, she doesn't like it, can we do anything for her and I'm like let me find her. So, I came and talked to her and I tried to tell her and get in her head there are so many other opportunities for her, let me try to help you. So, it took me a little while because we had no vacancies but um, we piecemealed a position for up in med-surg and I just saw her preceptor yesterday and she said, have you seen her? She flipped to nights so I don't see her as much and she said, oh my god, she is so happy...so, I think, I think the reason they appreciate, you know...

Michele: It goes back to being a good listener and you have to tell the story straight, it isn't always good news. I don't think you can, sometimes, it's just killing you, you know, you just have to say "No I can't do that, no we can't do that for this reason but I've come of the years to understand it's not really so much the message, but that you have been open and honest with me, and that's just the way it is. I think they deserve that from us.

Shelly: We're making things a little more stringent (regarding their (clinical ladder program-to be fair to everyone participating)... what I hope they tell you is that I am fair.

These CNOs believed that honesty was the best policy. They acknowledge the intelligence of their SNs and fully understand that you cannot pull the wool over their eyes. Therefore, the CNO's philosophy was to be honest when communicating with

the SNs. Even if the CNO has a difficult message to deliver, it cannot be sugar coated; it has to be honest and sincere.

Lea: I am a very honest person and I don't beat around the bush, here is the deal...

Michele: So, even when there were times when we couldn't give raises and corporate wanted us to wait and he said, "If they want to know in January and they ask the question, then I feel I need to share that in an easy a way I can because not everybody's is making the big bucks. So, I think they deserve an open honest answer.

Donna: It think it's openness, I think it's honesty...So, I try to be very, um, honest but not pessimistic.

Autonomy.

All these CNOs echoed how important autonomy was for the SNs. The CNOs elaborated on several examples on how autonomy is actualized in their acute care setting.

Michele: We began the TCAB (Transforming Care At the Bedside) journey and staff shines when they are able to express their own autonomy and ideas about their units and so I think that all put that whole package together and you are supported by your team and hospital administration helps for staff to feel like this is a place they really want to work.

Shelly: You have clinical power (referring to the SNs)...and then let's keep our eye on why we are here and all the things that you do, that is so important, and why you are so important.

Judy: I have involved them in a lot of decision making and autonomy which I don't think they had prior which I think they really value.

Respect.

Judy, Margaret, and the other CNOs share how important it is to be respectful to one another. According to the CNOs, being respectful does make a difference to the

SNs. Acknowledgement of respect further enhances the relationship between the CNO and the SNs.

Michele: I think above all, if we don't respect each other, we're going to have a hard time to work together...I think they need to be respected for what they do in their position.

Shelly: I hate criticism like anybody else but I do listen...I may not like it but I listen, but they think it is real cause I will go back to them and tell them, "you're right," and they like that...I always treat people very respectfully.

Donna: I think I show them a lot of respect for what they are doing and I know they are doing hard work. Believe me, I know its hard...

Non-Threatening.

Judy and Shelly make it a point to share that they want to make sure that the staff feel comfortable interacting with them. To put the SNs at ease, Shelly takes the approach of being warm and smiling when interacting with them and she will even tell them a joke. In doing so, Judy and Shelly, believe this will lead to a positive relationship with the SNs. They take pride in the fact that they are not an intimidating force. The other CNOs also agree with this type of approach and the benefits of fostering the sustainability of the relationship. The ultimate goal for the CNOs is to have the SNs feel safe in speaking up about any issues they have so they can work collaboratively to improve a situation.

Michele: Lunch with Linda was for the staff to come down and share the good things that were happening on the unit and how the physician-nurse collaboration was. It was just to talk. We never went with an agenda, and it was not, was not to be a setting where you came to complain about a physician or a staff member. This was to talk about our professional practice, what kinds of things would they like to see or educational, what types of things would they like for us

to bring in, what do you think we should feature for nurses day, uh, those types of things.

Margaret: Word gets out quickly, people aren't afraid to come to me with their issues. It's part of our nursing philosophy, and we developed that with our staff.

Protection.

It was quite interesting, the CNOs were really so protective over their SNs. It reminded me of a mother bear protecting her cubs. All of the CNOs provided examples of how they single handedly protected the SNs in their organization from harms way whether it was from a disciplinary action that was going to be taken or a termination, the CNO advocated for the SN and was the one who could see the situation objectively and provide guidance for the final outcome of the SN. The CNOs were very passionate about protecting and saving their nurses from harm. The CNOs were realistic in considering the circumstances surrounding the incidents that the SNs were involved in. The protection offered by the CNOs to the SNs augmented their relationship and trust in their relationship.

Lea: I think what helps build the relationship and I'll give you an example, this happened here um about three years ago. We had a very significant medication error and um with a pregnant mom and you know that is our bread and butter and the nurses in the entire MCH (Maternal Child Health) division were pretty exceptional. I have to say, they are amazing; besides St. Pete's in North Jersey... We deliver more babies than anybody else. So, this is the baby capital of South Jersey. So, it's a big, big, thing and we had a really significant issue, a medication issue and I think based on how we jumped on this and how we handled things and stuff like that, it was, is this woman going to lose her job? So, I am sitting with the director and I'm like, did she do it on purpose? And she is like, no...I said then, why should she lose her job? I said, I bet you 10 to 1 she will never do it again and she goes, oh my god, Lea, she has been crying for two weeks and I'm like, don't you think she already learned...do you know what I mean? I think that kind of philosophy has kind of helped to change the relationship

of the staff you know sometimes they don't know how to take me...do you know what I am saying? Well, it's like heck, we are all human, we come, we make a mistake, it's a whole different thing if it is intentful. But, that's, that's different...that wasn't the case. It wasn't egregious. I remember my, even my directors were like, wow.

Michele: Now, if I hear them, a doc, sometimes the doc's get going on them (SNs), I will step in, "You were just talking about...that's enough now." "We need to take the two of you and we'll talk about it." But I do defend them on that, because they are not here 24/7 and they don't always have the right answers...the staff nurses say, "Michele is somebody who always has our back." So, from that stand point too...they see that happen.

Shelly: I represent the nurses, the good, the bad, and the ugly... always, even the ugly...I have family members that say, I know that nurse didn't tell the truth and I let her in here I said, "I'm sorry," I said, "I represent that nurse and I represent the hospital, trust me that things will be done properly but I'm the person you need to speak to."

Similar to being protective, the CNOs shared many stories about how strongly they felt about their SNs and they clearly defended them to the end. They would not allow for their SNs to be taken advantage of by anyone. All CNOs were very clear about their position relative to defending the SNs. In one specific case, Shelly had a SN who was not truthful to her regarding a situation that transpired with a physician, but because the physician was wrong in his approach, Shelly continued to defend the SN. Michele and Margaret made a point of sharing that they will defend the SNs to the point that they can and it all comes down to trust, and according to Shelly, they know that their leader is fighting for them. Examples of how the CNOs defend their staff in the face of adversity is evident. This also helps to develop and sustain the relationship between the CNO and SNs.

Lea: The turtle is our little, um, our little mascot and the turtle means not

that you are slow and consistent but that you stick your neck out for what is right.

Judy: I think sometimes senior management; you know, has this, uh, uh, vision and they want to make it happen but you've got to remember that you've got all levels of staff, all generations of staff, learning levels are different, and you can't make it happen over night and you need to at least, to take time and you need to get buy in.

Reciprocal Support.

The third phase in developing and sustaining the CNOs relationship with the SNs was reciprocal support. It became apparent that reciprocal support was the outcome of building and cementing the CNOs relationship with the acute care SNs for the present and in the future. Specifically, reciprocal support emerged as a positive and significant turning point whereby the CNOs gave support to the SNs in various venues and the SNs gave the CNOs support not only in their role as the leader but also in their participation on projects and committees they served.

There were four categories which emerged from the data that formed the sub theme of reciprocal support. The four categories were; *support for one another*, *appreciation for one another*, *a sense of thankfulness*, and *a need to recognize each other*. The CNOs provided rich descriptions of each category, which are noted below.

Supportive.

All of the CNOs discussed, in depth, a great sense of reciprocal support they have encountered between them and their SNs. Specifically, this sense of reciprocal support gave the CNOs a feeling of validation for being there for their SNs, which in turn demonstrates that they are human, they have feelings, and they ultimately care

about the SNs. Conversely, the SNs were there to support the CNO. The CNOs verbalized the fact that reciprocal support added to their relationship with the SNs. Ultimately, once reciprocal support was achieved a trusting relationship was solidified. This statement was evidenced by the overwhelming sentiments of genuine love for each other from the CNO perspective.

Lea: We had someone who was in a car accident and his wife was in the trauma center at Cooper and we donated PTO (vacation time) and did everything, trying to help him. He didn't have enough money to fix the car. So, we got him taxi rides so he could go back and forth to see his wife...it's that kind of stuff and I think the more you try to demonstrate for your staff and I, my world is nursing, the more you try to demonstrate for your staff appreciation and caring, um, and that they are someone who is very valuable, um, the more they will give back to the organization...I have always believed that you get more with honey and um, again, if your employees feel like they are appreciated, cared for, and valued they will rise to the occasion...Many people have said to me, Lea, your people would do anything for you.

Michele: My relationships at work, it's like who will help me out when I need it and I'm here if you need me. So, I just think that's what ties into having a good relationship...I feel free to share those things with them about me so that's how I view it, that's to me loving them and they love me back

Margaret: The staff feels so supported...They are so supportive of me. We had a nurse who had metastatic cancer. She came to right down here to tell me, you know...we're all in this together...When people are in a crisis, they've got to know that we care about you.

Judy: When my father died and I had to leave suddenly and then came back, I just couldn't believe that during the time my family and I were grieving, the support I received from the front line staff as well as the managers and physicians, they came to my home in the time that I was grieving, they brought my family food, they were, I got letters from the front line staff, uh, the ancillary support as well as nursing, and I was just overwhelmed with the response and didn't expect it, didn't even think that, that,

would even happen...that was above and beyond...they didn't need to do that, there were no expectations, there were none whatsoever, but you know, it feels good to know that you are in such a caring environment, so supportive.

Appreciation.

A sense of appreciation was noted by all the CNOs. They truly understood the reality of what their SNs go through on a day to day basis and they sincerely appreciate all that they do for the patients, the patient's family/significant other, each other, and the organization as a whole. Because the CNOs in this study conduct rounds on the patient care units they can see what the frontline SNs endure and they appreciate them for their hard work. The CNOs also want to ensure that the SNs know that they do appreciate them. These CNOs do not take their SNs for granted.

Lea: I think they (SNs) appreciate being appreciated...I do believe recognition makes the employees feel appreciated...I have worked very hard very hard to let them (SNs) know how much I appreciate them.

Margaret: I appreciate them.

Shelly: We went through a storm and we came out better.

Thankful.

The CNOs verbalized how thankful they were to have such a great group of SNs. Donna commented how amazing it was to be part of a team, a winning team. The CNOs give credit to their SNs for making the organization successful as well as the positive patient care outcomes. The CNOs did not want to take credit for organizational achievements, positive patient satisfaction scores, and recognition for quality outcomes. The thankfulness by the CNOs came directly back to the SNs.

Lea and other CNOs described how the SNs would also thank them in an unsolicited way. Specifically, Lea had described a scenario regarding union negotiations with the SNs. As Lea was rounding, the key union leadership came up to her to say, "Thank you, it went well and we really appreciate everything you did." Additionally, the CNOs made it a point to share with me how they take the time out to send hand written thank you notes to the SNs and they mail the thank you notes to the SNs home. The CNOs felt it was so important to recognize the SNs and let them know how thankful they are for all that they do and their efforts do not go unnoticed. These examples illustrate the caring and concern for one another. Thus, the relationship between the CNO and SNs continues to evolve and strengthen.

Michele: When we did our 1st Nursing Summit and our theme was daffodils, one of the nurses does cross stitch and she presented that on behalf of all of them in 2005. I mean that's the kind of stuff you, you, can't buy that...(Michele walks over to framed crossed stitch on the wall and reads the following)... Thank you for your vision, Michele, one bulb at a time-
Love Your, Hospital Family.

Margaret: I send them thank you notes...I'll get thank you notes back for doing that.

Shelly: I am going to go upstairs and tell them how great they are, because they are...I get out there and I thank them, you know, it's one, one of those things that if they get in (referring to a snow storm), I've got to get in, but just these little things to say, "I appreciate you," "thank you," "thank you for coming in."

Recognition.

All CNOs have formal recognition programs in place for their SNs. The CNOs verbalized the importance of establishing and maintaining their programs. They felt it was a positive morale booster for the SNs. Again, the CNOs were so proud of their

SNs and they in turn want to recognize them. Although the recognition is provided to the SNs directly, the CNOs also share the SNs recognition both internally and externally. Additionally, the CNOs also have an informal ways of recognizing the staff. Shelly recalls how she often sends pizza to the Emergency Department when she recognized that they are holding or the Emergency Department volume is on the rise for the day. This type of recognition is done spontaneously. The SNs from the Emergency Department joke with her that she is the pizza lady. When Margaret makes rounds on the units and she observes a wow moment with a SN, she will reward them on the spot and recognize the SN in front of his/her peers. Overall, recognition has had a profound effect on the relationship between the CNO and the SNs.

Lea: I have never experienced such amazing, incredible nursing care, never, never, never...the extent and extreme of what they do for patients is absolutely overwhelming to me...We do celebration rounds once a month. We bring around, I don't want to say treats, but stuff, and we celebrate something, um, nights and days, um, so we can see everybody and say thank you for or we did great...cause the first thing they say (SNs) is what are we celebrating this week?

Donna: We recognize and celebrate a lot...certifications, educational achievements, customer service...So we congratulate and celebrate...I mean most of the recognition, we try, we do it formally; again, like I said, and informally. We have WAWA cards ten dollar WAWA cards and if you catch somebody doing something wonderful, we just give them a little personal note that goes to their home with the WAWA card. Yes, we are told that it is a big deal because it gets put on the refrigerator, people are very proud of that.

Judy: We celebrate nursing...I recognize nurses, we have a tea and we recognize nurses who have published, conducted research, received their certification, received an advanced degree, they are invited to meet with me for tea and we share our

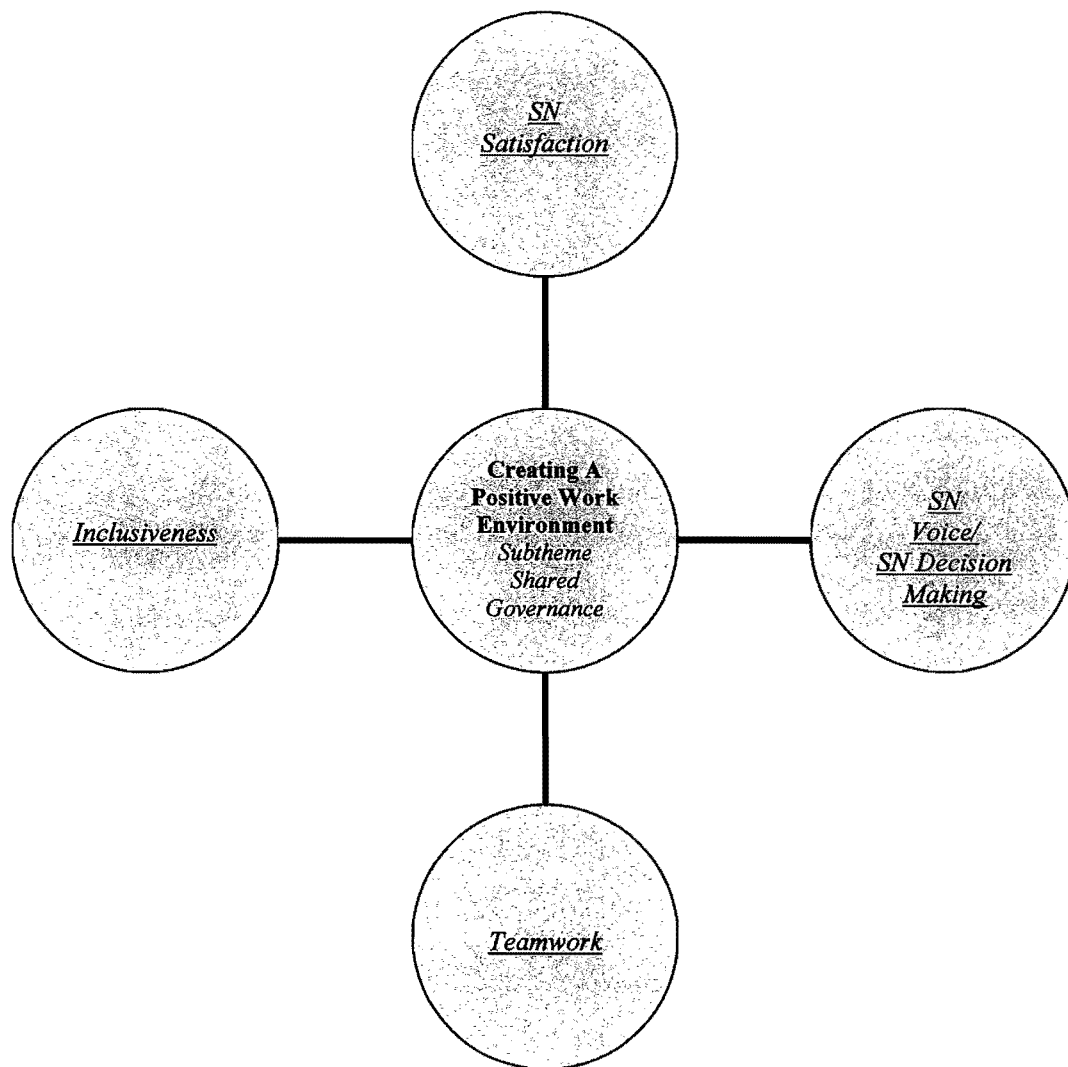
accomplishments. I send them personal letters.

Creating A Positive Work Environment

Creating a positive work environment was the second theme identified. The ability to create a positive work environment for the SNs was very important for the CNOs. The CNOs absolutely recognize that it is the SNs who are responsible to make things happen for the patients and the organization. It was the responsibility of the CNOs to ensure that the SNs have the resources they needed to provide the highest quality of care to their patients and that they create an environment whereby the SNs can thrive. From the CNOs perspective, the formation of their relationship with their SNs makes the difference in creating a positive work environment. *Shared Governance* was the subtheme which emerged from the data. There were four categories which emerged from the subtheme, they are as follows: *SN satisfaction, SN voice/SN decision making, teamwork, and inclusiveness* (see Figure 3). The rich descriptions are noted below.

Figure 3

Theme # 2-Creating a Positive Work Environment with *Subtheme-Shared Governance and Supporting Categories*



Shared Governance.

The CNOs expressed their desire to create a positive work environment for the SNs whereby they could establish a shared governance model which would take the SNs professional practice and growth to the next level. Every CNO had established professional practice councils, including those that were not a designated Magnet Hospital. The CNOs believed in forces of Magnetism and felt it was very important to get the staff involved as the expert and allow them to shape the delivery of care. The CNOs also expressed that they readily give up control and they want the SNs to drive the future of nursing in their organizations. The CNOs verbalized the positive impact this model has not only on the SNs but on the organization as a whole.

SN Satisfaction.

Lea and the other CNOs shared their beliefs that if a caring and compassionate environment could be created for the SNs, they would be satisfied. Michele and the CNOs all felt that the hospital environment had a family type of atmosphere and the CNOs can be there for the SNs. Overall, the CNOs wanted to ensure that their SNs were satisfied with them as leaders and that they were creating a positive work environment which would satisfy them at various levels such as professional growth and development, open lines of communication, and a sense of presence, just to name a few. Donna discussed the importance of employee engagement. She felt that engagement with the SNs would lead to a positive work environment because the SNs would be emotionally invested in their jobs and in the organization. Specifically, Donna shared that the SNs give their hearts and minds to their work; it is not just thinking about the SNs getting through their twelve hours shift and going home to

forget about everything. Margaret and the other CNOs were very proud to share that the SNs “love it” at the hospital. The statements below demonstrate the essence of what the CNOs did to positively impact SN satisfaction.

Lea: The mission of the system has two primary components, focusing on patients, patients, outstanding patient experience and also the employee. So, if you have happy employee, you will have happy patients and vice versa and all around. It is very refreshing to say the least...So, how do I keep them (SNs) happy? I think I had mentioned some of this but, um, we do have a strong, strong, focus on recognition. We have, I would say, unofficial recognition and very formal recognition...and we do that in a variety of ways. I'll just list a couple of them: we do “Caught you at your best.” It's a little card that we keep on the units so that employees or patients or families can fill them out. They get collected, um, once a month. We send a letter home to the employee. So, if somebody does something really cool at the moment, they could fill it out. They get a letter with something called ***Hospital Cash and it is a paper dollar that we've made that's available. They can spend it in the cafeteria or the coffee bar or something like that...We also recognize, um, the clinicians through Press Ganey (patient satisfaction tool). We send them letters, have parties...Formally, the health system also has something called the Superstar awards...that's where the employee gets an invitation in the mail to come and show up at a bus location at one of our sites and we tell them how to dress. They get on the bus. They have no idea where they are going and we bring them to a location and we have a big party; whether it be at a big art museum or the, you know, we had it at the Constitution Center. It is a really kind of spanky event, a nice event...We also make sure we, um, recognize for achievements; whether it be certifications or what happens in our nursing newsletter... those types of things and anybody who has graduated from school...more recognition than you could possibly imagine.

Michele: Now with the relief projects going on, people will give their time um, all you have to do is put a box out there and say what you need and people are willing to give a hand and we when we do our community fair, we have, the hospital is featured there. So we have many volunteers, we have to, they only have to come and spend a half an hour because it is not only the time they come in and serve the community, it is being able to be together and work together.

Shelly: I tell them how important nursing is and why we need nurses. I tell them, this is all about you, this is about you, because, you know, you're the best.

SN Voice/SN Decision Making.

The CNOs were all in agreement that it was paramount for the SNs in their organization to have a voice and more importantly for their voice to be heard. All the CNOs have established professional practice councils whereby the SNs have a voice and can make decisions about their own practice. Lea and Judy provide an illustration of her Professional Practice Council.

Lea: Something that gets me absolutely incredibly excited is that we have something called the Professional Practice Council and that is where one nurse from each unit meets with me once a month, all day, with me. So, I set the agenda...So, I have 15-16 nurses that sit on that council and they hear it straight from me. Whether it be reports, quality issues, what do you guys think, how about this kind of thing...I will tell you it is my favorite day of the month. It is exciting...It is fun. I get to know 15 nurses really well and they are on the committee for one year. I take them on road trips, um, do all kinds of stuff like that and it has been, like I said, my favorite day of the month. It's been pure joy for me.

Judy: You need to get buy in, that means not just getting buy in with the managers but with the front line staff.

In an effort to make improvements for the betterment of patient care and the organization, the CNOs understand the significance of establishing and sustaining their relationship with their SNs. The CNOs noted that they have to be behind the SNs. Some CNOs commented that they were the cheerleaders for the SNs because they wanted them to know how much they cared about them and several made comments that, "it's all about them." They were sincere in their comments and only wanted the best for the SNs. This goes a long way in making improvements. There

are several illustrations which depicts the deep descriptions for making improvements.

Margaret: You know we have unit practice councils and Shared Governance, and they have done so many wonderful things with pain management, changing how they deliver care, renovating the units, they designed our maternity, they designed the ICU (Intensive Care Unit). It's all from my staff. They picked the colors, they picked the pictures, they did the research, what's the best evidenced based color, what's the best evidenced based pictures, you know...

Margaret illuminated the general desire of the all the CNOs to have SNs on various committees in the acute care hospital. The CNOs are very much aware that SNs have to be intimately involved in being the decision makers for quality patient care outcomes. They also recognize the value of the SNs as decision makers. Over and over, the CNOs shared stories of how they have integrated the SNs into committees and the power the SNs have gained for the betterment of patient care. Shelly commented that it was her own staff that developed their Differentiated Practice Model (Clinical Ladder Program). Listed below are several examples of how SNs in the acute care hospitals are given the power and control to make both nursing and patient care decisions.

Lea: I also think that we have a process in this health system where we use a lot of six sigma tools which incorporates a lot of the front line employees into the decision making processes and transformation is going to change and um I think it is a huge focus on the value of the front line care giver and the information that they have that can help assist in that change.

Michele: Practice council always amazes me; the wonderful stuff they always come up with and the solutions that they have made.

Margaret: The system (the computer system) was built by my nurses, not me, I'm not the expert, they are. So, whenever we did the nursing documentation system I had a nurse from every single unit specialty area sit around the table with IT (informatics) and Siemens, and they built the nursing doc (documentation) system...So, they built it and they love it. We did the same thing with our care plan modules. A nurse from every single area, they built it, we cut down the number of care plans from three hundred to one hundred fifty six. We have a nursing task force for everything.

All the CNOs clearly expressed the need and desire for their SNs to be empowered. They did not want to hold them back from this opportunity. The CNOs were very thoughtful in sharing the benefits of an empowered nursing staff. Donna illustrates below the impact of SN empowerment.

Donna: I really try to encourage my staff that, you know, this is really what you do well (being a nurse), you need to really emphasize that and play to that...Promote yourself with your patients (meaning that they are empowered to make a difference).

Team Work.

In an effort to enhance the nature of the CNOs relationship with the SNs, it was important to create a strong sense of teamwork. It was not about shifts in power and control but it was about the CNOs recognizing the value of the SNs and coming together to make positive change in the work environment. Specifically, it was about helping one another through support and caring. Shelly provides two types of example to illustrate the sense of team work that demonstrate how together the CNO and the SNs work as team to ensure the best patient care, they are noted below.

Shelly: If I'm giving the nurses what they need, I know the patients will do great, it always goes back to the patients but it is through the nurse and then the patient gets, and it's my job

to make sure the nurses have what they need, educationally, mentorship, support, equipment, whatever, if they have what they need, they will do right by the patient.

Shelly: We pulled together to get us through (referring to the SNs helping each other in the ED without being asked)...they just stepped up.

Inclusiveness.

Judy and the other CNOs want the SNs involved and included in projects and changes that will affect them or their patients. The CNOs ascribe to including one and all to create a positive work environment. They do not want anyone left out of the process. Noted below are several comments made by the CNOs about inclusiveness.

Margaret: I sent out a memo to all nurses and said, if you can get away at nine o'clock, come down to the lobby and we are going to take your picture (for Magnet).

Margaret: The nurses give input and feedback as to where we are progressing quarterly (meaning the strategic plan). So, by having the plan, everybody is marching to the same drummer and we know where we want to go and how we are going to get there.

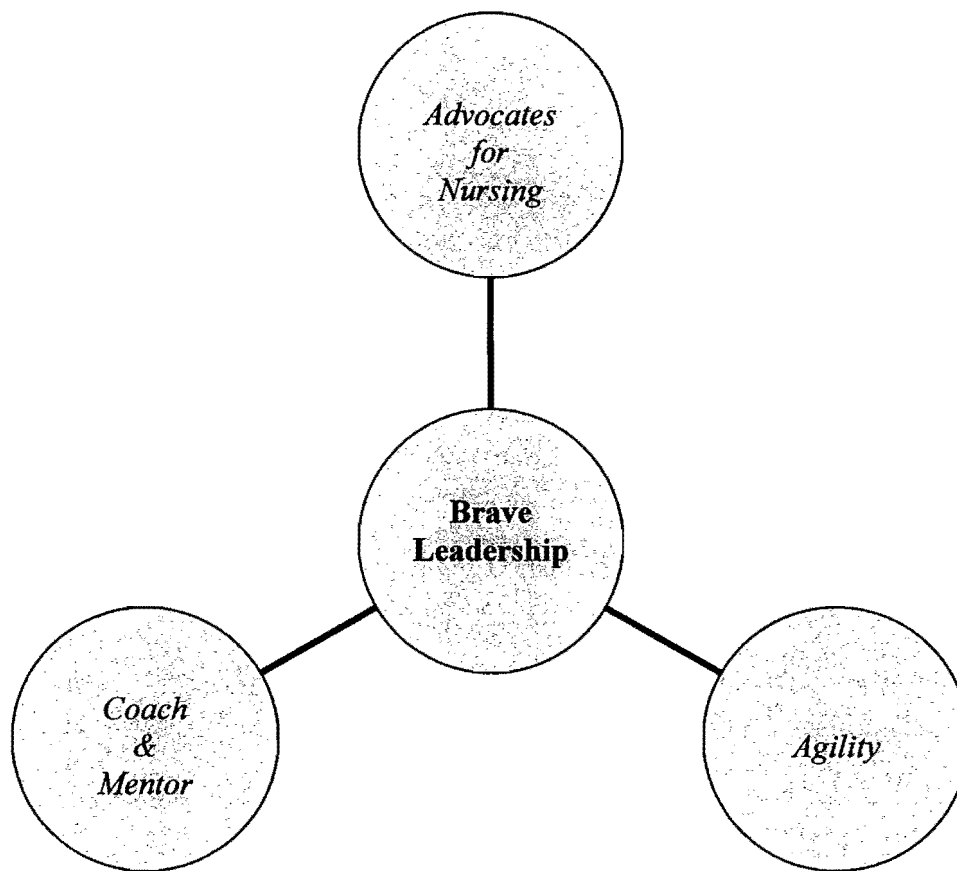
Donna: You need to include everybody who works there for you, you know, it's one of those social things that really are very important...As we integrate technology, particularly our, our, information systems, and you know, documentation on line and all, that's been you know, at times, a challenge and I don't want us to select systems or products that people are going to be like, "What was she thinking?"
 "This was her ultimate decision and she picks this?"
 So, I guess that inclusiveness and even making sure that I don't have the expertise, and believe me, I don't about a lot of things but I go to the people who do know and who can help me... We really have some people who are brilliant and who know way more than I know.

Brave Leadership

The third theme of this study was Brave leadership. The CNOs articulated clearly that they needed to be brave in their role as the Vice President of Patient Care Services/CNO. They stated they needed to be brave enough to stand up for what was right on behalf of their nursing staff, the patients, and the organization as a whole. There were three subthemes that together constituted the theme of Brave Leadership: *advocates for nursing, agility, and coach & mentor* (see Figure 4). The descriptions for each subtheme are noted below.

Figure 4

Theme # 3- **Brave Leadership** and Subthemes-*Advocates, Agility, and Coach & Mentor*



Advocate for nursing.

Lea stated it best when she said that she has incredible passion for her SNs. This statement captures the essence of how the CNOs feel about their SNs. It is through this passion that the CNOs advocate for their SNs. The CNOs truly care about their

SNs and want to ensure that they do right by the SNs in the sense of meeting their emotional and professional needs. By advocating for SNs, the CNOs further enhance their relationship with the SNs because the SNs know that the CNO has their back. Below are the three categories that lead to the emergence of this subtheme, advocating for nursing; *pride in nursing, visionary, and promotes nursing.*

Pride in nursing.

Michele shares that she feels “blessed” to work with her SNs and Lea feels like she is Cinderella because she is so fortunate to work with such a great group of SNs. She freely shares her sense of pride she has for her SNs. Shelly and Donna echo the same sentiments that they are proud of their SNs and Shelly commented that she is always proud of them.

Lea: I have been in 6, as I said to you, other health care institutions and they have all been like the Mecca kind of thing, at least in Philadelphia and you think you are in these exceptional places and then I got here and I have never experienced such amazing, incredible nursing care, Never, Never, Never. You know, the physicians are community physicians but the nursing care, and the extent and the extreme of what they do for patients is absolutely overwhelming, to me... We had a patient on our floor last fall, and his wife passed away, ok, and last fall he was the patient and he was very depressed, and no one could crack the shell and find out what was going on with this man. Everyone thought it was because of the loss of his wife. He was upset about his wife but that was not why he was so depressed. When he lost his wife and he had to be admitted to hospital, he had to give his dogs away and he gave it to a pound, he had 3 dogs, and he finally shared this with one of the nurses on the floor who's a wonder woman, she is just a pure joy and she was so taken by his story, that she went to the phone and called the pound, to find out about the dogs. All the dogs had been adopted and she got names of who they were adopted by so that he could call them and make sure they were all ok. So he finally gets discharged and he reaches out to these families and he gets to visit the dogs. It gets better, so this past week he happens to get admitted on

the same floor and he sees this nurse walk by the floor, he says, Marty, Marty, and she comes in and says, Oh my gosh, I can't believe you are back in...because she wasn't his nurse, and he says, I just want you to know what you did for me, it was so wonderful, and I will never forget you, on top of it, he was able to get his oldest dog back. He would have never been able to do that if it wasn't for Marty and I am like, this is what the nurses do.

Michele: When a patient from a nursing home was dying, that group of nurses would go in, so that's what they do, they call and they say, "You know what?" "It doesn't look good here," and they will go in and hold the patient's hand. You know that kind of stuff, you can't dictate it, I guess you don't get it when it doesn't come from the heart.

Shelly: I am very proud of them, of the nursing department. I want to say, we are the cream of the crop, we're getting there and I know it sounds very, um, whimsical but I believe that we are, we went through very tough times, we are in tough times but people are willing to stand up and do what's right.

Donna: I'm proud of them...I'm really their advocate.

Visionary.

The CNOs expressed both the desire and need to be visionary as a leader. Specifically, the CNOs set the vision and then shared that vision with the SNs, who in turn, became active participants in seeing that vision becomes a reality. The CNOs acknowledged the importance of the SNs involvement. Margaret made the best comment to illuminate the CNOs perception of being visionary as noted below:

Margaret: If you've a vision, you have to communicate it to the staff and get them behind it. So, I think the nursing strategic plan, we identify what goals we want to pursue for that and everybody works towards it. For Patient Satisfaction, we want to be in the 90th percentile, and everything I do, everything, I mean, we talk about is customer satisfaction.

Donna also made a similar commented to Margaret which is noted below:

Donna: Together, you kind of have to have the vision and then pull everyone along but I really think it's about people, people get it done.

One of the most consistent visions that the CNOs shared was that of either working on obtaining Magnet status or having achieved Magnet status. Shelly and Judy commented that they were on the Magnet journey and that was their vision. The CNOs were passionate about their desire for their SNs to be recognized not only internally but externally to the nursing community and to the community which they serve. Below is an example of how Michele's vision came to life regarding the establishment of a Shared Governance Model as part of the Magnet journey.

Michele: I think I have been so lucky, the things I learned because at the time the hospital was just starting with all the new things that were happening out there for nursing with all the new programs, um, and we were fully active, at one time, in VHA, and when you sat around that table, oh, you came away with a wealth of knowledge and what kind of programs you could do at your hospital and how you could lead your nurses and all the wonderful things about the Shared Governance Model and autonomy. So, I've been given that opportunity and, and, the slate to say take it where you want to and that's what we've done and I hope that I am doing the best for the staff and, but you know, that's only because I get the administrative support and they say, "Well, I don't quite understand it but if you think it would be good for the bottom line, go ahead."

Promotes nursing.

Judy and Shelly highlight the fact that they promote nursing at every chance they get. They and the other CNOs have such a sense of pride in the SNs that they want to let everyone know how special the SNs are. Shelly has always stated that she tells the SNs, "It's all about you!" Lea made a great point, which was echoed among the other CNOs as follows:

Lea: What people, I think, understand in this health system is we are only as good as the nurse at the bedside or the caregiver at the bedside. So, if you can, um, you know, absolutely impact the care giver at the bedside, we become that much of a stronger organization.

Margaret clearly told her senior administrative team why the SNs at the bedside are so valuable, so important, and so significant to the clinical care of the patients. Basically, Margaret's appeal to the senior administrative team allowed for the continuation of the SNs reimbursement for their participation in their DPM program at a time when raises were not given to other employees in the organization. It was this pride that the CNO had in the SNs that made the difference. Additionally, it was the basis of the relationship between the CNO and the SNs that solidified this sense of pride and the positive benefits of such.

Some of the CNOs also shared their sense of pride they had about their SNs in external forums. They wanted everyone to know how great their SNs were. The CNOs claimed bragging rights in regards to their SNs. One CNO provided an example of her proudness as noted below.

Donna: I was invited to a quality conference in New Mexico and we bragged about the nurses and the accomplishments they've made.

Agility.

The CNOs expressed the importance of agility as it emerged from three categories that saturated the data. The first category was being *adaptable/flexible*. The second category was *taking action*. The third category was *change agent*. Below are illustrations for each category as expressed by the various CNOs.

Adaptable/Flexible.

The CNOs described the necessity of being flexible in their role and how they relate to the SNs. They truly do not see things as black and white. They want to have a full understanding of situations affecting the SNs before they react. They are very sensitive to the needs of the SNs and want to do the right thing by them. The CNOs felt it was imperative to be known as being flexible and it was also a positive gesture to solidify their relationship with their SNs. Michele provides an example of being flexible.

Michele: I don't know and there again, if I know they are having a real busy day, in the ED, I will help transport, I am putting myself in their place, they can't get it done, and our transporters are really busy, I can push a stretcher, I can still do that and they say, "Oh, no you can't." Yeah I can. Well, I just think that that's what that means to me, that I can still step into helping them out in some way.

Given the turbulent health care environment, the CNOs must be adaptable in their leadership. Several of the CNOs also expressed that they had to be strong and brave in their approach. Below are two illustrations from Lea and Shelly which describes the way in which they have to be strong in the sense of brave leadership which includes being open to constructive criticism so you can adapt your style if necessary and the value of not being perceived as weak.

Lea: You have to be willing to take the criticism and internalize it to make yourself better. Feedback doesn't have to be negative, it's really just to help you.

Shelly: You have to be brave (referring to leadership)...you can't, you can't be perceived as being weak because if you are weak, that means you can't advocate, you have to be brave.

Takes action.

The CNOs are known for taking action. They verbalized that they are the “go to person” to get things done. In addition to this, the CNOs value the fact of having this reputation. It gives them added credibility with the SNs and it also further enhances the nature of the CNOs relationship with the SNs because they know the CNO will be there to take the appropriate action necessary. The CNO has to be brave to take on the challenges she has been confronted with. There are three examples by Lea, Margaret, and Judy who shares several insights about how they take action.

Lea: If you are not out and about, if they (SNs) don't feel comfortable coming to you and saying, “Lea, here's the dirt”...and what is crucially important is your response. You cannot over react. You have to thank them, regardless of what they just hit you with...as you know, the floor just blew up. Thank you for sharing but I think that the reaction is absolutely critical.

Margaret: There was a lot of distrust at that point (when Margaret first came to the hospital). So, I had to be very visible I had to be a cheerleader, I had to lead them to a better place. Magnet really helped.

Judy: I'll ask, if I had to fix one thing what is your biggest frustration when coming to work...So, they know I'm open, I am interested and I am spending time to talk to them (referring to them being able to take action and correct what is frustrating the SNs).

Change agent.

The CNOs stressed the importance of being a change agent. It demonstrated that they knew the literature and they wanted to be on the cutting edge of shaping their nursing division with the SNs by their side. The CNOs are not satisfied with the status quo and they had to be brave to try new things and bring new experiences to the SNs and to the organization as a whole. The CNOs had to be brave to introduce

these opportunities but the payoff was priceless. Several of the CNOs discussed the different types of journeys they were on with their SNs. Their journeys are noted below.

Lea: We applied for the Malcolm Baldrige Award.

Michele: We are on the Magnet journey.

Michele: We are a Plane Tree Affiliate.

Many of the CNOs also introduced new programs for the SNs in an effort to elevate their own professional development. These new programs also had an added benefit to the patients and recognized the value of the SNs. The CNOs were delighted to have been able to make positive changes on behalf of the SNs. The CNOs felt a great sense of accomplishment by being able to get the support from their Chief Executive Officer. If it were not for the CNOs advocating for the execution of such programs and being brave enough to introduce them, the SNs work environment would not be enhanced. Below are rich descriptions of brave leadership projects executed by Margaret and Judy.

Margaret: Being an advocate for nursing, I was able to improve things for the nursing staff, certification pay... we offered classes here for the staff to get their certification. They all passed. We paid for the test and then we gave them three bucks an hour more, once they got their certification... We gave them preceptor pay, we gave them charge pay, um, I got the staffing up to par, we're 1:6 on days and nights... When they need something or want something, I investigate it and I get back to them.

Judy: I just recently closed the Diploma School of Nursing and we are opening up a BSN program...The nurses are really involved with making that happen. We also have a big push toward nursing, nurses getting certification...We take the opportunity to raise the bar of nursing, changing expectations, giving more autonomy, and the value of nursing is the key.

Coach and Mentor.

Being a coach and mentor to the SNs was the third subtheme of Brave Leadership.

Shares knowledge was the category from which coach and mentor emerged.

According to the CNOs, being a coach/mentor to the SNs was just an incredible experience.

Shares Knowledge.

The CNOs believed they had to be a role model to the SNs. The CNOs do not expect the SNs to do anything they would not do themselves. This assists in the development of the relationship between the CNO and the SNs. By being a role model, the CNO is able to share knowledge with the SNs. Lea elaborates below on being a role model.

Lea: So, you know, if I expect them (the nursing directors) to round, then I have to role model that.

Donna: So, as part of the servant leadership thing, it was, you know, really the emphasis on us being role models and by transference you know, our managers and directors, the behaviors are the basic expectations so you can't be good in your job and be miserable, like that is not okay, and it's taken a long time for that to really kind of disseminate throughout the organization and people to be accountable for behaviors, but we're there.

Shelly and many of the CNOs are also role models by being affiliated and active with their professional organizations. Several of the CNOs have shared the benefits of the being part of their professional organization. As part of brave leadership, they are not

afraid to say they do not know everything but they are still engaged in learning new things and positively impacting the profession. Margaret and Donna share their perspective on learning new things and being knowledgeable below.

Margaret: I am part of ONE/NJ and I'm on the legislative committee and I'm out there fighting for um the legislation to recognize we need more nurses in the future.

Donna: I want to be perceived as you know, of course, knowledgeable, having expertise in nursing and in you know, nursing policy, and learning about things that are impacting our profession, at a higher level, um, and I think my involvement with ONE/NJ and NJHA Constituency Group, I kind of pushed myself to kind of do that not only to develop a network in the state but also so I could learn.

The CNOs embraced education of the SNs seriously. As a coach/mentor, the CNO created various learning opportunities for the SNs.

Margaret shares her experience of promoting education with her SNs. It is significant because as the CNO, she understands the value of SNs pursuing their education and wants to make sure the SNs have easy access to furthering their education. The CNO is brave by making an investment for the SNs and this ultimately both enhances and further describes the CNOs relationship with the SNs.

Margaret: We promoted education. We brought a local University on site so our nurses didn't have to travel to get their BSN and their Master's degree. We have a contract with an out of state and University and there's on-line courses that people go... I am an educator, you know, in training and that has really effected the way I do things, because I am trying to teach and develop others. Not a negative person, I feel that everybody deserves a chance. We've got to teach them a better way...So, I am very much into that and being a coach, being a mentor.

The CNOs really seemed to enjoy their role as coach/mentor. It provided the CNOs with a deeper relationship with the SNs. The SNs would seek out the CNOs

for advice on their career, education, or even on personal matters. This allowed for the evolution of a trusting relationship whereby the SNs respected the CNOs for their advice and guidance and the CNOs felt validated by the SNs. Below are several examples of the joy experienced by the CNOs as they fulfill their role as coach/mentor to the SNs by sharing knowledge.

Donna: I really feel that career counseling and my mentoring of everybody as well as some managers and directors, I love that. So, they kind of know that I'm the one they can talk to off the record, about what they want to kind of do next, or go back to school, or should they try to another department or another area and I really love that. So, it's kind of nice that I can give back.

Margaret: I'm a leader, I teach classes and I ask them, "Who do you think is a good leader," and they say, "You."

Judy: I have really been working on the teaching role, the mentoring role, leading through to be a more successful leader, it's developing people and taking the time to bring them along, not just making decisions that they don't understand.

All the CNOs spoke highly of the mentors they encountered in their careers. Some of the CNOs are still in touch, to this day, with their mentors. The CNOs had such positive experiences with their mentors and that translated to the CNOs wanting to emulate that experience with their own SNs. Judy explains her experience with her mentor.

Judy: I had a great mentor who really learned, uh, about you individually...she mentored us on a daily basis; personally and professionally, on how to make good decisions and gave us feedback when she felt we weren't making the best decision. That mentoring was really important to me (she shared it helped to shape her as a leader).

Return on Investment (ROI) in the relationship with SN's

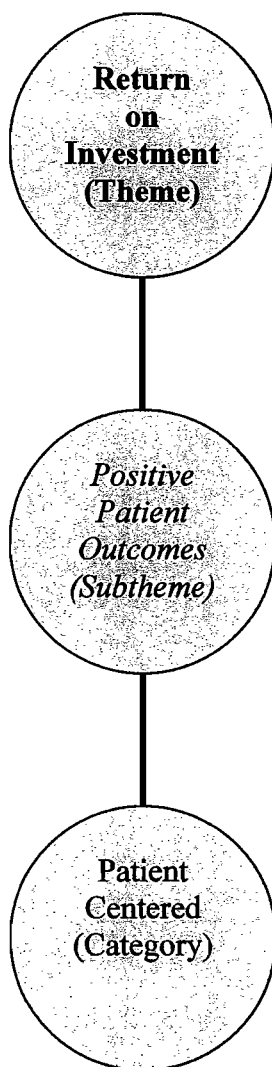
The fourth theme was Return on Investment (ROI) in developing a relationship with SNs. The CNOs believed that there was a positive return on their investment in the relationship with their SNs. By investing in the relationship, the CNOs believed that the SNs provided the patients in the acute care hospital setting with quality outcomes and the organization experienced success as a whole. According to the CNOs, it was the investment in the relationship with the SNs that resulted in the positive patient outcomes.

The subtheme for ROI was *positive patient outcomes*. One category emerged from this subtheme: *patient centered* (see Figure 5).

Figure 5-

Theme # 4- **Return on Investment**, Subtheme-*Positive Patient Outcomes and*

Category-Patient Centered



Positive Patient Outcomes.

Donna verbalized the fact that she believes the SNs are driving patient outcomes. This sentiment was also noted by the other CNOs. The CNOs shared the same point of view that if they invest in the SNs at the bedside, the patients would ultimately

benefit. Below are comments made by the other CNOs to support that SNs can influence positive patient outcomes.

Lea: The focus on having employees engaged and everything else actually helps our outcomes. So, that is why it is so important for this facility and me, that's why if I have happy employees then I know they're taking it to the bedside.

Margaret: They (SNs) are very happy. When you have happy staff, you have happy patients, you have good outcomes.

Shelly: It's the RN that has the greatest impact and significance on how well a patient will do and will reduce the incidence of complications and adverse things at the bedside, most often prevented by the RN. So, if you invest in the RN, in a way it helps them to improve practice, you are investing in the future of patient care...it's a no brainer.

Patient Centered.

Consistently, the CNOs shared wonderful stories about how the SNs demonstrated a strong sense of patient centeredness. The CNOs were so proud of their SNs in regards of how they went out of their way to do something special for their patients. Each CNO did not have to give the SNs permission to be patient centered; they empowered their SNs to make a difference in their patient's lives. Below is just one example to illustrate patient centeredness.

Michele: I'm telling you, it could be as simple as um just bringing in a birthday cake for a patient who just turned ninety or the last one we had, um, there was a patient on ICU that wasn't going to be able to make her daughters wedding and so the staff from housekeeping, dietary (and the SNs) they arranged from Chaplaincy, a simple ceremony at this mom's bedside so that she could see her daughter married. I mean, they didn't come down asking permission from administration, they were just allowed to do that. You know, it was quite the ceremony in the room, but that mom got to see that and they had a little cake and it was really cool. It's those types of things...

Chapter VI

FINDING MEANING

MetaTheme

A metatheme is considered to be drawn from the entire body of the data and it is also referred to as an overarching theme(s) (Ely, Vinz, Downing, and Anzul, 1997, p.206). Additionally, a metatheme is a major construct that highlights the overarching issues in a research study which may be considered against extant literature and experience (Ely, Vinz, Downing, and Anzul, 1997, p. 206). In this study, one metatheme emerged, *connective leadership*.

Connective Leadership

Connective Leadership emerged as the metatheme for this study. It captured the essence of the relationship and the four themes of this study. The CNOs described their relationships with the SNs as *connecting* with them during their daily activities, both formally and informally. Donna shares her beliefs on CNO connectivity as noted below.

Donna: The whole job is really about connecting with people, when you think about it.

Judy and the other CNOs expressed how important it was to develop the relationship with the SNs. The development of the relationship however was only one component of connective leadership. Through the development of the relationship, a sense of connection emerges and begins the process of connective leadership that includes being supportive, mentoring the SNs, creating a positive

work environment, having an true appreciation for what they face each and every day in the acute care setting, and standing up for them.

The CNOs knew that without a personal relationship, there would be no caring connection with the SNs. Judy and Lea illustrate their leadership perspective of CNO connectivity as it relates to developing the relationship with the SNs.

Judy: I've also really spent a lot of time in trying to develop relationships with front line staff.

Lea: There are a lot of things we talk about but it gives them (SNs) a direct connection into what I am like, what I am passionate about, and I get to know them that much better.

As the relationship evolves between the CNO and SNs, they *get to know one another*; a sense of *trust* with one another is gained. Once the CNO and SNs experience this level of trust then *reciprocal support* ensues. It is through this maturity of the relationship that connective leadership emerges. Specifically, the CNO and SNs sought out each other for different reasons; some personal and some were otherwise operational. Michele provides an example of how through connective leadership she is available to the staff regarding personal issues.

Michele: I make an effort to know family situations those types of things once they are hired and how they are doing and if they are having any problems, I really put myself out there enough to know them as people. I really do...um, because I really love them in there own way, even if they are cranky, or whatever, you just seek to find you know, where is that middle ground.

Donna and Lea illustrate the value of being visible and accessible to the SNs as noted below.

Donna: People need to see you and feel like they're connected, even if maybe they don't see you as frequently as you would like but

just that there is that connection.

Lea: The more they (SNs) see you, the more they get involved with you, the more they have to come to you with concerns or issues and stuff.

By *being present and making rounds*, the CNO felt they could personally connect with the SNs. A true sense of *support* was noted when the CNOs connected with the SNs on a personal level. Lea and Michele explain how being connected to the SNs lets them know you really care about them as a *human being*. The examples below support the concept of connective leadership.

Lea: It's not difficult, it's just time and people have to learn that this is what keeps your employees connected, this is what keeps them engaged because they really feel like they need to know you, that you care enough to know them and that, that is key.

Michele: When we get new people in the organization, I make it a point to be able to spend at least a half hour, a piece, with the new nurses before she goes on the ward, just to talk to her about her family, or wants and needs, where she wants to be professionally so that I feel like I've got that connection.

Overall the CNOs spoke about a sense of acceptance by the SNs. The CNOs attributed their acceptance by the SNs to their ability to connect with the SNs. Both Michele and Lea have illustrated two different situations which lead to the support of acceptance as a result of connectivity. The two examples are noted below.

Michele: I do rounds twice a month on the night shift and then we do 7p-7a so I usually come in around one in the morning and I am never not greeted with, "oh my gosh, I can't believe you are here, what are you doing here?" So, I think that is one of the ways I show them (meaning how the staff know you appreciate them). I have my face up there. I also do a lot during the day. They have more of an opportunity to see me. It's after the office is closed and I can go up and have some conversation, um, I know my staff, I know if they've got a child going off to college or I know if they have a mother who is ill and I can't say that for all 225 but those that I do know, I am blessed with, I don't have a real good

memory but if someone tells me a story about something going on, that's really unpleasant, I always make sure that I address it to see how they are feeling. It's just that personal connection.

Lea: There were petitions flying around signing for decert (decertify the union) and everything else, and I think what happened is that the union realized the militant bashing type of behavior does not work in this organization and it really turned the RNs off and they went to the union meetings and said they didn't want anything to do with you (meaning the union leadership), you are rude and obnoxious, and oh by the way, we really like Lea, she is a really nice person and she really cares about us.

Connective leadership included, *creating a positive work environment*. The CNOs recognized the value of the *Shared Governance Model* and they all established professional practice councils whereby the SNs would have *a voice and work together as a team* which would ultimately *create a positive work environment* for the SNs. The relationship of the CNO and the SN now goes well beyond a personal knowing. This is a bigger part of the nature of the CNOs relationship with their SNs. Donna captures the feeling of the other CNOs when she describes her feelings about creating a positive work environment for the SNs and the professional practice council impact.

Donna: You know, some is face to face (communication with the SNs), other, um, ways is about the open door which we talked about and email. People email me all the time and the nurse advisory council is really the one monthly venue when I connect with the nurses and they formally bring, you know, issues some are good things and whatever they want to talk about.

Additionally, the CNOs shared that through connective leadership they experienced an increase in cooperation and *teamwork* relative to executing plans or launching of new projects such as; Transforming Care at the Bedside (TCAB), reducing medication error, or reducing skin breakdown. Below, Margaret provides an example of how her connection with SNs led to the achievement of Magnet status.

Margaret: We have just been approved for redesignation (Magnet) and we had 0 deficiencies and 10 exemplar's so my staff are ecstatic. We are planning a party for next month. We already made the announcement on the overhead system, and at every meeting we are just cheering ourselves on, but the official party is going to be next month. We sent out a letter to all the staff to let them know and in the paper, as a matter of fact, today, we are making the announcement to the community. So, we are doing a lot of press releases right now.

Connective leadership includes *brave leadership*. The CNOs expressed their strong passion to *stand up for the SNs* and to make sure that everyone in the organization knew *how important the SNs were*. The CNOs bravely *advocated* for the SNs. The evidence of this metatheme was strong as it relates to being a brave leader. The CNOs discussed the importance of standing up for the SNs in different situations. Judy provides an illustration regarding the value of standing up for the SNs.

Judy: They (the SNs) need to know that whoever is making decisions for them and representing them, really has a vision on how it is going to impact the front line staff, and try to make it as easy as possible (for the SNs), and I think you have to be a really strong negotiator, because I am not always sure the senior management team understands what the front line nurses is all about or, or that a nurse is not a nurse and there are specialty areas and there are expectations, and you know, so, sometimes you really, uh, senior management really challenges you at times...you have to be very strong, supportive, and articulate...so, you are constantly trying to explain to your senior management why the front line staff role in the organization needs to be supported.

By *investing in the relationship* with the SNs, creating an excellent work environment, and advocating for the SNs, the CNOs believed there was a benefit to

the patient and the organization as a whole. Care to the patient was improved and quality outcomes were achieved.

Connective leadership goes beyond having a personal, trusting, supportive relationship between the CNO and the SNs. Connective leadership includes creating an excellent work environment and bravely advocating and supporting the SNs. Connective leadership captures the essence of a deeper relationship with the SNs and makes it possible for the SNs to provide excellent patient care. This study reveals that the nature of the CNOs' relationship is bigger than just getting to know each other and that the relationship, now conceptualized as connective leadership, also has benefits that the CNOs believe positively impacts the patients, and the organization as a whole.

Support for findings in the literature

In an effort for this lived experience to be better understood, from a leadership perspective, the findings of this study were interpreted within the framework of leadership theories.

There has been a paradigm shift in leadership theories. The findings from this study are consistent with Social Exchange Theory, Relational Leadership Theory, and Connective Leadership Theory. The findings from this study has relevance to each of these leadership theories, extending our understanding of each theory.

Social Exchange Theory.

Social Exchange Theory explains the development and evolution of the leader-follower relationship over time. There are three phases of the relationship in the Social Exchange Theory. The first is the stranger phase, the second is the

acquaintance phase, and the third is the maturity phase. This theory supports the findings of this study as it relates to the first theme; *developing and sustaining the relationship* along with the subthemes: *getting to know each other, trust, and reciprocal support*. Below is a description of each phase of the relationship which mirrors the findings of this study and lends support to the theory.

The first phase of the relationship is that the leader and followers are strangers whereby they come together with formal interactions and exchanges with one another are contractual. The leader provides the follow with only what they need.

The second phase of the relationship is an opportunity to enhance the working relationship with an offer which is a career-oriented social exchange that is made and then accepted. This is known as the acquaintance phase. Both the leader and the followers exchange and share more information with one another as well as resources; it is also a mixture of social and work related exchanges. At this phase both parties (the leader and the followers) are testing one another. Additionally, equitable favors are returned between the leader and the followers.

In the third phase, known as mature partnership exchanges, the relationship is growing to the next level. Specifically, the leader and followers can count on each other and there is a high level of support and loyalty. It is noted, the social exchanges at this phase are not only behavioral but they are also emotional whereby mutual respect, trust, and an obligation to one another is demonstrated.

Relational Leadership Theory.

“Relational leadership theory is a relatively new term in leadership literature” (Uhl-Bien, 2006, p. 654). Relational means that “an individual likes people and

thrives on relationships” (Lipman-Blumen, 1996, p. 165). According to Uhl-Bien (2006) and Drath (2001) the new way to look at leadership is through relationships rather than authority, and superiority. This theory allows us to examine leadership processes on “social dynamics by which leadership relationships form and evolve in the workplace” (Uhl-Bien, 2006, p. 672). Relational Leadership Theory involves “some type of connection or bond between one individual and another” (Uhl-Bien, 2006, p. 669). In relational leadership, “people work together to define and develop their relationships not just as questions of influence or leadership, but also as questions of how to keep all of this moving and working together” (Murrell, 1997, p. 40). All four themes and the metatheme of this study; connective leadership, provide support for the Relational Leadership theory and further describe the process of the developing the relationship.

Connective Leadership Theory.

Connective Leadership Theory was described by Jean Lipman-Blumen in 1988. Lipman-Blumen (1997) posits, to be an effective leader in today’s environment, connectivity in our everyday action is key. Additionally, the connective leader must be brave enough to weather the storms of change, and they must be bold enough to redefine leadership (Lipman-Blumen, 1997). The findings from this study lend support to Connective Leadership whereby the CNOs ensure that they are connecting with their SNs in their everyday action and interaction. The CNOs view connectivity as paramount to their work and the positive impact that transpires as a result of being connected to the SNs.

The connective leader will play a part in other's successes, to act as a mentor, to construct social networks, and entrust their vision to others by bringing them together (Lipman-Blumen, 1997). This study's findings are consistent with Lipman-Blumen's Connective Leadership. The CNOs established a shared governance model that brings the SNs together to work on solving problems. Additionally, the findings from this study demonstrate that the CNOs act as a mentor to the SNs and this provides further support for Lipman-Blumen's Connective Leadership Theory.

The connective leader is authentic. The CNOs from this study felt it was very important to be transparent and honest with their SNs. The findings from this study support the theory of connective leadership.

Connective leaders are interested in building a community which is framed within a sense of belongingness and the work environment is inclusive. Additionally, the followers are rewarded and recognized. The CNOs from this study have clearly demonstrated support of their SNs as evidenced by connective leadership theory in that they create a positive working environment for the SNs and they reward and recognized their SNs

A connective leader grows and develops their followers through coaching and mentoring. This study found that the CNOs coached and mentored their SNs. These findings are consistent with connective leadership theory.

The connective leader gives up control and does not micro-manage their followers but entrusts them with the responsibility to execute the plan. There is a sense of reciprocal trust and support between the connective leader and followers. Connective

leaders take risks. The findings from this study are consistent with connective leadership theory.

Connective leaders are in search of a deeper understanding of themselves, their followers, and the organizations in which they lead. In doing so, the organizations they lead provide the followers with opportunities to make a positive impact. Thus, the connective leader encourages the followers to exceed their own expectations. The findings of this study are in alignment with connective leadership theory.

According to Klakovich (1994), connective leadership is consistent with CNOs fostering interdisciplinary respect and cooperation as well as understanding the SN's concerns while representing their needs. Additionally, Murphy and DeBack (1991) posit that CNOs are change agents and that reveals qualities of connective leadership whereby the CNO strategically aligns SNs and other stakeholders to accomplish the established goal, decrease the competition, and create a win for all. "Connective leadership has great potential for empowering nursing staff and influencing positive outcomes for patients, nurses, and the organization" (Klakovich, 1994, p. 52).

Although the findings of this study support components of Connective Leadership Theory, the theory skims the surface of nature of the CNOs relationship with their SNs. There is more to the relationship and the findings from this study describe the relationship more completely. A fuller understanding of the process of the relationship and the outcomes of the connection is evident from these findings. Once the relationship is formed, through the leadership of the CNO, a positive work environment is created, the CNOs advocate for the SNs utilizing brave leadership, and then there is a return on investing in the relationship with the SNs. Overall, the

literature review on Connective Leadership generally supports the findings of this research. The findings of this research extends our understanding of Connective Leadership Theory.

Nursing Leadership Perspective.

Nursing leaders have adopted business leadership theories. Emphasis on nursing leadership has been placed on relational leadership (Kosowski, Grabbe, Grams, Lobb, Willoughby, Davis, and Sims, 1990). Additionally, the nursing leadership literature incorporates the human aspects of leadership such as caring (Miller, 1987, Nyberg, 1989).

Interpersonal skills are an important for CNO leadership as CNO effectiveness is dependent upon it (Moore, Biordi, Holm, and McElmurry, 1988). Interpersonal competence is imperative for developing the relationship with the followers (Fagin, 1988). Therefore, the nursing leader must be able to advance the goals of the organization by interpersonal relationships with the staff nurses (Fagin, 1988).

Nursing research has been conducted on leadership styles, personality traits, characteristics of nursing leaders, and behaviors, there are no studies to date which explore the leadership process or the relationship between the CNO and the SNs until this study. According to Lundrigan (1992, p. 49), “while an abundance of literature exists on leadership, no studies were found that attempted to illuminate the basic social process of nursing leadership.” The findings of this study do indeed illuminate the basic social process of nursing leadership.

Chapter VII

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary

The aim of this study was to better understand and describe the nature of the CNOs relationship with their SNs from an acute care hospital setting. The methodology selected for this study was phenomenology. By utilizing this method, the lived experience of this phenomenon was explored with six CNOs. Through interviews with the participants, data were collected from the actual spoken words of the CNOs. Four themes and one metatheme were identified. The four themes were; *developing and sustaining the relationship, creating a positive work environment, brave leadership, and return on the investment*. The metatheme that captured the essence of the relationship of the CNO with the SNs was *connective leadership*. The findings from this study were compared with leader-member relational leadership theories and a review of the literature. As a result of this research, a new understanding of the nature of the CNOs relationship with their acute care SNs was discovered.

Conclusions

Four themes emerged that described *the nature of the CNOs relationship with their acute care SNs, they are as follows:*

- *Developing and sustaining the relationship* was an important component for the CNOs to engage in with their SNs

- *Creating a positive work environment* so that the SNs could thrive in their professional practice
- *Brave leadership* which was demonstrated by each CNO in support of their relationship with their SNs
- *Return of the investment* whereby the CNOs invested in the relationship with the SNs and in turn the SNs gave back in many ways such as in patient care outcomes.

One metatheme, *connective leadership*, captured the essence of the relationship of the CNO with the SNs. The CNOs demonstrated their connection with their SNs during their day to day activities so that a relationship could be formed. Additionally, connective leadership included the creation of a positive work environment for the SNs and the CNO bravely advocates for the SNs. The CNO believed that there was a return on the investment whereby there was a benefit to the patient and the organization as a whole so the SNs can provide excellent patient care.

The findings of this research are not consistent with the literature. The literature suggests that CNOs are not connected, accessible, or visible with their SNs (HCAB, 2006). The CNOs in this study expressed concern for the SNs and a full appreciation of their day to day work life challenges. The findings of this study refute the literature that suggests that the SNs feel their CNOs did not care about them (HCAB, 2006). The findings from this study do provide support for several current leadership theories such as Social Exchange Theory, Relational Leadership Theory, and Connective Leadership Theory.

Strengths and Limitations of the Study

Phenomenology was very useful in describing and understanding of the CNOs personal experiences of the nature of their relationship with their SNs. The true meaning of the phenomenon of interest rests with the person who is having the experience (Munhall, 2007). In this study, it was the CNO who was the expert and the CNO is the one who provided the deeper meaning of this experience.

Trustworthiness of this study was maintained at all times and this is considered a strength of the study. The criteria for maintaining trustworthiness by Lincoln and Guba (1985) was adhered to. Specifically, the four criteria of trustworthiness included the following: credibility, transferability, dependability, and confirmability. For this study, the rich descriptions gleaned from the CNOs allow for transferability.

Even though this was a rigorous study, it had several limitations. One limitation to this study was related to gender. All participants were female. Although participation was open to both male and female CNOs, only the female CNOs were willing to participate. Another limitation was that the participants were Caucasian and there was a lack of diversity. There was a geographic limitation as all the participants in the study were from New Jersey. Also, there was a hospital setting limitation as all the CNOs were from an acute care setting.

This research only examined the CNO experience of her relationship with SNs. Interviewing both the CNO and their SNs would have strengthened the study. All six CNOs were exemplar nursing leaders who verbalized positive relationships with their SNs and there were no CNOs who participated that had a negative relationship with their SNs. Therefore, the participants were a homogeneous group; this was a

limitation. It is possible that CNOs who do not value their relationship with their SNs were not interested in participating in this research.

Personal Reflections

Through data analysis, I captured the lived experience from the CNOs' perspective on the nature of their relationship with their acute care SNs. The findings from this study have allowed me to reconsider my own thoughts, assumptions, biases and beliefs. Some changes to my worldview emerged as a result of the six CNOs experience.

Through the process of data collection and analysis, I felt I had a general understanding of what elements were necessary for a CNO to have a positive working relationship with his/her SNs. I truly was unsure of what would emerge from the data, although I had my own hunches and hopes. All of the CNOs in the study demonstrated a true sense of caring and concern for their SNs. They felt a responsibility in developing and sustaining a relationship with the SNs and through that relationship benefits were derived. I was pleasantly surprised by the findings and felt reassured with my initial hunches.

After much pondering, my pre-research beliefs have changed. I now have a deeper understanding of the process of developing the relationship between the CNO and the SNs. I now see that there are three phases to the initial relationship that is based on taking the time to get to know each other, mutual trust, and reciprocal support of one another. I now believe that the CNO, SNs, the patients, and the organization benefits from the relationship; all of this achieved by the CNO being connected to the SNs. I also now see the relationship as part of something larger,

Connective Leadership. I walked away from this experience learning so much from these stellar CNOs.

Personal change.

During this journey, my personal philosophy resonated with the philosopher, Epictetus (Matherson, 1968) who shared his thoughts on knowing...What is the first order of business for one who philosophizes? It is up to the philosopher to part with self-conceit. For it is impractical for one to learn what one thinks that one already knows. This has become my new lens in which I view the world. I have consistently challenged myself to unknow what I think I know. Specifically, I took to heart the teachings of Munhall (2007) whereby she encourages the researcher to unknow what they already know. According to Munhall (2007, p.76), "Once we believe something or think we know something, we cease further exploration or explanation." An important process that assisted me in remaining receptive to the CNOs experience was by reading and reading the spoken words on the transcripts. It was also beneficial to listen to the audio recordings of the CNOs. This opportunity allowed me to capture the emphasis of the spoken words of the CNOs and the framework of the rich descriptions regarding their own experience.

Although I maintained professional relationships with many CNOs from New Jersey acute care hospitals, I did not have any understanding of their relationships with their SNs. By interviewing the six CNOs, they knew that they were providing me with an intimate insight about what their actual relationship was like with their SNs. The CNOs took their role seriously as their contributions and their expressions of their experiences were so important to this study. I believe that each CNO spoke

honestly with me about the reality of their perspective relative to their relationship with their SNs. Each CNO willingly took time out of her busy work schedule to participate in this study. I was fortunate that none of the CNOs requested to end their participation in the study.

*Reflections on Dissertations: A CNO's Experience in
Becoming a Qualitative Researcher*

I thought I knew...
I thought my way was right...
I thought how else could it be?
I was ready to put up a fight.

To unknow what I know,
That is the key,
For the Qualitative Researcher is who I want to be.

I came to terms that I may not be right,
I came to terms that it was alright,
I now know that unknowing is my plight.

To unknow what I know,
That is the key,
For the Qualitative Researcher is who I want to be.

The CNOs spoken words
Are the words to be heard.
It is through their experience, that I can now say,
I know what I know, from the CNOs I met with, on those special days.

Implications for Nursing Practice

The rich descriptions of the lived experiences of these CNOs, along with the four themes and the metatheme that emerged, provide a deeper understanding of the

experiences of the CNOs relationship with their SNs and the potential value of the relationship.

The findings from this research have potential implications for nursing practice relative to nursing administration. The potential implications are grounded in the results of this study, which are based on the empirical data found, and the spoken recommendations of the CNOs. The potential implications are as follows:

1. The CNOs should take the time to get to know their SNs.

Note: CNOs encouraged connecting with new hires for 1:1 time.

The CNOs encouraged the development of various forums to provide both formal and informal meeting times with SNs to open dialogue.

They also advised that CNOs should be present and accessible to their SNs.

2. Whenever possible the CNOs should be fair, honest, and transparent with the SNs so that a sense of trust is felt.

Note: The CNOs shared how important it was from them to be fair and honest with the SNs. The CNOs thought it was important to mean what you say and say what you mean.

3. Encourage the CNOs to develop a sense of reciprocal support with the SNs.

Note: The CNO should consider taking any opportunity to demonstrate appropriate support and recognition to the SNs on a job well done.

The CNOs should share their appreciation of the SNs by encouraging a sense of reciprocal support.

4. Work to create a positive work environment for the SNs.

Note: By giving the SNs a platform to have a voice and make decisions, they are empowered. They are recognized for their clinical expertise. The SNs opinion matters and it is valued.

5. Be brave and encourage other CNOs to be brave in supporting their SNs.

Note: The CNOs recommended taking a firm stand on advocating for the SNs. They will defend the SNs from harms way.

6. Whenever possible, the CNO should take the opportunity to be a coach and mentor to the SNs.

Note: Spend time with the SNs when they seek out advice on future career and educational pursuits.

7. Invest in the relationship with the SNs.

Note: By investing in the relationship with the SNs, there is return on the investment whereby the patient outcomes are enhanced.

Recommendations for Future Research

In an effort to further advance the body of nursing administrative knowledge and practice, more qualitative research is needed which will hopefully add a broader perspective on the nature of the CNOs' relationship with their SNs. The results of this qualitative study suggest several recommendations for future research. I have identified five potential areas for future research they are as follows:

1. Future research needs to include male CNOs from an acute care hospital setting and more diversity in the CNO participants.
2. Future research should focus on understanding the nature of the SNs relationship with their CNO from an acute care hospital setting.

3. This study should be replicated with CNOs, from an acute care hospital setting located outside of New Jersey.

4. Replicate this study by exploring the nature of the Magnet CNOs relationship to their SNs versus the nature of the Non Magnet CNOs relationship to their SNs from an acute care hospital setting.

5. Further research is needed that explores the fit of these findings with existing leadership theories.

A Final Thought

CNO Relationships

It is my goal to get to know you.
I want to understand your cares and concerns
I never want you to come to work and be blue
You have to know that I am here for you

I value what you do
and I will always stick up for you
I can be there in a just a few

You put your trust in me
I put my trust in you
Together there is nothing we can't do

We are connected to each other
through genuine love and support for one another
I treasure the relationship we have just as if you were my sister or my brother.

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Appendix A

Methodological Outline for Doing Phenomenology (van Manen, 1997, p. 5)

A) Turning to the nature of the lived experience

1. Orient to the phenomenon of interest
2. Formulate the phenomenological question
3. Explicating assumptions and preunderstandings

B) Investigating the experience as we live it in everyday as opposed to conceptualizing it;

4. Explore the phenomenon: generate “data”
 - 4.1 Use personal experience as a starting point
 - 4.2 Trace etymological sources
 - 4.3 Search idiomatic phrases
 - 4.4 Obtain experiential descriptions from subjects
 - 4.5 Locating experiential descriptions in literature, art, poems, etc.
5. Consult phenomenological literature

C) Phenomenological Reflection

6. Conduct thematic analysis
 - 6.1.1 Uncover thematic aspects in lifeworld descriptions
 - 6.1.2 Isolating thematic statements
 - 6.1.3 Composing linguistic transformation
- 6.2 Gleaning thematic descriptions from artistic sources
7. Determine essential themes

D) Phenomenological Writing

8. Attending to the speaking of language

9. Varying the examples

10. Writing

11. Rewriting

Appendix B
Permission to Invite Potential Participants at the Local Level in New Jersey

Deanna Sperling,
President, ONE/NJ
Organization of Nurse Executives/New Jersey
C/O The New Jersey Hospital Association
760 Alexander Road P.O. Box 1
Princeton, New Jersey 08543-0001

Dear Ms. Sperling:

I am a Ph.D. candidate, at Seton Hall University College of Nursing. For my dissertation research, I plan to conduct a qualitative study to describe and understand the nature of the Chief Nursing Officer's relationship with Staff Nurses working in an acute care hospital.

The purpose of this letter is to request an opportunity to address the Chief Nursing Officer members of ONE/NJ during a regularly scheduled meeting in order to explain the purpose of my study and request volunteers who may be interested in participating in this study. I will need approximately fifteen minutes time to discuss the study purpose and to answer members' questions, as well as to explain requirements for participation in the study. I also plan to distribute written information about the study and documents the members can review at home before making a decision about whether to participate. I am enclosing, as part of my request, draft copies of these three documents for your prior review as you consider your response to my request.

The first of the three documents is the script I will read to the Chief Nursing Officers as part of my fifteen minute presentation. The second is a Letter of Invitation in which the CNO is formally described and requested. It contains directions for interested individuals to return their signed Consent Form as well as the process I will use to contact those who are interested. The third and last document is the formal Consent Form for the study participation.

An important prerequisite for the Seton Hall University application for IRB approval process is that the researcher demonstrates prior planned access to potential participants for the study being proposed. Thus, in order to meet this requirement, and because I must provide the SHU IRB with a Letter of Permission from those organizations from which I will seek potential study participants. I am also asking you to forward to me, a letter agreeing to allow me to address the membership of ONE/NJ for the purpose of seeking participants for my research study. Because I value your time, I am enclosing a form letter, indicating your agreement to my request to address members at the ONE/NJ that meets the above SHU IRB requirement. Once the IRB approves this study I will send you the official IRB Approval of this study, with the approved Letter of Invitation, and Consent Form. According to University policy all documents including those attached to this request remain as draft versions until final IRB approval of the study.

I also request permission to utilize your organization's list serve, to access members who may not attend the meeting at which I present the proposed research. I will only use the list

serve to invite participants if a sufficient number of study participants cannot be accessed at the regularly scheduled ONE/NJ meeting. If permission to use the list serve is granted and if its use is necessary, I will provide ONE/NJ with the necessary information/documents for distribution to members such as the three documents all other potential participants will receive and which are attached to this request in draft form.

Please accept my thanks in advance, for your consideration of my requests as outlined in this letter. In summary, I am a.) Requesting permission to address the ONE/NJ members at a regularly scheduled meeting, b.) Per SHU requirement, requesting your letter of permission to attend a ONE/NJ meeting to discuss my proposed research and c.) Asking for your agreement that I may use the ONE/NJ list serve to invite potential volunteers for my research study if necessary. If you agree, and for your convenience, I have attached a sample letter for you to sign and return it in the self addressed stamped envelope by January 5, 2010.

If you have any questions, you can reach me at Mary.Clyne@shu.edu or you may contact Sharon Venino, Administrative Assistant to the Ph.D. Program, Seton Hall University College of Nursing at (973) 313-6040. Mrs. Venino will forward your message to me and I will contact you as soon as possible.

Thank you, again.

Sincerely,

Mary Ellen Clyne, MSN, RN, NEA-BC

Elizabeth Sheridan
Chair, Chief Nursing Officers Constituency Group
C/O The New Jersey Hospital Association
760 Alexander Road
P.O. Box 1
Princeton, New Jersey
08543-0001

Dear Mrs. Sheridan:

I am a Ph.D. candidate, at Seton Hall University College of Nursing. For my dissertation research, I plan to conduct a qualitative study to describe and understand the nature of the Chief Nursing Officer's relationship with Staff Nurses working in an acute care hospital.

The purpose of this letter is to request an opportunity to address the Chief Nursing Officers Constituency Group of the New Jersey Hospital Association members during a regularly scheduled meeting in order to explain the purpose of my study and request volunteers who may be interested in participating in this study. I will need approximately fifteen minutes time to discuss the study purpose and to answer members' questions, as well as to explain the requirements for participation in the study. I also plan to distribute written information about the study and documents the members can review at home before making a decision about whether to participate. I am enclosing, as part of my request, draft copies of these three documents for your prior review as you consider your response to my request.

The first of the three documents is the script I will read to the Chief Nursing Officers as part of my fifteen minute presentation. The second is a Letter of Invitation in which the CNO is formally described and requested. It contains directions for interested individuals to return their signed Consent Form as well as the process I will use to contact those who are interested. The third and last document is the formal Consent Form for the study participation.

An important prerequisite for the Seton Hall University application for IRB approval process is that the researcher demonstrates prior planned access to potential participants for the study being proposed. Thus, in order to meet this requirement, and because I must provide the SHU IRB with a Letter of Permission from those organizations from which I will seek potential study participants. I am also asking you to forward to me, a letter agreeing to allow me to address the CNOCG-NJHA for the purpose of seeking participants for my research study. Because I value your time, I am enclosing a form letter, indicating your agreement to my request to address members at the CNOCG-NJHA that meets the above SHU IRB requirement. Once the IRB approves this study I will send you the official IRB Approval of this study, with the approved Letter of Invitation, and Consent Form. According to University policy all documents including those attached to this request remain as draft versions until final IRB approval of the study.

I also request permission to utilize your organization's list serve, to access members who may not attend the meeting at which I present my research. I will only use the list serve to invite participants if a sufficient number of study participants cannot be accessed at the regularly scheduled CNOCG-NJHA meeting. If permission to use the list serve is granted and if its use is necessary, I will provide CNOCG-NJHA with the necessary

information/documents for distribution to members such as the three documents all other potential participants will receive and which are attached to this request in draft form.

Please accept my thanks in advance, for your consideration of my requests as outlined in this letter. In summary, I am a.) Requesting permission to address the CNOCG-NJHA members at a regularly scheduled meeting, b.) Per SHU requirement, requesting your letter of permission to attend a CNOCG-NJHA meeting to discuss my proposed research and c.) Asking for your agreement that I may use the CNOCG-NJHA list serve to invite potential volunteers for my research study if necessary. If you agree, and for your convenience, I have attached a sample letter for you to sign and return it in the self addressed stamped envelope by January 5, 2010.

If you have any questions, you can reach me at Mary.Clyne@shu.edu or you may contact Sharon Venino, Administrative Assistant to the Ph.D. Program, Seton Hall University College of Nursing at (973) 313-6040. Mrs. Venino will forward your message to me and I will contact you as soon as possible.

Thank you, again.

Sincerely,

Mary Ellen Clyne, MSN, RN, NEA-BC

Appendix C-Acceptance Letter Template to Organization

Name of Contact for the Organization
Title of Contact for the Organization
Street Address of the Organization
City, State, Zip Code

Dear Ms. Clyne,

I am in receipt of your letter to the (Name of the Organization) indicating you are seeking permission as a doctoral candidate from the College of Nursing at Seton Hall University, to access our membership in an effort to invite potential volunteers for your research study investigating the, "Nature of the Chief Nursing Officer's relationship with Staff Nurses from an acute care hospital setting."

On behalf of the (Name of the Organization), permission is granted for you to invite potential volunteers for your research study. You can access our membership during our regularly scheduled meeting or if necessary through our list serve.

In closing, if I have any questions, I will contact you at the telephone number provided or through your Seton Hall University email. If I can be of further assistance to you, feel free to contact me.

Sincerely,

Signature of Contact from the Organization
Title of Contact Person

Appendix D Script

My name is Mary Ellen Clyne and I am in the Ph.D. Program, at Seton Hall University College of Nursing. I am conducting a qualitative research study to describe and understand the nature of the Chief Nursing Officer's relationship with Staff Nurses from an acute care hospital setting.

I am here today to invite the Chief Nursing Officers of this Organization to participate in this study. This study would entail several audio taped interviews with me. Some interview questions may include, "Tell me about your relationship with your acute care Staff Nurses," and "Share with me how you interact with your Staff Nurses."

Your participation in this research study is completely voluntary. The data collected for this study will be kept confidential and maintained in a secured locked drawer that only I will have access to.

I have provided for you a packet of information for your review which includes a Letter of Invitation, a Consent Form, and a self addressed stamped envelope. I would appreciate it if you could read through the information and if interested in participating, return to me the signed Consent Form by April 10, 2010.

If you have any questions when completing documents, you can feel free to contact me via Sharon Venino, Administrative Assistant to the College of Nursing, Ph.D. Program at Seton Hall University at (973) 313-6040. She will provide me with your contact information and I will return your call as soon as possible or if you rather, you can reach me via email at Mary.Clyne@shu.edu.

Thank you for your time and for considering to participate in this study.

Does anyone have any questions?

Thank you.

Appendix E- Letter of Invitation

Dear Potential Research Volunteer:

I am in the Ph. D. Program, at Seton Hall University College of Nursing. My dissertation is a qualitative research study of the Chief Nursing Officer's relationship with Staff Nurses working in an acute care hospital.

Because you are a Chief Nursing Officer, you are being invited to participate in this study investigating the nature of the Chief Nursing Officer's relationship with Staff Nurses from an acute care hospital setting. The study requires your participation in several audio taped interviews with me. Examples of interview questions that maybe included are, "Tell me about your relationship with your acute care Staff Nurses," and "Share with me how you interact with your Staff Nurses."

Your participation in this research is completely voluntary and there is no penalty if you do not participate. Although you are not anonymous to me, no one else will know your identity. Specifically, audio tapes will be coded with a number so that your identity will not be known to anyone except to the researcher. Study data and identification of participants will be maintained confidentially and securely locked in a drawer, to which only the researcher has access.

I invite you to read through the information provided, in the envelope. If you think you may be willing to participate, please read and return your signed Consent Form to me in the self addressed stamped envelope within the next week, or by April 10, 2010 at the latest. I

will personally telephone you as soon as I receive your signed consent form to answer any questions and to discuss your possible participation. If you have any questions, before or while you are reviewing the documents, please call Sharon Venino, Assistant to the Ph.D. Program, College of Nursing, Seton Hall University, at (973) 313-6040 and she will forward your message to me and I will contact you as soon as possible. If you prefer, you can reach me via email at Mary.Clyne@shu.edu. I look forward to hearing from you.

Sincerely,

Mary Ellen Clyne, MSN, RN, NEA-BC

Appendix F

Consent Form

Mary Ellen Clyne is a doctoral candidate at Seton Hall University College of Nursing. She is conducting a qualitative research study to describe and understand the nature of the Chief Nursing Officer's relationship with acute care Staff Nurses.

You are being asked to participate in this study because you are the Chief Nursing Officer, of your acute care hospital (the highest ranking nursing leader in the organization), you have been/were in your position for at least three and a half years, you know about the nature of the Chief Nursing Officers relationship with Staff Nurses, and you were not terminated from your position.

If you agree to participate in this study, you will allow for Mary Ellen Clyne, the researcher, to conduct a minimum of 2-3 scheduled interviews. The interview sessions will be open ended and therefore a time limitation cannot be predetermined, but it is expected that each encounter should last no longer than 2 hours. The meeting will be schedule at a location and a time of your choice, that will allow for an uninterrupted, private dialogue between you and Mary Ellen Clyne. The interviews will be audio taped and transcribed verbatim by a professional transcriptionist who will not know your identity. The researcher will make observations about the session which will be recorded as field notes.

There are no anticipated risks or benefits to you for participating in this study. You may withdraw from this study at any time, without reprisal. There is no cost to you for participating in this study except your time. Funding for this study will be the responsibility of the researcher and you will not be paid for your participation.

Overall results from this study will be published in the aggregate. Confidentiality will be maintained and upheld. Although you may not be anonymous to the researcher, no one else will know your identity. The researcher and Dissertation Chair will have access to the field notes, audio tapes, and transcriptions. All data will be kept in a secured locked drawer to which only the researcher will have access. Your identity will not be disclosed on any field notes, audio tapes, or transcriptions as it will be coded with a number which only the researcher will know.

You are encouraged to ask any question about this research study now or in the future. You can direct your question(s) to Mary Ellen Clyne via email at Mary.Clyne@shu.edu or through Sharon Venino, Administrative Assistant to the College of Nursing, Ph.D. Program at Seton Hall University at (973) 313-6040. If you prefer, you may contact the Dissertation Chair for this study, Dr. Judith Lothian at (973) 761-9306. If you have any questions regarding your rights as a human participant, please contact Mary Ruzicka, Ph.D., Director of Seton Hall University IRB, at (973) 313-6314. You will be given a copy of this signed consent form for your records at the time of the first interview.

I, _____ (print your name) _____, hereby authorized my participation in the research study on the nature of the Chief Nursing Officers relationship with acute care Staff Nurses and I consent to be audio taped. I have read the risks of this study, and I understand that I can withdraw from this study at any time, without reprisal.

Signature of Participant

Date

Thank you in advance for considering to participate in this study.

Sincerely,

Mary Ellen Clyne, MSN, RN, NEA-BC

Appendix G

Introductory List Serve Cover Letter

Hello, my name is Mary Ellen Clyne. I am in the Ph.D. Program, at Seton Hall University College of Nursing, South Orange, New Jersey. I am conducting a dissertation research study to describe and understand the nature of the Chief Nursing Officer's relationship with Staff Nurses from an acute care hospital setting.

I am writing today, to invite the Chief Nursing Officers of this Organization, to participate in my study. The study requires you to participate in several audio taped interviews with me. Some interview questions may include, "Tell me about your relationship with your acute care Staff Nurses," and "Share with me how you interact with your Staff Nurses."

Your participation in this research study is completely voluntary. The data collected for this study will be kept confidential and maintained in a secured locked drawer that can only be accessed by the researcher.

I have provided two documents for your review with information about this study. The first document is a Letter of Invitation and the second document is a Consent Form. After reading through the information, please contact me if you are interested in participating. I will send you a self addressed stamped envelope which you can return to me with your signed Consent Form by April 10, 2010.

If you have any questions about the study or when reviewing/completing the documents, please contact me by telephone through Sharon Venino, Administrative Assistant to the College of Nursing, Ph.D. Program at Seton Hall University at (973)

313-6040. She will provide me with your contact information and I will return your call as soon as possible. I can also be reached via email at Mary.Clyne@shu.edu. Thank you for your time and for considering to participate in this study.

Sincerely,

Mary Ellen Clyne, MSN, RN, NEA-BC

Appendix H

Interview Guideline/Outline

1. Tell me a little bit about yourself?
2. Describe your relationship with your staff nurses?
3. Share with me some examples of your interactions with your staff nurses?
4. How did you first develop a relationship with the acute care staff nurses when you started at this organization?