CLINICAL NURSE LEADER^{SM} STORIES:

A PHENOMENOLOGICAL STUDY ABOUT THE MEANING OF LEADERSHIP AT THE BEDSIDE

By

Barbara C. Sorbello

A Dissertation Submitted to the Faculty of

The Christine E. Lynn College of Nursing

in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Florida Atlantic University

Boca Raton, FL

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This dissertation was prepared under the direction of the candidate's dissertation advisor, Dr. Anne Boykin, Ph.D., RN and has been approved by the members of her supervisory committee. It was submitted to the faculty of the Christine E. Lynne College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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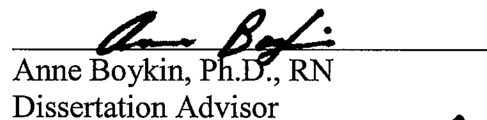

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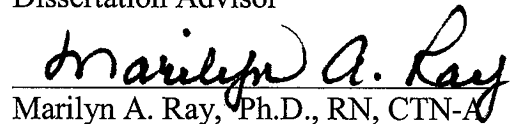

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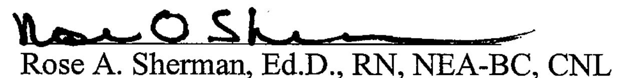

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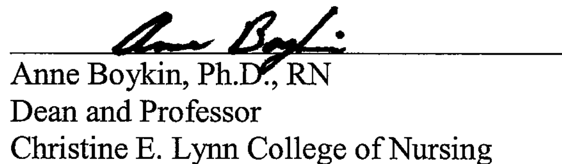

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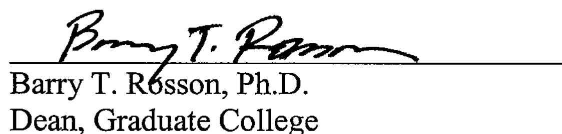

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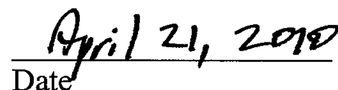

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Gratefully, I would like to extend my appreciation to the members of my dissertation committee for the time, energy and talent invested to critique my work, provide insight and challenge my thinking. To my chair, Dr. Anne Boykin, and committee members, Dr. Rose Sherman and Dr. Marilyn (Dee) Ray, a heartfelt thank you for helping me to grow as caring person and scholar. You all have been and continue to be mentors and role models for me, and I owe a great deal to you.

Finally, to the CNLs® who participated in this study, thank-you for helping me to gain understanding about your lived experiences as leaders at the bedside through sharing your stories. You brought me to laughter and tears as I listened to how you live caring and touch the lives of others; and as pioneers in this new role in nursing, you pave the way for those CNLs® who will follow.

ABSTRACT

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A new role has been developed in nursing named the Clinical Nurse Leader^{SM} (CNL®). This new role positions the masters prepared nurse at the patient's bedside to oversee care coordination and serve as a resource for the clinical nursing team, and to bridge the gaps in health care delivery to better meet the needs of patients in all health care delivery settings. Since this is a new role, there is a paucity of research that has been conducted surrounding these nurses. A phenomenological investigation examined the lived experiences of CNLs® to gain understanding about the meaning of leadership at the point of care and to discover the unique expressions of living caring that CNLs® experience as they embark upon this new role in the acute care hospital setting.

Ten CNL® participants were interviewed for this study. Their stories about patient situations and relationships with other disciplines were shared with rich description and emotion. Hermeneutic analysis of the text revealed six essential themes. Six essential themes emerged revealing the essence of leading at the bedside and living caring in the CNL® role: navigating safe passage, pride in making a difference, bringing the bedside point of view, knowing the patient as person, helping nurses to grow, and CNLs® needing to be known, understood and affirmed.

Taken as a whole through a synthesis of the themes, the understanding of the meaning of leading to CNLs® includes keeping their patients safe, being proud of their accomplishments and the respect gained from others, as well as being a helper and advocate for other nurses. This is accomplished through their privileged place at the bedside, where they come to know their patients as person and work hand in hand with nursing colleagues. When CNLs® are supported by management, and their roles are planned and understood, they are more fully able to optimally practice and live and grow in caring.

To my husband Ross and daughter Melissa

For their never ending love, support and patience.

To my extended family, those who are here and those who have passed

You paved the way for us and we stand on your shoulders.

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CHAPTER 1

INTRODUCTION

The acute care hospital setting is dynamic and complex, and continues to evolve in response to societal, political, technological and economic changes. Economic constraints, external agency regulatory requirements, patient safety initiatives, biomedical advances, new technologies and decreased lengths of stay and an aging population are just some of the factors that affect the care of patients (Bartels, 2005: Wiggins, 2006).

Coupled with these factors are issues within the nursing profession that impact patient care: a national nursing shortage, nurses prepared at different educational levels, use of unlicensed assistive personnel, utilization of contract nursing labor and 12 hour shifts. As a result, there is little continuity in care planning and delivery in the hospital setting. These conditions, plus an aging population contribute to creating what has been termed “the perfect storm” (Bartels, 2005, p. 221; Bleich & Hewlett, 2004, p. 2) of health care; a state where patient safety and outcomes, care provider satisfaction, and relationships between nurses, patients and other health care providers are threatened (Bartels, 2005; Reineck & Furino, 2005).

Navigating this complex health care system, advocating for, and coordinating the care of the patient through collaboration with others have evolved into pivotal nursing responsibilities. It is the nurse working within this fragmented system who provides care around-the-clock. The nurse at the bedside is challenged with the critical responsibilities for prevention of error and promotion of safety (Begun, Tornabeni & White, 2006) and competent, compassionate care. Recognizing that nurses are in this privileged and pivotal position to transform the care of patients and care delivery systems, it is imperative that they be adequately prepared to meet this challenge. Bartels (2005) proposed that professional nursing education should substantially change to prepare nurses for clinical leadership roles to fully participate in shaping an improved health care delivery system for our patients, our profession, and for the health of the community.

Inception of the Clinical Nurse Leader[SM] Role

In response to the need to improve the continuity and quality of care, the American Association of Colleges of Nursing (AACN) in collaboration with participants from a Stakeholders' Reaction Panel Meeting, initiated a working paper to design a new role in the healthcare delivery system (2003). The working paper was revised in 2004 and the latest version, the AACN white paper on *The Education and Role of the Clinical Nurse Leader[SM]* present nursing leadership competencies and the graduate nursing curriculum to prepare Clinical Nurse Leaders[SM] (2007a). This new role positions the masters prepared nurse at the patient's bedside to oversee care coordination and serve as a resource for the clinical nursing team. The AACN conceptualized this role to bridge the gaps in health care delivery to better meet the needs of patients in all health care delivery

settings. In the five years since the first AACN CNL® paper was published, more than 90 universities have created CNL® curricula in collaboration with clinical practice partners to prepare nurses for this new clinical leadership role.

The Clinical Nurse Leader℠ and CNL® titles are service marks and registered trademarks of the AACN with the United States Patent and Trademark office. The registered trademark is indicated by the “®”superscript in the CNL® title, and by the service mark “℠” in the Clinical Nurse Leader℠ title (AACN, 2009a). These trademarked titles may only be used by nurses who have graduated from master’s programs that incorporate the competencies delineated in the AACN white paper on *The Education and Role of the Clinical Nurse Leader℠* (AACN, 2007a), and who have successfully passed the Clinical Nurse Leader℠ Certification Examination. The Commission on Nurse Certification (CNC) of the AACN administers the Clinical Nurse Leader℠ Certification Examination. Candidates who meet all eligibility requirements and successfully pass the exam earn the credential and certification of CNL® and may use the initials CNL® in their credentials (AACN, 2009b).

Purpose of Study

The purpose of this phenomenological study was to gain understanding about the meaning of leadership at the point of care; and to discover the unique expressions of living caring in the CNL® role. Gaining an understanding of leadership as lived in the CNL® role will inform nurse administrators who create care delivery models of the unique contributions of this role to nursing; will inform nurse administrators of strategies and support essential to the living out of this role; and inform educators who develop

CNL® curricula.

The AACN has identified measures to evaluate the role that incorporate nurse sensitive indicators including patient falls, infections, hospital acquired pressure ulcers, and other empirical measures to look at patient outcomes and evidence-based practice. These quantitative measures will offer important findings about the value of this new role related to diagnostic and treatment activities. However, these data alone will not communicate the richness of the CNL® experience lived in relationships with patients, nurses and other staff members at the point of care.

Definition of Terms

This study focuses on perceptions of practicing CNLs® within the context of nursing situations at the point of care; and leading at the bedside in complex bureaucratic acute care settings. Terms used in this research that need to be defined to enhance common understanding include: description of the CNL® role; leadership and management; the concept of leading at the bedside; the nursing situation; the point of care; and the complex bureaucratic acute care hospital setting.

Clinical Nurse Leader℠: A leader in the health care delivery system across all settings in which health care is delivered, not just the acute care hospital (AACN, 2007b). The CNL® creates and manages microsystems of care, implements quality improvement strategies, contributes to the nursing profession and serves as a patient advocate within the three tiered framework of nursing leadership, clinical outcomes management and care environment management (AACN, 2007b). The role is defined by the AACN as a leader in the health care delivery system although the CNL® role is not one of administration or

management. The CNL® role requires specific graduate nursing education and professional certification. It is designed to include eight broad dimensions: outcomes manager, advocate, member of a profession, team manager, information manager, systems analyst/risk anticipator, clinician, and educator. The AACN delineates the fundamental aspects of the CNL® role (AACN, 2007a, pp.10-11):

- Leadership in the care of the sick in and across all environments
- Design and provision of health promotion and risk reduction services for diverse populations
- Provision of evidence-based practice
- Population-appropriate health care to individuals, clinical groups/units, and communities
- Clinical decision-making
- Design and implementation of plans of care
- Risk anticipation
- Participation in identification and collection of care outcomes
- Accountability for evaluation and improvement of point-of-care outcomes;
- Mass customization of care;
- Client and community advocacy;
- Education and information management;
- Delegation and oversight of care delivery and outcomes;
- Team management and collaboration with other health professional team members

- Development and leveraging of human, environmental and material resources;
- Management and use of client-care and information technology; and
- Lateral integration of care for a specified group of patients.

Leadership and Management: The terms leadership and management are used by the AACN in describing fundamental aspects of the CNL® role. Although these terms are often used interchangeably, the meanings are distinct and need to be distinguished. According to Tappen, Weiss and Whitehead (2004), managers have formal authority to direct the work of others and are formally responsible for the quality and budgets associated with the work. These conditions are not necessarily aspects of being a leader. The essence of leadership is the ability to influence others through shared vision, goals, teamwork and motivation. "Leadership is an essential part of effective management; but the reverse is not true; you do not have to be a manager to be an effective leader…" (Tappen, Weiss & Whitehead, 2004, p. 6).

As a leader, the CNL® works with and influences others to improve patient care. It is not designated as a management role in the organization. Management functions of the CNL® are related to management of patient care rather than aspects of formal management which include the authority for hiring and firing, evaluating employee performance, developing and monitoring budgets. Leading change and implementation of care practices are facilitated through developing networks of relationships rather than through authority. This is what differentiates and distinguishes this role from a middle management role such as the Nurse Manager.

Leading at the bedside: A synthesized definition of leading at the bedside was developed by this researcher through concept analysis. Leading at the bedside, or bedside leadership is defined as a way of being there, being with the patient, using influence, advocacy and expertise to facilitate and coordinate care through collaboration. The bedside leader also serves as mentor and role model for others (Sorbello, 2005). The following is a description of the essential aspects of leading at the bedside:

1. Being There and Being With the Patient

   The bedside leader practices within the nursing situation, being there with the patient. The characteristics and influence of the nurse as bedside leader are made possible due to the nurse's "intentionality and authentic presence" (Boykin & Schoenhofer, 2001, p. 61). The nurse is a visible presence who spends time with patients and other health care providers at all hours of the day and night. The quantity and quality of time spent with patients afford the nurse the opportunity to come to know patients as persons and to respond to that which matters most to them. Nurses witness the life changing events that patients face through their experiences with illness and health.

2. Collaboration and Relationship Building

   The nurse must consult and collaborate with others in order to plan, coordinate and maximize the efforts of many disciplines. This process requires critical communication skills including initiation and maintenance of constructive dialogue, coming to know others as caring persons

(Boykin & Schoenhofer, 2001), and valuing each person's contributions. Shared values and respectful relationships engender trust and are considered to be more important than attention to management of roles (Anderson & McDaniel, 2000).

3. Nursing Expertise

In addition to developing artful relationships with others, the nurse must have state of the art knowledge of the clinical specialty and technological skills in order to lead others, delegate, and create and carry out a plan of care (Benner, 2001; Perra, 2001). The nurse serves as a source of information for patients and other health care providers, and incorporates research-based findings into the clinical setting (Stetler, Brunell, Giuliano, Morsi, Prince & Newell-Stokes, 1998; Ingersoll, 2000). Clinical expertise establishes credibility with nursing staff, other disciplines, and in particular with the medical staff (Spitzer-Lehman, 1993; Warfel, Allen, McGoldrick, McLane & Martin, 1994).

4. Personal Influence as Advocate

Bedside leaders employ the skillful use of self as negotiator and advocate for patients' unique needs. The nurse represents the patients' best interests, views and concerns; aligns, motivates and inspires others through a leadership style grounded in respect and honoring persons. The nurse becomes the "go to" person who steps in during critical situations, mobilizes resources (Iacono, 2003; Peters, 2007), and uses persuasion and

character rather than position to overcome resistance to change (Gage, 1998; Mitchell & Bournes, 2000). A keen sense of how things work here, and who does what, is important in understanding organizational dynamics and how to work within and affect change in systems. Other important attributes include advocacy for the organization and the profession and involvement in policy making.

5. Facilitating and Coordinating of Care

   Nurses are educated to coordinate and integrate care for the whole person. This role requires understanding the importance and meaning of health and illness to patients as well as their hopes and dreams for the future. Serving in a horizontal or lateral leadership position, the nurse at the bedside coordinates the care of the team to meet patient needs and improve health care outcomes (Palmier, 1998; Shaver, 2004; Begun, Tornabeni & White, 2006).

6. Creativity

   Nurses as bedside leaders do not accept the status quo. Rather they look for opportunities to make positive changes by imagining the future and using resources and innovations that can benefit the organization and patients served. Being a risk taker, mustering different points of view to gain new insights, and improvising and playing off the strengths of others are all examples of creativity (Anderson & McDaniel, 2000). Being creative includes being open to new ways of looking at the world,

incorporating what Pink (2005) calls whole brain thinking. Pink (2005) posits that whole brain thinking is where left brain and right brain qualities join to offer a balanced view of the world. In this way of thinking, pattern recognition, understanding relationships between relationships, seeing the big picture, and aligning different perspectives are regarded as important qualities for creativity (Pink, 2005).

7. Mentor and Role Model

   Being a resource for others, modeling professional behaviors, living caring, teaching concepts and techniques are all characteristics of being a mentor and role model. Leaders at the bedside are of utmost importance in the growth and development of novice nurses. Nursing leaders are lifelong learners. They inspire confidence in co-workers, find the spark of talent in others and fan it into a flame. They participate in support, coaching and teaching activities.

The point of care: The point of care is where the direct care of patients occurs, such as in a nursing unit, operating room or emergency department. These locations are also characterized as microcosms. According to the AACN (2007), the CNL® role:

> "Functions within a microsystem to assume accountability for healthcare outcomes for a specific group of clients within a unit or setting through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. The CNL® is a provider and a manager of care at the point of care to individuals and cohorts. The CNL® will create and manage

microsystems of care that will be responsive to the health care needs of individuals and families (p. 6) and uses knowledge at the point of care to improve health care outcomes" (p.10).

Within the context of this study, the microcosm of care or point of care is the setting where the CNL® is providing care, namely the acute care nursing unit.

Nursing situation: The definition of the nursing situation is taken from the theory of Nursing as Caring (Boykin & Schoenhofer, 2001). It is defined as the "shared lived experience in which the caring between nurse and nursed enhances personhood…it is the locus of all that is known and done in nursing" (p.13). Each nursing situation is unique; a "lived experience involving two unique persons where the nurse must be willing to risk entering the other's world and the other person must be willing to allow the nurse to enter his or her world" (p. 14). A nursing situation occurs when the nurse engages in any situation from a nursing focus. It is in the nursing situation where calls for nursing are heard and responses to these calls are expressed. From the lens of this theory, living and knowing the value of nursing occurs within the context of the nursing situation (Boykin & Schoenhofer, 1997).

The complex bureaucratic acute care hospital setting: Bureaucratic organizations have been defined as social systems with hierarchical divisions of labor, supervision, differentiated authority, rules, regulations and goals created to achieve maximum organizational efficiency (Eisenstadt, 1959; Meyer, 1995; Ray, 2006). There is some degree of bureaucracy in virtually every organization, and a hierarchical structure of some kind to promote smooth operations within large and complex groups (Tappen,

Weiss & Whitehead, 2004). Acute care hospitals have been conceptualized as fragmented bureaucratic systems comprised of many professional disciplines working within silos, and customers and stakeholders who oftentimes have conflicting world views and agendas (Begun, Tornabeni & White, 2006; Gibbons & Krajnak, 1989; Globerman, Davies, Mackenzie & Walsh, 1996; Jacques, 2000; McWilliam & Wong, 1994; Nyberg, 1991; Ray, 2006; Weinberg, 2003). Hospitals have also been characterized as being 20 times more complex than most organizational systems (Bartels, 2005).

Acute care hospitals that were previously conceptualized as incorporating an industrial age model, were static, compartmentalized systems are now described as complex adaptive systems through a complexity science lens (Wheatley, 1999; Wiggins, 2006). Complex systems are created through networks of interacting people or systems. The higher the number of interacting agents within the system, the higher the degree of complexity and unpredictability of outcomes (Clancy, 2004). The social networks, relationships, and flow of information among members within the system act as the catalyst for organizational learning, environmental and structural change through adaptation (Clancy, 2008). In complex adaptive systems, effective leadership values relationship building and the value of interdependencies among people.

Agents or systems within the complex acute care hospital system include members of the community served, individual staff members, medical staff, volunteers, vendors, payors and all the processes that occur simultaneously to care for patients and keep the organizations functioning. A focus on increasing information flow, listening, enhancing relationships, cultivating shared vision, mental models and values are ways to

gain coordination and unity of effort among those working within complex systems (Anderson & McDaniel, 2000; Arndt & Bigelow, 2000; Burns, 2002; Holden, 2005; Ray et al., 1995; Senge, 1990; Zimmerman, Lindberg & Plsek, 2001).

Health care organizations are in a constant state of change. Interactions between the systems and people within the organization that create adaptations during times of great change or crisis is referred to as the "edge of chaos" (Holden, 2004). According to Ray, Turkel and Marino (2002), there is a bifurcation point at the edge of chaos where "either disintegration of relationships or systems, or a movement toward self-organization" occurs (p.13). In organizations that support and value the connections and interactions of the people within them, the organization can continue to grow and evolve in a positive way. An example is the organization that encourages open dialogue and decision making through shared governance among the nurses and interdisciplinary health care team members. Conversely, in an organization where open dialogue is not encouraged and decision making is centralized within department and hierarchical silos, poor communication channels and interdepartmental conflict may occur.

Theoretical Perspectives

Ray's holographic theory of Bureaucratic Caring (2006) and Boykin and Schoenhofer's theory of Nursing as Caring (2001) frame the context of this study. These theories were selected for the context they provide in understanding how nursing and nursing leadership's values of caring can successfully flourish within the complex acute care hospital system, and for the importance that the nursing situation, and stories of nursing have for understanding caring relationships and advancing the knowledge of

nursing.

Ray's Holographic Theory of Bureaucratic Caring (2006): The theory of Bureaucratic Caring originated as a grounded theory from a qualititative study of caring conducted within health care organizations, originally published by Ray in the author's 1981 dissertation. Study findings revealed that nurses and other health care professionals in hospitals struggled with "the paradox of serving the bureaucracy and serving human beings through caring" (Ray, 2006, p. 364). The formal Theory of Bureaucratic Caring was created as a result of a Hegelian dialectical process of examining "the thesis of caring as humanistic, social, educational, ethical and religious/spiritual, and the antithesis of caring as economic, political, legal, and technological dimensions of bureaucracy" (p. 364).

The theory of Bureaucratic Caring evolved from its development in the 1980's to the Holographic theory of Bureaucratic Caring in 2006 (Ray, 2006). The theory includes the assumptions that organizations are complex, with humanistic nursing values of spiritual-ethical caring woven interdependently and balancing the political, technological/physiological, economic, educational/social and legal dimensions of the organization. With spiritual/ethical caring infused throughout the organization, and by its integrative and relational connection to other dimensions of the organization, the values of doing good and facilitating choices for the good of others can be accomplished (Ray, 2006).

Acute care hospitals have been characterized as complex bureaucratic organizations which present nurses with the challenge of providing high quality nursing

care. Ray theorizes that leadership models remain fundamentally hierarchical and that the understanding of bureaucracy, power and economics are important domains of knowledge for nurses. This theory proposes that all nurses serve as leaders in the organization regardless of their position by advocating for patients, maintaining the organization's viability, and balancing ethical caring with ethical economics (Ray, 2006).

Boykin and Schoenhofer's Theory of Nursing as Caring (2001): The fundamental assumptions of the theory are that each person is caring and lives and grows in caring throughout life; persons are whole or complete in the moment; caring is lived moment to moment; the process of living caring is enhanced through being in relationships with other persons; and nursing is a discipline and a profession. Relationships between persons are viewed as opportunities to be authentic and "draw forth caring possibilities" (p. 4) and through "entering, experiencing and appreciating the world of the other, the nature of being human is more fully understood" (p.5).

The nurse's intention in a nursing situation is to be authentically present to know the other as caring person. Through being with the nursed, calls for nursing are heard and nursing responses created. The theory of Nursing as Caring (2001) differs from many other nursing theories in how the calls for nursing are conceptualized. Rather than viewing calls for nursing as the need to correct deficits in self-care or solve problems, calls for nursing are calls for nurturance "that bears witness to and celebrates the human person in the fullness of his or her being, rather than on some less-than-whole condition of being" (p.16).

Nursing knowledge is discovered within the nursing situation, and when shared

with others through venues such as stories and esthetic presentations, the richness of nursing is rediscovered and the unique contribution that nursing makes emerges. Reflection and dialogue about the calls for nursing and nurturing responses are necessary for the nurse to better know self and others as caring persons. Through dialogue, nurses openly engage in the study of nursing and the meaning and value of caring to those who nurse and who are nursed. “This is the value of nursing, the reason nursing exists as a distinguishable social and human service” (p.60).

Theoretical Links to this Study

Despite recent attempts by leaders to flatten organizational hierarchies and incorporate human values; organizational structures typically reflect bureaucratic values with an emphasis on competition, economics and outcomes as driving forces. It is within this complex organizational structure, that CNLs® practice nursing and are challenged to live caring and come to know others as caring persons.

As leaders at the bedside, CNLs® are expected to improve patient care by collaborating with others, facilitating and coordinating care, and advocating for the patient. In addition, CNLs® are expected to be role models for novice nurses, positively impacting nurse retention. The CNL® role will be evaluated in these organizations by looking at national patient outcome benchmarks, costs of care and nursing turnover. With an emphasis on empirical outcome measurement, the human value of caring and personal dimension of nursing that lives within the nursing situation must not be overlooked.

In this study, the CNLs® were asked to reflect upon and share unique nursing situations and experiences at the point of care that have special meaning for them and

reflect the essence of what it means to be a CNL®. When nurses tell stories about their nursing, it "brings to light the sustenance they find in the nursing situation…crystallizing the essential meaning of nursing…" (Boykin & Schoenhofer, 2001 p.25). Reflecting on the uniqueness of nursing situations through story, unveils the unique contributions of nursing. According to Boykin and Schoenhofer (2001), through dialogue, nurses can freely express who they are as person and nurse living caring. Story provides nurses the opportunity to "affirm their values of self and of the discipline of nursing, and how these values are lived in practice" (p. 45).

The caring theories selected as frameworks for this study ground the understanding of the focus of nursing as living caring and nurturing growing in caring of others; and the importance of nursing's caring values within the bureaucratic acute care hospital setting. Both theories honor patients as persons, and make explicit that nursing's unique contributions remind, "all players of the real bottom line, the person being cared for" (Boykin & Schoenhofer, 2001, p. 30).

Researcher's Perspective

Meaningful delivery of health care requires nurses to possess the knowledge, skills and understanding that enable them to know self and others as caring persons (Boykin & Schoenhofer, 2001; Roach, 2002; Watson, 2002). In coming to know the other as caring person, the nurse brings esthetic, personal, empirical and ethical ways of knowing to the nursing situation (Carper, 1978). Utilizing expert knowledge and skills and taking advantage of the unique position that nurses have at patients' bedsides offer an opportunity for nurses to come to know self and others as caring persons, serve as leaders

in nurturing personhood, advance care delivery and advocate for patient choices.

This researcher's interest is to gain understanding of the meaning of leadership at the point of care; to discover the unique expressions of living caring that CNLs® experience as they embark upon this new role in the acute care hospital setting. Through hearing their stories, their caring is relived and new nursing knowledge is generated. This type of inquiry lends itself to qualitative study.

Research Question

The research question that guided this study is: What is the meaning of leadership as experienced by CNLs®? Sub-questions that support this phenomenological question include:

- What is it like to be a CNL®?
- What does it mean to lead at the point of care?
- How is caring lived in the role of CNL®?

Significance

As a new clinical leadership role for nursing, the CNL® holds much promise to transform the care of patients and explicate the real value that nurses as bedside leaders bring to the delivery of health care. This research has implications for patient care, nursing administration and nursing education.

Implications for care of patients: The shared stories of CNLs® can inform their knowing about what is meaningful in their practice, and assist them in their living and growing in caring. Other CNLs® and CNL® students can learn from these stories through "enter[ing] into this shared lived experience of nursing" (Boykin & Schoenhofer, 2001, p.

20), where calls for nursing are heard and caring responses are created. According to the AACN (2003), the CNL® serves as an outcomes manager, advocate, member of a profession, team manager, information manager, systems analyst/risk anticipator, clinician, and educator. This study can shed light on whether or not CNLs® experience these roles in practice, and if so, what is meaningful about these roles in caring for persons. This study can add to the body of knowledge of theory-based nursing practice.

Implications for nursing administration: This study has import for nurse administrators who have CNLs or are considering incorporating the CNL® role into the care delivery model. Understanding what is meaningful to CNLs® in their practice their contributions to patient outcomes, and how they experience living caring within their role will enable nurse administrators to articulate their unique contributions to nursing practice and to create and support an environment for this practice of nursing. With this understanding, the nurse administrator can design care delivery models with CNL® role responsibilities that incorporate what is meaningful to them and promote positive patient outcomes. Nurse administrators can create ways to support CNLs® and other nurses at the bedside by advocating for the economic resources needed to support nurse-patient relationships. Additionally, nurse administrators can promote a culture where nursing and caring are valued and lived.

Implications for nursing education: The stories and meanings that emerge from the experiences shared by CNLs® provide a method for studying nursing. Through the sharing of these nursing situations, students can discern important aspects of being a leader at the point of care and develop an understanding of unique ways to live caring in

practice. Knowledge gained through the nursing situations of CNLs® can be incorporated into CNL® nursing curricula to help students gain new understandings.

Implications for nursing research: This phenomenological study informs our understanding of what CNLs® find meaningful about their roles as bedside leaders. Additional qualitative studies are needed to determine whether or not other CNLs® share these same experiences and perceptions and to study outcomes of care from a human perspective, rather than just an empirical perspective. Research focused on studying the perceptions and experiences of those nursed by CNLs® as well as the meaning of this role to nurses and other members of the healthcare team is needed.

Chapter Summary

In this chapter, the complexities of caring within the acute care hospital system and role of the CNL® were introduced and defined. The theoretical perspectives that provide the context for understanding how nursing and nursing leadership's values of caring can successfully flourish within the complex acute care hospital system, as well as this researcher's perspectives were explained. Finally, the research question, purpose and implications of this study were outlined.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The review of the literature is organized into two major sections. The first section presents an overview of what is published about leadership at the bedside. The second section presents an overview of the Clinical Nurse Leader^{SM} role.

Quantitative Studies of Leadership

No quantitative studies were found that focused on the leadership of nurses in non-management roles at the bedside. The search was broadened to include studies of leadership of nurses at different hierarchical levels in the acute care setting.

Stordeur, Vanderberghe and D'hoore's (2000) correlational study examined whether there was a cascading effect of transformational leadership or "falling dominoes effect" across hierarchical levels in nursing departments (p. 38). A sample of 464 respondents from 41 units in eight hospitals completed a survey questionnaire describing the leadership behaviors of their direct supervisor. For the staff nurse, the supervisor was the head nurse; for the head nurse, the supervisor was the associate director; and for the associate director, the supervisor was the nurse executive. The MLQ-5X instrument, used for measuring leadership behaviors, was given to the respondents to rate how frequently their leader exhibited the target behaviors. Correlation analysis was used to test for a cascading effect. The findings did not support a cascading effect of leadership across

hierarchical levels, suggesting that leadership patterns were not replicated from leaders at the upper level of the hierarchy to those at the lower levels. Leadership styles and positive outcomes were explained primarily by organizational context and culture of the units studied, with transformational leadership behaviors correlating higher with nursing satisfaction than transactional leadership (Stordeur, Vanderberghe & D'hoore, 2000).

Ingersoll, Wagner, Merck, Kirsch, Hepworth and Williams (2002) studied staff nurse perceptions of their work environment in two hospitals after an organizational redesign of care delivery was undertaken. Data were collected six months prior to and after implementing a patient-focused redesign using the Organizational Culture Inventory, Innovativeness and Cooperation Subscales of the Sociotechnical Systems Assessment Scale, and a modified Collaborative Practice Scale. The majority (78%) of the 688 respondents were clinical nursing staff from all shifts, 18% were administrators or managers, and the remaining respondents categorized themselves as "other". The authors do not describe the actual changes implemented in the patient-focused redesign which is a limitation of this study. However, the findings do support Stordeur, Vanderberghe and D'hoore's (2000) findings that leadership patterns are not necessarily replicated across hierarchical levels. This study revealed that mid-level managers' leadership skills are more important to staff nurses than the vision of the senior executive; that the manager's leadership style influenced whether the work environment was viewed as being supportive or threatening; and that managers were viewed as being the "linchpins" for information exchange and problem resolution (p. 169).

Kramer and Schmalenberg (2003) studied staff nurse descriptions of control over

their nursing practice in 14 magnet hospitals. A sample of 279 nurses included 51% from medical surgical units, 29% from critical care, 12% from obstetric and pediatric units, and 8% from outpatient units. The instrument used was the 37 item Essentials of Magnetism List, synthesized from the original 65 item Nursing Work Index (NWI) developed by Kramer and Schmalenberg. Dimensions of control over practice were categorized according to a five level scale:

- Category 1: Highly effective control structure
- Category 2: Control with reservations
- Category 3: Input but no control
- Category 4: Refer to authority source
- Category 5: Minimal or no control over practice

Findings revealed that almost 60% of clinical nurses in magnet hospitals described little or no control over practice. Nurses described control over practice belonging to nurses in formal leadership roles (nurse managers or supervisors) and to the physicians. This finding was unexpected, since one of the hallmarks of a magnet hospital is a high degree of staff nurse control over nursing practice (Kramer & Schmalenberg, 2003).

In a descriptive study conducted in two military medical centers, 103 military and civilian nurses described their perceptions of autonomy and control over practice (Foley, Kee, Minick, Harvey & Jennings, 2002). The Nursing Work Index-Revised (NWI-R) was used to measure autonomy, control over practice and collaborative relationships. The Manifestations of Early Recognition (MER) instrument was used to measure clinical

nursing expertise. Perceptions of autonomy, control over practice, and nurse-physician relationships were found to be higher in the military nurses. The authors speculated that this could be due to their formal officer status. The authors also speculated that positive perceptions about nurse-physician relationships could be attributed to the officer rank that affords military nurses a relatively equal status with the physicians they work with. This study tied positive perceptions of the work environment, autonomy and collaborative practice with nurses occupying an official hierarchical leadership role.

Lee and Cummings (2008) conducted a systematic review of the research literature to examine the determinants of front line nurse manager job satisfaction. The authors posit that front line managers are the vital link between senior management and clinical nurses, and that their role is invaluable in helping to promote quality nursing care and positive patient outcomes. Thus, ensuring their job satisfaction is a key factor in retaining them. Twelve studies were reviewed and five categories were delineated as predictors of front line nurse manager job satisfaction. These categories include organizational change, organizational support, job characteristics, the managerial role and educational development. Findings from this review provide evidence of a positive relationship between support for managers, participative organizations, empowerment and job satisfaction of nurse managers. The authors conclude that reducing managerial span of control and workload, and developing strategies to increase support and empowerment of front line managers are pivotal to positively influence patient and staff outcomes. Such strategies also serve to retain front line nurse managers and recruit future nurse managers.

Schmalenberg and Kramer (2009) synthesized results from seven research studies they conducted between 2001-2007 focusing on the question, "What behaviors of nurse managers do staff nurses perceive as supportive?" From interviews with 29 staff nurses, focus group interviews with 132 nurse managers, and 61 nurse executives in 14 magnet hospitals, ten supportive behaviors were identified in 2001. These behaviors became items on the Nurse Manager Support Scale. The Nurse Manager Support Scale was further developed, tested and validated by the researchers. Data were collected with this scale from 2,300 staff member participants from 14 teaching and community hospitals of different sizes, from diverse regions of the United States and Canada. A final comprehensive list of the most supportive role behaviors of nurse managers that are universally meaningful was developed. The list includes:

- Being diplomatic, fair and honest in resolving conflicts between nurses, physicians and other departments
- Seeing that there are adequate numbers of competent staff to get the job done.
- Representing the position and interests of the nursing unit and the staff to other departments and to administration. He or she "watches our back."
- Being accessible, approachable and safe
- Living the values of the organization regarding patient care. He or she "walks the talk"
- Promoting staff cohesiveness and is a positive force in getting us to work together
- Fostering sound decision making by asking for the best practice evidence that we are using

- Making it possible for us to attend continuing education, outside courses and or degree completion programs
- Procuring resources such as equipment or supplies that are needed
- Providing both positive and negative specific examples when giving feedback

This study is important in highlighting the central role the nurse manager has in promoting nursing practice, serving as a role model and advocate for nurses and for patient care on their units. Nurse Manager support is a critical factor in maintaining healthy work environments which support the work of Stordeur, Vanderberghe and D'hoore (2000), and Ingersoll, Wagner, Merck, Kirsch, Hepworth and Williams (2002).

Other quantitative studies examined the organizational context in which nurses practice, organizational culture, healthy work environments and desired leadership practices (Aiken & Patrician, 2000; Capuano, Bokovoy, Hitchings, & Houser, 2005; Lavoie-Tremblay et al, 2008; Schmalenberg & Kramer, 2008; Tourangeau & McGilton, 2004; Ulrich et al, 2009; Wieck, Prydun, & Walsh, 2002). Overall findings from these studies reveal that transformational leadership style, coupled with an environment that facilitates shared governance and control over nursing practice promotes positive nurse satisfaction and a healthy work environment for nursing practice.

These findings are important for informing nursing leadership practice; however, these studies did not concentrate on leadership at the clinical nurse level, but rather on the leadership practices of middle managers and nurse administrators.

Qualitative Studies of Nursing Leadership

Qualitative studies have focused on the role of the nurse leader, decision making by nurses practicing at the beside, and the development of future nurse leaders.

Cook (2001) conducted a grounded theory study in Australia to determine what could be learned about the attributes of effective clinical nurse leaders, and from these attributes, if a theoretical model of effective nurse leadership could be generated. Clinical nurse leaders in this study are not the CNLs® that are the focus of this researcher's study. The study participants represented hospital based nursing, community adult nursing, specialist sexual health nursing and specialist family and children's mental health nursing. A purposive sample of 12 nurse participants was chosen. Of the 12, only four were available to participate in the study. They provided direct clinical care and had leadership responsibility for their clinical areas. Data were collected by observing the participants in their practice setting and by interview.

This research was conducted with participants that were not in conventional nursing leadership positions, yet they displayed many of the attributes of highly effective leaders. Five attributes of effective clinical nurse leaders that emerged from the data include highlighting, respecting, influencing, creating and supporting. Five typologies that emerged include the clinical nurse leader being the discoverer, valuer, enabler, shaper and modifier. These attributes and typologies along with constraining and facilitating factors comprised the theoretical framework developed as a result of the study. The author suggests that the capacity to undertake leadership roles exists at many levels, and as a result of an interdisciplinary focus group review and agreement with the

findings, that this framework of leadership attributes can be applicable to other healthcare workers (Cook, 2001).

Upenieks (2002) studied 16 nurse leaders from four acute care hospitals to determine what they perceived to be effective leadership traits and what organizational infrastructures support the work of nurses. Kanter's Structural Theory of Organizational Behavior was used as a framework for this study. This theory proposes that employee empowerment develops from both formal and informal systems of the organization. Formal power is derived from the position held; and informal power is derived from relationships, political processes, and alliances with others. Data were generated from content analysis of interviews. Findings supported Kanter's theory of formal and informal factors influencing leadership effectiveness. Leadership attributes included business intelligence, the ability to strike a balance between the needs of the nursing staff and economic requirements, a passion for nursing and ability to communicate this passion, and collaboration with other disciplines as being vital in today's economically oriented environment. Organizational constructs perceived as supporting leadership were identified as access to information and resources, coupled with an empowering and supportive environment that enhances the success and worth of the nurse leader (Upenieks, 2002). A limitation of the study, as described by the author, was the fact that the participants who volunteered for the study were powerful, confident and influential nurse leaders, representing an elite group, as compared to a balanced or representative group of nurse leaders which may have influenced the results.

Stanley (2006) conducted a three year grounded theory study to identify and

explore the qualities and characteristics of clinical leaders. Data were collected via interviews of a random selection of 188 staff nurses working in the British National Health Service. Findings of this study were that leaders could be recognized by their clinical competence, knowledge, effective communication, decision making, empowerment of others, motivation, openness and approachability, visibility and willingness to be a role model. The concept of "congruent leadership" was the determining factor for enabling these nurses to be viewed as leaders. Congruent leadership is defined as leaders who stand by their principles, with values and beliefs matching ones' actions (p.110).

Five other qualitative studies examined nursing leadership. One approached the study from the perspective of the role of the bedside nurse (Endacott, 1999), the second focused on the competencies of charge nurses (Connelly, 2003), the third delved into what influenced nurses to accept or reject nursing leadership positions (Sherman, 2005), and the fourth explored reasons why nurse leaders leave their roles (Skytt, Ljunggren & Carlsson, 2007), and the fifth explored the experience of being a shift leader on a hospital ward (Goldblatt, Granot, Admi, Drach-Zahavy, 2008).

Endacott (1999) conducted an ethnographic study that compared the shift leader role (charge nurse) with that of the clinical staff nurse in a pediatric intensive care unit. Findings revealed that the shift leader did not control the nurse's care delivery and decisions, but provided a supportive involvement role. The bedside clinical nurse was given the lead in identifying, legitimizing and acting on the needs of the critically ill child, using strategies such as "gate-keeping, prioritizing, and making clinical decisions"

whereas the shift leader acted in a supporting role (p. 17). The two roles were viewed as distinct but complementary.

Connelly (2003) conducted an exploratory qualitative study in a military medical center to determine the competencies needed to effectively carry out the role of charge nurse. Forty two participants including nurses at the staff, charge nurse, head nurse and supervisory level were interviewed. Charge nurses were viewed as “on-the ground leaders” who cared for the issues at hand, were problem solvers and managers of quality of care (p.300). Charge nurses needed to use human relations skills and make best use of resources. The relationship between head nurse and charge nurse was crucial for teamwork. The charge nurse was viewed as being first-line management, supporting the efforts and goals of the head nurse (p.305).

Sherman (2005) conducted focus groups of 48 nurses under the age of 40 from 14 health care agencies in South Florida to determine what factors influenced their decisions to accept of reject nursing leadership positions. Findings revealed that leadership positions were viewed as being important for providing a safe environment for staff and patients and for making an impact on patient care. Nurses identified personal growth, status and being a mentor as incentives for accepting a leadership role. Areas of concern identified by nurses in the study included loss of pay due to a pre-established salary as compared to hourly compensation with overtime and shift differentials, fear of failure, too much responsibility, job insecurity, work-life stresses, inability to please everyone, and fear of losing their clinical skills (Sherman, 2005).

Sherman’s study supports the findings of an earlier qualitative study conducted by

Rudan (2002), exploring why advance practice nursing graduate students were not drawn to studying nursing administration to identify educational initiatives to address this problem. Fifty-two participants from two schools of nursing at both masters' and doctoral levels were interviewed. Categories that emerged from the data included graduate students feeling that their managers were not supportive, the job was too political, the hours were long and inflexible, a concern about losing clinical expertise and patient contact, a lack of monetary incentive to work as a nurse administrator, and high expectations of the job requiring the skills of a "magician" (Rudan, 2002, p. 187).

Skytt, Ljunggren and Carlsson (2007) explored the reasons by way of a qualititative approach why 32 first line Swedish nurse managers resigned from their positions. Findings included insufficient support and respect from superiors, problems implementing change when they had no involvement in the decision making process, dissatisfaction with salary, overwhelming responsibilities and dissatisfaction with staffing. Participants described difficulties experienced "in between being loyal to their superior and the management team as well as to the group of staff" (p.298). The position of being in-between staff and supervisor, vague framework for the role, and lack of authority influenced the managers' decisions to leave. These findings correspond with Sherman's (2005) study of factors that influence nurses to not seek leadership positions.

Goldblatt, Granot, Admi and Drach-Zahavy (2008) interviewed 28 Israeli registered nurses in 2005 to explore the experience of being a shift-leader in a hospital ward setting. Data were collected through three focus group sessions followed by individual interviews. The researchers chose this population of nurses to study due to a

scarcity of research published on this level of nurse leader. The shift-leader was defined as a registered nurse to whom the ward nurse manager delegated partial authority and managerial responsibilities for a given shift to manage patient care. Content analysis revealed two main themes which constitute the essence of being a shift-leader:

- I am like an octopus-one head, many legs: The burden of responsibility, depicting how shift-leaders move between maximum control and relinquishing control by delegating authority to other nurses
- I see the end before I start: The temporal character of the role. On one hand focusing on the present shift and anticipating completion of the shift without incident.

The core of the shift-leader's role included a high degree of responsibility without established authority, which presented the participants with stress. They exhibited tight control over the work environment and staff as a means of coping with stress. The researchers' recommendations included shift leaders developing a broader repertoire of leadership skills such as empowerment of staff nurses to limit their tendency to use tight control over staff to reduce stress, and create a more positive work environment for both the shift leader and staff nurses.

Findings from these studies support the importance of creating a work environment that is supportive to personal and professional growth of nurses as leaders. Developing leadership skills and structuring roles within care delivery models to incorporate leadership behaviors and competencies are important for nursing satisfaction and retention. Nurses who are empowered to make decisions and are involved in the

decision making process can positively effect change. When organizational support is lacking, roles are not clear, and nurses do not have the education and skill sets for leadership, role overload and dissatisfaction occurs. This often leads to nurse turnover or unwillingness to accept a leadership position.

Nurses as Leaders at the Bedside

Organizational structures of hospitals are changing in response to the complexities in health care delivery. The traditional bureaucratic structure is becoming flattened and the traditional vertical chain of command is increasingly being replaced with horizontal networks of professional collaboration and lateral integration (Palmier, 1998; Tappen, Weiss & Whitehead, 2004). Despite the intent to decrease the levels of bureaucracy, hospitals are complex adaptive systems, and as such, work processes, patterns of interactions, connections, relationships and hierarchies emerge as the system self-organizes (Anderson & McDaniel, 2000).

As front line leaders at the crossroads of patient care delivery, nurses at the bedside have the opportunity to advocate for patients through caring approaches (Turkel & Ray, 2000). Kerfoot (1998) posits that nurses as leaders at the bedside assess opportunities for improvement, leveraging their relationships with patients and other disciplines to effect positive change and bring the humanistic values of caring to the hospital setting. Harper (1995) defines clinical leaders as those who possess clinical expertise in a specialty practice area and who use interpersonal skills to support nurses and other providers to deliver quality care. Cook (2001) fine tunes this definition through a nursing lens, positing that a clinical leader is “a nurse directly involved in providing

clinical care that continuously improves care through influencing others" (p.39). Kowalski (2008) maintains that strong positive leadership is based on a positive relationship between the leader and the staff and effective leadership does not evolve from expert clinical skills but from a separate and distinct set of skills which focus on leading and managing.

Over the past ten years, there has been an increased focus in the nursing literature reaffirming the nature of nursing's work. Nursing practice must be relationship centered and interdisciplinary. The conceptual literature defines relationship building, improvising, coordinating efforts, clinical expertise, recognizing interdependence among disciplines, modeling caring, doing what is right, exerting influence and political skills, and inspiring others as key nursing leadership behaviors (Antrobus & Kitson, 1999; Duffy, 2003; Gage, 1998; Gilmartin, 1998; Goleman, 1998; Koloroutis et al, 2004; Porter-O'Grady, 2004; Shaver, 2004; Sorrells-Jones, 1997; Witt, 2004). Cook (2001) concurs with these authors and adds that clinical leaders also need to possess strong team building skills and self confidence to engender the respect of others.

Although autonomous practice has been a professional goal for nursing, there is a growing recognition that nurses must work with others in interdisciplinary teams to find synergistic solutions to health care delivery problems (Gage, 1998). Hay (2004) describes nurses at the front line not only being the voice of nursing but the voice of other disciplines, facilitating the participation of others while anticipating what it takes to deliver high quality care. Through interrelating with others, nurses create the climate that is conducive to providing excellent inpatient care (Hay, 2004). Nurses are viewed as

ambassadors that translate vision into action, oversee and assure that proper care is delivered, and represent the values of the organization as service expediters and liaisons for services (Spitzer-Lehman, 1993).

Nurses do not work in isolation. They are well positioned within the health care delivery system to bring a humanistic and holistic perspective to care delivery; and create an atmosphere where living caring can be nurtured. The conceptual literature is rich with information about characteristics of nursing leadership; however, there is little written on leadership behaviors of bedside nurses.

CNL® Type Roles

Published research studies about the CNL® role are sparse. Drenkard (2004) studied the implementation of a new team coordinator role, similar to the role of the CNL®, in the care delivery model at an American Nurses' Credentialing Center (ANCC) magnet hospital in Fairfax, Virginia. The role evolved from 1999-2001, and in 2001 the role was evaluated through quantitative data collection and qualitative surveying of the team coordinators and other key stakeholders. Results revealed overall satisfaction with the role, especially from team coordinators and physicians who were pleased with the role in relation to their patients' clinical progression. Other results included role dissatisfaction of the team coordinators due to role overload, role ambiguity, and lack of understanding and support of the role from staff registered nurses. Although the team coordinator role has much in common with the new CNL® role, the author recognized that the roles were not identical. The author compared the roles utilizing the AACN CNL® competencies as a framework for comparison. The team coordinators did not

possess the knowledge of global health care, health care systems and policy expertise that are key competencies of the CNL® role (Drenkard, 2004).

Similarly, a pilot project was conducted in 2004 on a 39 bed unit of a 551 bed hospital in Augusta, Georgia, with implementation of a care coordinator role. The role was named care coordinator since there were no graduates from CNL® programs at that time; although AACN CNL® role competencies and responsibilities were included in the design of the role. After several months, this role was implemented on a second nursing unit serving patients with cardiac disease. Findings included improvement in patient centered outcomes such as discharge planning, home health care referrals, pain management, and management of diabetes. Incidental findings were that a 39 bed unit was too broad a scope of responsibility for one care coordinator and the recommendation was made to limit the scope of responsibility to oversight for no more than 20 patients, and to expand the care coordinator role from five days per week to seven days per week (Bowcutt, Wall & Goolsby, 2006).

In 2001, a hospital in Miami, Florida implemented a Patient Care Facilitator (PCF) role which closely resembles the CNL® role. This role was implemented within a 12-bed hospital care delivery model, and effectiveness of the model was studied through an action research method. A triangulated approach to data collection included use of the Caring Behaviors Assessment instrument (Cronin & Harrison, 2002), qualitative interviews of 27 patients and staff members, and guided focus groups. Quantitative and qualitative findings revealed an improvement in continuity of care and patient perceptions of caring. All interviews contained the themes of teamwork, continuity,

relationship, helping, competence and communication. The authors describe "caring as the core of the model forming the soul of the PCF" (Brown, et al., 2005, p.54).

A hospital in Bloomington, Illinois replicated the PCF role used in Miami in 2005 (Smith & Dabbs, 2007). They divided the pilot unit into four mini-units, with a PCF coordinating care at the microsystem level for each of the mini-units. Each PCF was expected to complete a masters CNL® program. One year post implementation of the new model, evaluation revealed decrease in patient falls and pressure ulcer rates, increase in patient satisfaction and decrease in staff turnover. As of December 2006, all inpatient units with the exception of obstetrics had implemented this new care delivery model.

Smith, Manfredi, Hagos, Drummond-Huth and Moore (2006) also used the AACN CNL® competencies to design a new role in the care delivery system of an acute care hospital in northeast Florida. Three masters prepared nurses, who were not graduates of a masters CNL® program, were chosen to develop and implement this model. This modified CNL role incorporated the AACN CNL® competencies in the acute care setting, with the intent to ascertain whether this role impacted patient, physician and nurse satisfaction. Quantitative measures included the Conditions of Work Effectiveness Questionnaire II (CWEQ-II) adapted by Laschinger and Wong in 1999 to study nurse satisfaction, patient and physician surveys, length of stay, fall rates, restraint usage, contract labor use and cost per patient day. Findings included improved nurse, patient and physician satisfaction, and decrease in patient length of stay. Unanticipated results included a decrease in the use of restraints, fewer falls and elimination of contract labor (Smith et al., 2006).

These articles inform our understanding of how similar roles have been implemented in acute care hospital settings and the impact of these roles in care delivery. However, there are limitations in applying these findings to implementation of the CNL® role. Nurses in similar roles did not have the same AACN curriculum graduate education that prepares students for the CNL® role. This curriculum as described by the AACN includes a deliberate and integrated inclusion of leadership education and socialization that begins on the first day of class and continues throughout the CNL® education program. This formal program of study includes 400-500 clinical contact hours (AACN, 2007b).

The CNL® Role

Eleven articles were found where the actual CNL® role was implemented in the care delivery model. Tachibana and Nelson-Peterson (2007) described implementation of the CNL® role in 2004 in an acute care hospital in Seattle, Washington. The role was implemented within the framework of Rapid Process Improvement (RPI) and the Toyota Production System (TPS). Within six months, a 7% reduction in length of stay and increase in patient satisfaction resulted. This study did not include a demographic description of the CNLs® who were chosen for the role or characteristics of the nursing units.

Wiggins (2006) described a Partnership Care Delivery model incorporating the CNL® role at Maine Medical Center. This system of care delivery has safe patient and family-centered care at its core. This model emphasizes the interdependencies between disciplines, rather than one discipline over another. Positive outcomes of this model

include daily interdisciplinary rounds, dietary department reclaiming food service to patients, and patients and families involved in all aspects of care planning and delivery (Wiggins, 2006). Although this article described the CNL® as at the heart of this model, there is little information about the actual CNL® role, number and educational preparation of the CNLs®, numbers of patients they are responsible for and details related to the implementation.

In a later article, the seven CNLs® who were involved in the CNL® implementation project at Maine Medical Center described their experiences as the first group of nurses within that organization to assume this new role (Poulin-Tabor, Quirk, Wildon, Orff, Gallant, Swan, et al., 2008). These CNLs® worked in special care, pediatric, cardio-thoracic, surgical, and medical-cardiology units. Their immersion experience was 1,000 hours as compared to the norm of 500 hours. They determined that they needed this additional time to acquire a more global knowledge base of their institution. This approach was later called the "view from 40,000 feet" (p.624). The article highlighted the importance of CNLs® developing trusting, collaborative relationships, maintaining a holistic person centered focus, and knowing the patient's story, "engaging them in being true partners in their own health care" (p. 626).

Hartranft, Garcia and Adams (2007) described implementation of the CNL® role on a 15 bed remote telemetry area within a medical surgical unit, and 44 bed oncology unit in an acute care hospital on the west coast of Florida. The authors described positive outcomes of the role which included improvement in patient safety, physician satisfaction, nursing retention, and impetus for other nurses to return to school.

Recognizing that future success of their role needed to be linked to positive outcomes, the CNLs® kept a daily log of their "saves and qualitative accomplishments that are not easily measured" (Hartranft, Garcia & Adams, 2007, p. 262).

In 2007, Sorbello's qualitative pilot study with two CNLs® from the west coast of Florida focused on what CNLs® valued about their role. Themes that emerged from this study include valuing care of their patients, seeing the big picture, being the problem solver, making collaborative connections, protecting the patients and supporting the overburdened nurse. Incidental themes that emerged from the data reflect both gratifying and distressing perceptions that CNLs® have about their roles and include having the best of both worlds, appreciation of autonomy, trying to be everything to everyone, dealing with staff resentment and having to earn their keep (Sorbello, 2007).

Gabuat, Hilton, Kinnaird and Sherman (2008) published a case study on the implementation of the CNL® role at a 194 bed for-profit medical center in St. Lucie, Florida. This article described the development of the academic and clinical partnership between the medical center with Florida Atlantic University Christine E. Lynn College of Nursing, the planning, implementation and evaluation phases, and lessons learned along the way. Key leadership strategies presented by the authors include the vital role that the Chief Nursing Officer (CNO) has in: promoting innovative change within the organization; maintaining the momentum and sustainability of the project; gaining executive team support; selecting the right staff and units to pilot the role; marketing the role to the medical staff; maintaining a strong clinical academic partnership relationship; and considering the impact of the CNL® role on the case management role. This case

study is unique in that the model was introduced into a for-profit medical center, one of few that are involved in the national CNL® project. The study also supports Sherman's (2008) earlier grounded theory study which demonstrated the key role of CNOs to successful implementation of the CNL® project in their hospitals.

Stanley, Gannon, Gabuat, Hartranft, Adams, Mayes, et al. (2008) published findings from three case studies where CNLs® were introduced into three different organizations in Florida. In the first case study, a CNL® was introduced into a new patient-centered delivery model on a 17 bed oncology unit in an academic medical center in Jacksonville, Florida. In the second case study, two CNLs® were introduced into the care delivery model, one on a 43 bed medical surgical unit with 15 telemetry beds, and the other on a 44 bed oncology unit at a not-for-profit medical center in Clearwater, Florida. The second case study describes the same CNL® implementation described in an earlier article previously referenced by Hartranft, Garcia and Adams (2007). The third case study describes the implementation of two CNLs®; one on a 36 bed progressive care unit, and one on a 45 bed medical surgical unit at a for-profit medical center in Port St. Lucie, Florida. This case study describes the same CNL® implementation project described in the Gabuat, Hilton, Kinnaird and Sherman (2008) article referenced earlier. Some of the common findings from these three case studies include improvement in Center for Medicare and Medicaid Services (CMS) core measures, patient satisfaction, physician collaboration, care coordination, nurse retention, cost savings and decreased patient length of stay.

Sherman, Edwards, Giovengo and Hilton (2009) described implementation of the

CNL® role at St. Lucie Medical Center in Florida, as referenced earlier in articles by Gabuat, Hilton, Kinnaird and Sherman (2008), and Gabuat, Hilton, Kinnaird and Sherman (2008). This article focused on the CNLs®' impact on improving the health of the work environment. Through building trusting relationships with nursing staff, improving communication, initiating unit councils, coaching and mentoring novice nurses, St. Lucie Medical Center was recognized as being a destination hospital by the Advisory Board for attracting and retaining nurses (p.268).

Brown (2008), a CNL® in a 24 bed medical unit at an academic children's hospital in Jacksonville, Florida published a case study providing the perspective of what a CNL® does, including lateral integration of care, collaboration with other staff, patient advocate and problem solver. She differentiates the CNL® role from the CNS role and considers the CNL® role as being lateral to the nurse manager, having 24 hour accountability for the clinical care provided on the unit. Like previous case studies, implementation of the CNL® role was seen as being a positive addition for improving patient care and outcomes. This author experienced organizational, nursing staff and physician support for her role. An interesting finding was the challenge she faced in defining her role within the organization and "standing firm" (p.41). She described the potential for CNLs® being pulled away from the nursing unit to apply their diverse and valuable skills to benefit other areas, but that they must commit to staying at the bedside to help nurses and patients.

One qualitative study was found where the Chief Nursing Officers (CNOs) from hospitals that participated in the CNL® project were interviewed. Sherman (2008)

conducted a grounded theory study exploring why ten CNOs in the state of Florida involved their organizations in implementation of the CNL® project. Five major factors were identified as common themes for involving their organizations:

- Organizational needs: The CNL® role was viewed as having potential at the point of care to help with improvement in Joint Commission regulatory issues, core measures, nursing sensitive indicators which in turn would positively influence pay for performance and overall economic value for the organization.
- Desire to improve patient care: CNOs identified the CNL® as the person at the point of care who could fix system issues and improve overall patient outcomes and patient safety. The CNL® was compared to an "air traffic controller" (p. 239).
- Opportunity to redesign care delivery: The opportunity to design innovative care delivery models that promotes relationship and knowledge based care, as opposed to task-based care was an identified driver.
- Promotion of professional development: CNOs identified problems with professional disengagement of the nursing staff in their organizations, and viewed the CNL® role as an opportunity to keep the best and brightest nurses at the point of care, who in turn would serve as professional role models for other nurses.
- Enhancement of physician-nurse relationships: The consistent presence of the CNL® on the nursing unit was viewed as a way to improve collegial relationships with physicians.

An interesting demographic is that three of the ten CNOs in the sample were from magnet designated hospitals, and six were from hospitals that were in the process of

working toward magnet designation. Findings from this study support earlier studies where implementation of the CNL® role was associated with improvement in nursing sensitive indicators, core measures, patient safety (Gabuat, Hilton, Kinnaird & Sherman, 2008; Hartranft, Garcia & Adams, 2007; Stanley, Gannon, Gabuat, Hartranft, Adams, Mayes, et al., 2008). This study underscores the importance of the CNO building the business case and being a strong and visible supporter of the CNL® role implementation, as highlighted in the Gabuat, Hilton, Kinnaird and Sherman (2008) study.

Harris and Ott (2008) stressed the importance of building a business case for implementation the CNL® in the care delivery model. Crafting a business case includes determining organizational readiness, identifying opportunities, objectives, project costs and benefits, pros and cons, stakeholders, timelines and evaluation measures. The authors provided an example of a successful business case where implementation of the CNL® role in a gastrointestinal (GI) lab resulted in increased GI lab efficiency, improved resource utilization, reduced post-procedure recovery time and improved patient satisfaction (p.28). This example was described in more detail in an article authored by the CNL® who worked in the GI lab at the Tennessee Valley Healthcare System. This CNL® received a recognition award from the central nursing office of the Veteran Affairs for being on of the first nurses to successfully implement the CNL® role in an outpatient setting (Miller, 2008).

Articles that underscore the need for this new role also highlight the necessity to re-design the care delivery model to incorporate this role and achieve cost neutrality (Drenkard, 2004; Drenkard & Cohen, 2004; Harris, Tornabeni & Walters, 2005; Long,

2004; Rogers Gibson, 2005-2006). As posited by Turkel and Ray (2000), the economic environment of health care influences the practice of professional nursing. Developing innovative approaches and models of care delivery where both quality care and controlling costs are considered necessary for the economic survival of the organization.

Since the CNL® role is relatively new, most articles focus on the importance of this role for health promotion, evidence-based practice, continuity of care planning and delivery, problem solving and improved patient outcomes (Allan, Stanley, Crabtree, Werner & Swenson, 2005; Bartels & Bednash, 2005; Begun, Tornabeni & White, 2006; Brown et al., 2005; Burke et al., 2005; Drenkard & Cohen, 2004; Haase-Herrick & Herrin, 2007; Maag, Buccheri, Capella & Jennings, 2006; Tornabeni, Stanhope & Wiggins, 2006). With the addition of a new role in nursing, comes debate about the necessity for the role, challenges in role implementation, and differentiation of the role with existing roles. Some authors question whether the new CNL® role is the answer to the problems of today, and whether the CNLs®' educational preparation is adequate to prepare them to be successful leaders in today's health care environment (Erickson & Ditomassi, 2005; Girard, 2005; McCabe, 2006; Murray, 2007; Radzyminski, 2005; Scott & Cleary, 2007). Other authors question whether introducing a new role in nursing should be undertaken when the educational preparation for the entry level for nursing has not yet been agreed upon (Glazer, 2005; Grindel, 2005; Hooper, 2006).

The CNL® is conceptualized as being in a unique position at the point of care to manage a patient's care throughout the patient's length of stay at the microsystem level. Leadership skills such as systems thinking, interdisciplinary collaboration, and

knowledge about health care systems, patient outcomes, and evidence-based practice are identified as being important components of the role (Brown, 2008; Drenkard & Cohen, 2004; Dzurec et al., 2006; Hartranft, Garcia & Adams, 2007; Picard & Henneman, 2007; Quataro & Reid, 2006; Tornabeni, Stanhope & Wiggins, 2006). These authors highlight expectations and competencies for the CNL®, differentiate leadership from management, delineate CNL® role functions, and posit that as frontline providers and leaders of care, the CNL® can create seamless, patient-centered, high-quality, safe and efficient healthcare.

The CNL® is viewed as being integral to protecting patient safety through assessing patient risk, advocating for patients, providing lateral integration of care and implementing evidence-based practice (Peters, 2007, Picard & Henneman, 2007; Stanley, Hoiting, Burton, Harris & Norman, 2007; Stanton, 2006; Tornabeni, 2006; Tornabeni, Stanhope & Wiggins, 2006; Woods, 2003). Tornabeni (2006) and Norris and McKeon (2008) posit that the CNL® will have an extraordinary effect on patient safety by reducing medical error and sentinel events which will in turn improve clinical outcomes and save the health care system millions of dollars. Warren and Connors (2007) concur and add that the CNL® positively impacts patient safety through the application of informatics competencies, which supports the Institute of Medicine (IOM) recommendation to optimize the use of health information technology to promote patient safety. Karshmer, Seed and Torkelson (2009), claim that in the psychiatric setting the CNL® role is key in evaluating systems issues to prevent errors, improve interdisciplinary care and quality outcomes.

Contrary to the assertions that the CNL® will positively transform the care of patients are assertions that this new role is not needed due to potential role overlap and role confusion with other nursing roles. Controversy exists concerning potential role overlap with the Clinical Nurse Specialist (CNS) and Nurse Manager roles. This concern over duplication of roles has resulted in resistance to change and implementation of this new role (Goudreau, 2008; Kennedy, 2004, 2007; Kupperschmidt & Barnhouse, 2005-2006; MacPhee, McLean & Woo, 2005; National Association of Clinical Nurse Specialists, 2004, 2005; Nelson, 2005; Newkirk, 2005-2006; Scott & Cleary, 2007; Stringer, 2007; Thompson & Lulham, 2007).

The United American Nurses (UAN) position statement on the CNL® role asserts that the CNL® directly conflicts with the UAN collective bargaining work, creates an additional layer of nursing personnel causing more confusion within the heath care team, and moves responsibility for patient care away from the RN at the point of care (UAN, 2006). In addition to concerns about role overlap and confusion, there are concerns for role overload where CNLs® will not be able to live up to the lofty goals set before them (McCabe, 2006; Nelson, 2005;) and that the CNL® is a generalist and "jack of all trades and a master of none" (McCabe, 2006, p. 254).

Chapter Summary

Review of the peer and non-peer reviewed nursing literature focusing on leadership and the CNL® role provides a good overview of CNL® role competencies and leadership skills, the role of the CNO in supporting CNLs®, and descriptions of implementation of both CNL® and CNL® type roles into care delivery models. Pilot

studies focus on the impact of the CNL® role as measured by patient outcomes such as length of stay, fall rates and pain management, patient and staff satisfaction. Qualitative studies illuminating the perceptions of what it is like to be a CNL® and the meanings they find in their role have not yet been published.

The conceptual and research literature offer much information on the value of nursing leadership as experienced and demonstrated by leaders at the middle and executive hierarchical levels, and information about the new CNL® role, competencies and characteristics, but little on the perceptions and experiences of leadership of bedside nurses. There is a paucity of research conducted on leadership of nurses working at the bedside and therefore much more is to be learned. The scarceness of quantitative and qualitative studies focusing on the new CNL® role, as well as on bedside (clinical) nurses serving as nursing leaders support the need for additional studies such as the research proposed in this study.

CHAPTER 3

METHODOLOGY

Introduction

The research question was "What is the meaning of leadership as experienced by CNLs®?" To answer this question the methodology of qualitative research as a phenomenological approach was used. Phenomenology involves the assumption that meaning is derived from persons interacting with others in their environment (Munhall, 2001). Following are descriptions of Van Manen's (1990) phenomenological approach, steps of the method, description of the participants, ethical considerations, rigor and limitations of the study.

Tradition of Phenomenology

Phenomenology emerged from the philosophical traditions associated with Husserl, Kierkegaard, Heidegger, Marcel, Sartre, Ricouer, Gadamer and Merleau Ponty. The overarching question that phenomenologists are interested in is gaining understanding of the meaning of one's lived experience (Burns & Grove, 1997). Omery (1983) describes the phenomenological method as an inductive, descriptive research method that "describes phenomena, including the human experience, in the way these phenomena appear in their fullest breadth and depth" (p. 50). Van Manen (1990)

describes phenomenology as the study of lived or existential meaning, described with a certain level of depth and richness.

Hermeneutic Phenomenology

Hermeneutic phenomenology, based on Heideggerian philosophy, is an interpretive phenomenology. It is a qualitative research method used when the research question seeks to understand the meaning of human experience (Crist & Tanner, 2003). The word itself, hermeneutics, is derived from the Greek word *heuresis,* which means the power of discovery (Finch, 2004). Hermeneutic analysis provides a way to reflect upon the text to make interpretive sense of the phenomena, focusing on meanings or the nature of experience. Finch (2004) posits that through "hermeneutics, (understanding and interpretation) the essence of beliefs, values and commitments can become known and clarified (p.253).

Van Manen's (1990) hermeneutic phenomenological approach was used for this study. Van Manen (1990) describes hermeneutic phenomenology as a "philosophy of the personal, the individual, which is pursued against the background of an understanding of the logos of other, the whole, or the communal" (p.7). Van Manen (1990) posits that the research process cannot be separated from the writing process. This research method does not offer a procedural system as such, however, there is a process which requires the researcher to be reflective, insightful, and sensitive to what emerges from the dialogue, and constantly open to experience. The product of phenomenological research is articulations of meaning embedded in experience, meaning as it is lived. The researcher does not seek to solve problems or find cause and effect, but rather to search for the

meaning and significance of phenomena (Van Manen, 1990).

Van Manen's (1990) hermeneutic phenomenological approach includes six research activities. Although Van Manen states that these methods are not intended to be followed as "a mechanistic set of procedures," they were used to ground this study (pp.30-31):

- Turning to a phenomenon which seriously interests us and commits us to the world;
- Investigating experience as we live it rather than as we conceptualize it;
- Reflecting on the essential themes which characterize the phenomenon;
- Describing the phenomenon through the art of writing and rewriting;
- Maintaining a strong and oriented relation to the phenomenon;
- Balancing the research context by considering parts and whole.

Turning to a phenomenon of interest is defined by Van Manen (1990) as the first step of phenomenological inquiry where the researcher sets out to make sense of a certain aspect of lived experience through deep questioning and through the practice of thoughtfulness. This researcher became interested in the CNL® role through working with CNLs® while practicing as a Nurse Administrator and faculty member teaching CNL® students.

The second step of the phenomenological research includes investigating experience as we live it, not as we conceptualize it. In this study, the experiential accounts of the participants were recorded through the interview process to facilitate understanding of what it is like to be a CNL® from their perspectives, not from the

researcher's perspective.

The third step of reflecting on the essential themes requires a thoughtful, reflective grasping of the essence or special significance of phenomena. Van Manen (1990) likens unearthing themes to "mining meaning" from the text (p.86). Next, the phenomena are described through the writing and rewriting of the phenomenological text. This process includes "re-thinking, re-flecting and re-cognizing" the text to be able to capture the essences of experience (p.131). In this study, the text was written and re-written, read and re-read in order to more fully understand the essences of the lived experience of the participants.

Van Manen (1990) claims that in phenomenological research, in order for the researcher to have a strong and oriented relation to the fundamental question being studied, he or she must be interested in the phenomenon, stay focused, involved and reflective. Lastly, the researcher balances the parts of the text with seeing how the parts fit together in the whole of the textual structure. Similar to the reading and re-reading process it was necessary at several points to step back and look at the total...and how each of the parts contributed toward understanding of the phenomenon of interest in this study.

Ethical Considerations

Institutional Review Board (IRB) approval for this study was obtained from the Florida Atlantic University (FAU) (Appendix A). Participant informed consent was obtained prior to any data collection. Participants were provided information on risks and benefits of participating in the study and had the right to withdraw from the study at any time. Each participant was given a code so that their identities would not be disclosed.

Taped interviews and transcribed text were kept locked in a file cabinet in this researcher's office, and will be kept under lock and key to cross compare with future studies.

Risks and Benefits

Risks to the participants included the potential to elicit emotions and feelings that could be uncomfortable when answering and reflecting upon the research questions. A precaution to minimize this risk included encouraging the participants to share as much information as they felt comfortable, but that anytime the conversation went in a direction that was not comfortable, that the interview could be stopped or take another direction. A collaborative review of the text also provided an opportunity for the participants to not include any information that was thought to be inaccurate or should not be shared. Participants might have shared information in the course of discussion that revealed ethical dilemmas related to patient care and organizational policy. If this occurred, the participants would have been asked how they could share or act upon this information toward a positive outcome or resolution.

Benefits to the participants include the opportunity to reflect upon and appreciate the value of their role to the care of patients and the organization, the opportunity to improve their leadership and clinical practice as a result of reflection, and as a result, the care of patients. Reflection and dialogue on nursing situations help nurses live and grow as caring persons. Participants also benefit by increasing their knowledge of the research process and by knowing that they are contributing to an emerging body of nursing knowledge.

Data Collection

Interviews averaged 60 minutes, respecting the participants' time and acknowledging that in-depth interviews and sharing stories often require much emotional energy and could be tiring. Interviews were conducted at private locations, such as empty meeting rooms and conference rooms in the hotel where the CNL® conference was held, to be conducive to open dialogue. The interviews consisted of participants sharing stories of meaningful nursing situations and experiences from practice. These interviews were tape recorded and transcribed by this researcher. Field notes were taken so that observations such as vocal intonations, physical expressions and gestures that might not be audible in the recorded interview were available when listening to the taped recordings. The notes were later incorporated into the transcribed narrative text (Crist & Tanner, 2003). A journal was kept to document experiences during the data collection and analysis to help reflect on my thoughts and offer a decision trail for others to be able to follow the research process as a method of auditability which enhance the rigor of the findings.

The Use of Story

In this study, the CNLs® were asked to share stories of their life experiences as bedside leaders, illuminating what it is like to be a CNL®. The unstructured interview began with: Tell me what it is like to be a CNL®. Participants were also asked to reflect on and share a story of a specific nursing situation or other situation that they believe has

captured the essence of their leadership in the CNL® role. The participants were asked to reflect and give as much detail as possible about the situation rather than focus on specific answers to questions. From this story, additional reflective questions were asked to clarify and amplify concepts that emerged from the interview process.

According to Boykin and Schoenhofer (2001), through dialogue, nurses can freely express who they are as person and nurse living caring. Story provides nurses the opportunity to "affirm their values of self and of the discipline of nursing, and how these values are lived in practice" (p. 45). Stories of nursing situations illuminate the unique contributions of nursing.

Smith and Liehr (2003) describe stories as fundamental dimensions of human experience, and that stories "express who people are, where they've been, and where they are going" (p.167). Through story-sharing, intentional dialogue and true presence, persons gain new insights and deeper understandings of themselves and the meanings that define the significance of events in their lives (p. 169). Their middle range theory of Attentively Embracing Story (2003) was developed to provide a story-centered foundation for guiding nursing practice and research.

Story method is consistent with Van Manen's (1990) method because he describes listening to one's personal story as one of several methods for collecting accounts of personal experiences. Stories and narratives are about individuals, how they think and feel, rather than what they do or have done to them. Life experiences expressed through story capture the essence of experience and "retrieve what is unique, particular and irreplaceable" (p. 152). The researcher may ask about the participant's experience of

a certain phenomenon, what the experience is like and to think of an instance, situation, person or event, and "then explore the whole experience to the fullest" (p. 67).

Van Manen offers an example of a school principal that tells a story about the way he or she interacts with a student, teacher or a parent. Through this story he or she is in effect saying "This is what it is like to be principal. This is how a principal is to act" (p. 170). According to Van Manen, the significance of story in human science is that (p.70)

- Story provides us with possible human experiences;
- Story enables us to experience life situations, feelings, emotions and events that we would not normally experience;
- Story allows us to broaden the horizons of our normal existential landscape by creating possible worlds;
- Story tends to appeal to us and involve us in a personal way;
- Story is an artistic device that lets us turn back to life as lived, whether fictional or real;
- Story evokes the quality of vividness in detailing unique and particular aspects of a life that could be my life or your life:
- And yet…stories transcend the particularity of their plots and protagonists… which makes them subject to thematic analysis and criticism.

Sample

A purposive sample was selected, consisting of 10 nurses who graduated from a

CNL® master's program, passed their CNL® certification exams, and have practiced in the CNL® role in an acute care hospital for a minimum of six months. A minimum of six months of experience was delineated so that the CNLs® would have already completed a probationary period and have developed a comfort level in their practice. The acute care hospital setting was selected as the participants' work site since this is where patient care is particularly fragmented and where the role is primarily being implemented. This purposive sample is appropriate for this study because the participants represent the phenomenon being studied (Sandelowski, 1986, p. 31).

Recruitment Procedures

Access to the CNLs® was accomplished via contact with the American Association of Colleges of Nursing (AACN). Permission to conduct interviews with CNLs® at the annual Clinical Nurse Leader conference in New Orleans, Louisiana was provided by Dr. Joan Stanley, Educational Director (Appendix C). After obtaining Dr. Stanley's support, an email briefly describing the study and requesting CNL® participants was sent out via the AACN CNL list serve (Appendix D). Out of 15 respondents to the email invitation to participate in the study, 10 met the participant criteria and were selected as participants. Interviews were scheduled to take place at their annual CNL conference at times that did not interfere with conference sessions. Informed consent was obtained from the CNLs® at the conference (Appendix B).

Description of Participants

Eight CNLs® were interviewed in January 2009 at the American Association of Colleges of Nursing (AACN) annual conference held in New Orleans, Louisiana. Two

CNLs® were unable to make their interview appointments at the conference and were interviewed via telephone. Participants were provided a demographic data form to complete (Appendix E). All of the participants graduated from a CNL® masters program and had their national certification. Seven out of the ten participants were the only CNLs® in their organizations; five worked at Veterans Administration hospitals and five worked at non- profit medical centers; four were from the northeast, three from the southeast, one from the northwest, one from the midwest, and one from the southwestern portion of the United States representing nine different states (Appendix F). Participants are described as follows:

Mary: Mary is a 51 year old Caucasian female with 25 years of nursing experience, the last 18 months of them practicing as a CNL® at a 275 bed non profit community medical center in the northeast. Mary works on a 34 bed orthopedic-neurology unit and is the only CNL® in her organization. She currently serves as the President of the Clinical Nurse Leader ℠ Association and described her hopes for the future as advancing the CNL® role. She appeared confident with a poise and air of maturity surrounding her.

Jeanne: Jeanne is a 55 year old Caucasian female. She has worked in nursing for 27 years and at her hospital as a CNL® for 18 months. Jeanne works on a very busy 31 bed internal medicine nursing unit with telemetry. She described her unit as being the busiest unit in the hospital with an average of eight patients admitted and discharged each day. She is the only CNL® in her hospital. Her role was established as a one year pilot, but was deemed a success after three months as a result of the overwhelming physician

support for the role.

Collette: Collette is a 52 year old Caucasian female who has been a nurse for 17 years and a CNL® for 18 months. She works at a non-profit medical center. Collette started her CNL® role in November of 2007 with responsibility for the patients in two medical units; one 29 beds, and the other 31 beds. In 2008, Collette spoke to her director and requested that the span of her responsibility be reduced to have responsibility for only one of the nursing units in order to be more effective in her role. This request was granted and she currently is working on the 29 bed nursing unit. She is the only CNL® in her organization.

Shaun: Shaun is a 37 year old Caucasian male who has been a nurse for two and a half years, with just six months of experience in the CNL® role. He is the only CNL® in his organization. After working in a surgical intensive care unit for two years, Shaun began his CNL® practice on a 28 bed medical unit. Shaun was the only male participant in this study.

Sue: Sue is a 54 year old Caucasian female with 29 years of nursing experience; the last eight months of which have been in the CNL® role. She is the only CNL in her organization and practices on a 20 bed medical telemetry unit.

Danita: Danita is a 39 year old African American female who has been a nurse for seven years and a CNL® for the past 16 months. She practices on a 44 bed mother-baby unit and is the only CNL® in her organization. Her situation is unique from the other CNL® participants in that she is currently practicing in two roles; one of them as

Assistant Manager over a new computer system for labor and delivery, and the other as a CNL®.

Susan: Susan is a 50 year old African American female who has been a nurse for 20 years and a CNL® for two and a half years. She currently works on a 26 bed medical surgical unit. There are two other CNLs® who work at this medical center.

Jennifer: Jennifer is a 30 year old Caucasian female who has been a nurse for four years, with the last year in the role as CNL®. She is one of three CNLs® at her hospital. She started practicing on a 40 bed emergency dept. and then transitioned to practicing on four 38 bed medical surgical units at the request of her Director of Nursing.

Carrie: Carrie is a 42 year old Caucasian female who works on a 44 bed medical surgical unit. She is the only CNL® in her hospital. She has applied to a university to get her doctoral degree in nursing practice (DNP) in executive leadership in order to obtain the educational level to be a CNL® expert within her health system.

Angela: Angela is a 43 year old Caucasian female with nine years of nursing; the last two of which have been as a CNL® working at a non-profit hospital in the northeast. She works on a 32 bed medical surgical telemetry respiratory unit. She currently is the only CNL® in her setting. She is working on a proposal to become the "Lead CNL®" at her hospital, to help an anticipated eight new CNLs® transition in their new roles and help design the care delivery models to optimally utilize these new roles.

Limitations of the Study

The purpose of this study was to gain understanding about the meaning of lived

experience of a sample of CNLs®, which may not be generalizable to a broader population of CNLs®. The data may not be generalizable from a positivistic perspective; however, in phenomenology there can be a universal understanding of meaning of the role from thematic analysis (Ray, 2010).

Even though the participants were from different regions in the country, the majority of the participants were Caucasian females (70% of the sample were Caucasian females, 20% were African American females, and 10% was a Caucasian male). Fifty percent of the participants worked in Veterans Administration hospitals, and the other 50% worked in community or academic non-profit organizations. None of the participants worked in for-profit organizations, which could have added another dimension to the data.

Data Analysis and Synthesis

Data were analyzed using transcribed audio taped interviews. The transcripts were read multiple times and reflected upon to determine themes that describe the experiences of CNLs® and reveal the meanings they derive from being leaders at the bedside. Van Manen (1990) presents three approaches for uncovering and isolating thematic aspects of a phenomenon from the text. These approaches include the wholistic or sententious approach, the selective or highlighting reading approach, and the detailed reading approach (pp.93-94).

- The wholistic or sententious approach: The text is considered as a whole. The researcher asks, "*What sententious phrase may capture the fundamental meaning or main significance of the text as a whole?*" The meaning is then expressed by

formulation of that phrase.

- The selective or highlighting reading approach: The text is read several times for phrases, sentences or part-sentences that seem to be thematic of the experience. The researcher asks, *"What statements or phrases seem particularly essential or revealing about the phenomenon or experience being described?"* These statements or phrases are selected and highlighted.
- The detailed or line-by-line approach: Each sentence in the text is reviewed and the researcher asks, *"What does this sentence or sentence cluster reveal about the phenomenon or experience being described?"*

The selective or highlighting reading approach was selected in this study for thematic analysis.

Isolating themes. In the selective reading approach, the text is read several times to determine what statements or phrases appear to be essential to the phenomena or experiences being described. These statements are then highlighted in the transcript to discern emerging themes within the text. The text is read again with particular attention to the highlighted statements and phrases to discern the relationship between them. Highlighted phrases with similar meanings are grouped into categories and then into themes that capture the meaning of the phenomena. In this study, phrases that appeared essential to the phenomena of leadership were highlighted. The transcript was highlighted with different colored markers to identify and then organize similar phrases into preliminary themes.

Collaborative review of the text. Van Manen (1990) recommends that once

transcript themes have been identified from the highlighted text, the findings be reviewed individually with each participant in collaboration to “interpret the significance of the preliminary themes in the light of the original phenomenological question” (p.99). This process provides a “validating circle of inquiry” where participants recollect lived experience and validate that the phenomenological description captures this experience (Van Manen, 1990, p. 27). A collaborative review of the text provides an opportunity for the participants to question information that is thought to be inaccurate or should not be shared, review the emerging themes as being either essential or incidental, and strengthen what is weak in the text.

In this study, the transcribed interviews and themes were shared with each participant to establish a collaborative hermeneutic reflection between researcher and participant. Through this process, the participants affirmed that the interpretations rang true to them.

Forming thematic groups. After collaborative review with the participants, this researcher reflected upon the emerging themes to more fully understand their essential nature and relationship. Six thematic groups of meaning that provide a meaningful, holistic interpretation of the participants lived experience of leadership were synthesized from the emerging themes. These thematic groups were then identified as being essential to the phenomena studied.

Rigor of the Study

The rigor of qualitative research cannot be judged with the same rules developed to judge quantitative studies (Burns & Grove, 1997). Sandelowski (1986) proposes that

qualitative research is an artistic mode that emphasizes the meaningfulness of the phenomenon being studied rather than control of the process...a blending of scientific rules and artistic imagination (p.29). Credibility (truth value), applicability (fittingness), consistency (auditability), and neutrality (freedom from bias) are factors used to test the rigor of quantitative studies, but can also be useful in determining methodological rigor of qualitative studies (Sandelowski, 1986). Applications of these factors differ in qualitative research as compared to how they are applied in quantitative research.

Credibility. The credibility or truth value of a qualitative study resides in the discovery of human phenomena or experiences as they are lived by the participants, or "subject-oriented rather than researcher-defined" (Sandelowski, 1986, p.30). Truth value is associated with the credibility of a study. A qualitative study is credible when it presents a faithful description of the experiences of participants so that they would be able to recognize these descriptions as their own. Credibility in this study was achieved by listening to the CNLs®' stories without predetermining the value and meaning that they find in their roles. Substantial segments of the transcribed data are included in the dissertation results for the reader to come to know the participants and understand their experiences. Sharing transcribed stories and themes with the participants to validate themes was another way to achieve credibility and stay true to the meanings that participants derive from their experiences.

Applicability. Applicability of qualitative research is evaluated by the "fittingness" of the study (Sandelowski, 1986, p.32). Studies meet the criterion of fittingness when readers view the findings as meaningful and applicable to their own

experiences. Applicability was achieved for this study by selecting a purposeful sample of CNLs® from different parts of the country who were practicing as leaders at the bedside. Participant review of the phenomenological descriptions affirmed that the findings were applicable to their lived experiences.

Consistency. Consistency in qualitative studies is reflected in the auditability of the findings. A study and its findings are auditable when other researchers can follow the researcher's decision trail, and come to similar conclusions. Van Manen (1990) refers to the "phenomenological nod" as an indicator of good phenomenological description. The phenomenological nod occurs when others read the text and recognize the experience as one that they have had or could have had and can nod to it (p. 27). Auditability was achieved in this study by inclusion of substantial selections of narrative for the reader to recognize and understand the experiences and the nature of the themes that emerged. Keeping a journal also added to the auditability and confirmability of the study by enabling another researcher or colleague if necessary to logically follow the process, procedures and interpretations of the inquiry.

Neutrality. Neutrality refers to freedom from bias and scientific objectivity. In qualitative research, the meaningfulness of findings is achieved by reducing the distance between the researcher and participants and eliminating artificial lines between subjective and objective reality. Qualitative research emphasizes engagement of the researcher with study participants and the subjective reality or meanings that participants give to and derive from their unique life experiences, therefore, confirmability is used as the criterion of neutrality in qualitative research rather than objectivity Confirmability is achieved

when auditability, truth value and applicability are established (Sandelowski, 1986, pp. 33-34).

Van Manen (1990) concurs with Sandelowski (1986) and posits that phenomenological research does not fit within the positivistic scientific standards of objectivity and subjectivity. In phenomenology, the researcher is objective by remaining oriented to the object or that which stands in front of him or her, remaining true to the object. The researcher is subjective by being perceptive, insightful and discerning, in strong orientation to the object of study (p. 20).

Van Manen (1990) suggests that to orient oneself to a phenomenon always implies a particular interest in and vantage point or orientation to the phenomenon (p. 40). It is because of the researcher's interest and vantage point that freedom from bias is not an indicator of rigor in phenomenological research. Furthermore, researchers cannot totally bracket or suspend their knowledge and assumptions about a phenomenon. Van Manen (1990) suggests instead that it is better to make explicit ones understandings, beliefs, biases, assumptions, presuppositions and theories to more fully understand the phenomenon of interest (p.47).

An extensive review of the concept of bedside leadership and inception of the CNL® role, as well as conducting a pilot study of practicing CNLs® have already informed this researcher's views about the experiences of CNLs® leading at the bedside. This researcher also taught CNL® students and worked as a nurse administrator with CNLs® as members of the nursing care team. Prior to analyzing the data, this researcher intentionally focused on the data to be open to the experiences of the participants so that

researcher views and prior experiences did not bias the findings. Keeping a research journal was a way to reflect upon my own presuppositions, so that I was able to stay true to the meanings that came from the language of the participants. To establish confirmability in this study auditability of findings, staying true to the experiences of the participants, and applicability or fittingness of the findings were established.

Chapter Summary

In this chapter, the phenomenological method of research was chosen as the best fit to study the meanings that CNLs® attach to their practice as leaders at the bedside. An overview of phenomenology and hermeneutic phenomenology as a philosophy and method for inquiry provided a framework for the design of the study. A plan for selecting participants, obtaining informed consent to protect human subjects, risks and benefits to participants, method of data collection and data analysis were presented. Rigor in qualitative research and strategies to achieve rigor in this study were addressed to ensure confirmability of the study to advance the body of nursing knowledge.

CHAPTER 4

PRESENTATION OF FINDINGS

This chapter presents the findings of the study. The research question that guided this study was, “What is the meaning of leadership as experienced by CNLs®?” To gain understanding about this question, data were collected from ten CNL® participants using a phenomenological research method. Through the selective or highlighting approach of analyzing text described by Van Manen (1990), the fundamental meanings of the experience of leading at the bedside were synthesized into six essential thematic categories and related subcategories.

Uncovering Themes

This section reports the data which was derived from asking the question “*What is it like to be a CNL®*?” From this introductory question, following the direction of the interviews, subsequent questions were asked of the participants to gain understanding about what the meaning of leadership has for them and how they live caring in their roles as CNLs®. Interviews were recorded, transcribed and read several times. Key statements and phrases were highlighted with different colored markers to isolate emerging themes of experience. These emerging themes were shared with the participants to validate the

findings. Through this collaborative analysis and prolonged immersion in the data, I gained further insight into understanding the phenomena of leading and living caring at the bedside as experienced by the participants. Thematic categories were then identified from the emerging themes, and were shared with the participants to determine if these themes captured their experiences. The Chair of this dissertation committee, who is an expert on nursing as caring, reviewed the thematic categories and provided recommendations for further clarification of the themes. Thematic categories were then classified as essential to the meaning or essence of the phenomena being studied.

Essential themes. An essential theme is defined as the essence or quality "that makes a phenomenon what it is and without which the phenomenon could not be what it is" (Van Manen, 1990, p. 107). In this study, six essential themes emerged from the statements and expressions from each of the participants. Although each of these themes incorporate the essences of leading and living caring, the first three themes are more illustrative of the meaning of leading, and the last three are more illustrative of CNLs® living caring. The essential themes of meaning that leading at the bedside has for CNLs® include:

1. Navigating Safe Passage
2. Making a Difference Evokes Pride
3. Bringing the Bedside Point of View
4. Knowing the Patient as Caring Person
5. Living Caring With Nurses
6. Needing to be Known, Understood and Affirmed

Essential Themes

The six essential themes and subthemes are presented in the table below:

Table 1

Essential Themes and Subthemes

Themes	Subthemes
1. Navigating Safe Passage	Being the Connector
	Seeing the Big Picture
2. Making a Difference	Having Moxie
Evokes Pride	Being the Get it Done Person
	Cultivating Respect from Others
3. Bringing the Bedside	Being the Consistent Presence
Point of View	Bringing the Bedside Nurses' Perspective
	Working Hand in Hand With Nurses
4. Knowing Patient as	Dancing With Patients
Caring Person	Authentic Listening
	Bringing Truth to Light for Patients and Families
5. Living Caring With	Developing Their Best
Nurses	Advocating for Nurses
6. Needing to be Known,	Breaking Through the Barriers
Understood and	Needing Management Support
Affirmed	Justifying their Existence

Navigating Safe Passage

Each participant discussed the importance of protecting patient safety in his or her daily practice. They believed that the CNL® serves as an important safety net for patients in the acute care setting, guiding the patient safely through turbulent waters. Subthemes that support this essential theme include: “Being the connector, and Seeing the big picture.”

Being the connector: Participants described fragmentation at the point of care, related to multiple care providers and consultants caring for patients. Mary spoke about the central role that the CNL® plays in protecting patient safety. She said, “It is beyond the shadow of a doubt, starting from the IOM to the AACN, the answer to what patients need in the hospital, reducing the risks for the hospital…very much a patient safety focus.” She shared that her interactions with physicians, like those with nurses, intentionally highlight that each patient and patient situation are unique. Mary described examples of fragmentation of care where patients’ unique needs were not recognized; however, she was steadfast in personally working to meet these needs and engaging with others as evidenced in the following story.

> We had a woman who had back surgery for a rare malformation and had complication after complication. Her husband was very involved in her care and actually fired doctors and wouldn’t let certain nurses take care of her. I followed her everyday when she was up in the ICU and PCU. I would follow her and the

> family and helped to coordinate a lot of her care. Since I knew her across the continuum, I knew that the doctor forgot to reorder her medications. She had bowel issues so we had to be proactive with that; she had an inner ear thing so we had to put her on Antivert and Meclizine. I had to call three different physicians and two nursing home services to coordinate her care throughout the continuum.

Jeanne described her role in bringing the care providers together for the good of the patient as being a “lateral integrator” in coordinating care for her patients. In addition to connecting these health care providers, Jeanne talked about the importance of building relationships with others, improving communication, and in particular, listening to the patient’s story.

> …trying to balance the needs of the patients, the needs of the nursing staff and the needs of the medical staff. Trying to have those three elements, instead of pulling apart, trying to come together. And I think the biggest thing I work on everyday is communication because that is always the key. Trying to keep people all together on the same page is the biggest thing I do…I stay connected to the patients. I stay connected to the nurses. Being the lateral integrator, I am the person who knows the patients. I see the patient in the room with so many different people coming in…coming and going…they just…they are not quite sure about what is happening to them. They have to tell their story over and over. Some CNLs® get pulled away to do projects and things like that, but what is most important is being in relationship with people. Being in relationship with others is most important.

Sue shared the following story of bringing the different care providers together to coordinate the care for a patient with congestive heart failure (CHF) as an important aspect of her role.

> I had a patient who was an employee and was in for CHF and he had a lot of needs. He was a bachelor, didn't eat right, was extremely morbidly obese. He told me he never smoked, but told other people that he smokes occasionally, drinks occasionally. He was a fairly young gentleman who still needs to work to keep his insurance. I spent an hour with him, going over everything, and we got contacts for him with Dietary, with home based telehealth, connected him with the Respiratory Nurse Practitioner, who came in and got him set up with in home oxygen... things like that. He had sleep apnea which was affecting his job performance. He was falling asleep at work, so she got him set up with BIPAP. It's not just one thing is isolation. It is everything working together.

Sue went on to describe her role as being the connector using the following analogy: "I look at the CNL® role as being like a sandwich cookie. The bottom of the crust is the staff nurse, the top of the crust is the manager, and I am sort of the filling in between. I am adhering the bottom and top together so that we have one unified whole. Like an Oreo cookie."

When I asked Jennifer what she believed the most important aspect of her role was she replied in an instant, "patient safety." She described, "Blowing up patient safety, transitioning what is on the paper to the bedside, having the nurses hardwired for safety." She impressed upon the staff the importance of "having side rails up, brakes on,

handwashing, and implementing creative ways to be sure that you can't do it wrong." She shared that there was a "big disconnect"; a generalized lack of communication between physicians, nurses and patient care technicians, lack of follow through on aspects of care, and no designated charge nurses. Continuity in patient assignments and daily work flow suffered due to inconsistent leadership at the point of care. Jennifer viewed garnering and sharing knowledge with other health care providers to keep patients safe, an example of the CNL® being a connector. She described herself as being a "knowledge broker." I asked her to describe what she meant:

> A knowledge broker is the one who gets all this information and of course you can't retain it, and of course you can't be an expert in everything, so you broker it out, and you know, you pull from one and give to another, and then eventually it all evens out…crossing boundaries throughout the organization on a daily basis.

When I asked Jennifer what she is most proud of in her role, she paused for a few moments before she spoke. In a quieter voice, she said, "It's what hasn't happened. When the potential for error is there, when the potential for you know…honestly, it's when a patient doesn't die…when you come in in the morning and the patient is still there and hasn't fallen."

Carrie described, "pulling it all together" and connecting the different disciplines as being important aspects of her role. When I asked her what was most rewarding about her work she replied:

> I would say that just the general collaboration, and pulling together all of the aspects, like working with the social workers, working with the physicians,

> working with the nurses, and pulling it all together and getting that care delivery fine tuned, and giving it all, getting all of it done, and pushing that patient forward, and getting that good outcome. I think that is the most rewarding.

When I asked Angela what she found the most satisfying about her role as a CNL® she shared that it was "being able to be at the bedside with the patient and the new staff, connecting the dots and putting people together. I get the disciplines together, and it works right because of my interaction." She shared the following story that exemplifies this comment.

> I was just discussing a case with a nurse on Monday. This is a perfect example. I was called into a room by a brand new nurse of about six months. She said, "Angela, this patient in 15, I think he may be septic and we need your help." I went in with her to see what was going on. We interacted with each other, with the patient, with the family. We interacted with the disciplines and I got the patient down to ICU...I interjected and said we can monitor that patient more closely in the unit...the patient expired. But the goal was to get the patient to the ICU and I worked with the family and the nurse to make that happen.

Danita shared her experience as being a connector:

> I think patient care is really fragmented. You know, if I have nephrology look at a patient, they might never see my OB doctors. They just look at whatever is in the notes. They never talk to one another. I hear the patients and what the nurses say so I bring it all together.

Seeing the big picture. Participants described seeing the big picture and knowing

what to do in order to navigate a safe passage for patients during their hospital stay. Through coming to know their patients, surveilling the environment, and knowing how to navigate within the system, these CNLs® were able to pick up on what others missed, and steer patients safely through the hazardous waters of the acute care hospital. The phrases "I see," "I look out for," and "I see the big picture" were used often by the participants to describe their ability to pick up on things and visualize what others did not see, supporting Brown's (2008) experience as a CNL®.

Mary described situations where the patient would have fallen through the cracks if she was not there to pick up on things that the physicians miss:

> They *(meaning the physicians)* might order an HBA1C but they didn't do anything with it. That's part of the care coordination that I do. I remind them about the best protocols like DVT prophylaxis, getting a statin going for high lipids, getting the cardiac monitor off, and all that stuff. You may have a patient who is 85 years old and they leave the IV running at 125 for 3 days, and I call them to reduce the IV so this patient doesn't go into CHF.

When I asked Collette what she believed to be the most important aspect of her role, she replied without hesitation, "keeping patients safe." She described her role steering patients safely along their journeys and the ability to see the big picture like a "view from the balcony":

> Without the CNL® there isn't a consistent person for that patient to feel like they are safe along their journey…that someone is putting the picture together and knows them. Safety-wise, from your education, you think of things that are

> like…from the balcony. When I look at a patient, I know the patient safety goals. I know what the risks are in care. It's really looking out for patient safety. The culture of safety was taken on our unit, and it was the lowest of the low. I have done a lot of work looking at why patients were falling and negotiated system resources to get things in place, to look at having improvements in place…You have to put processes in place to maintain the interventions and make it easier for the staff…make it easier to do the right thing. I implemented safety huddles in the morning at change of shift. We use five to seven minutes to talk about the safety needs of the patients every day, every shift. I implemented that… I get chills... It is so fun.

Like Collette, Sue described patient safety as being one of the most important aspects of her role with seeing the big picture as a key component, as exemplified in the following story she shared:

> We had a patient on the unit last week who was a laryngectomy patient with lots of secretions. The doctor insisted the patient go down for a test, and as he was being wheeled down the hall, I stopped the escort and said where are you taking this gentleman? And he said "down for a test." I knew there were no nurses down there to monitor him. So I stopped his nurse and said we can't send him down for this test. There is no one down there to monitor him. This man can't speak, nor clear his airway. So I went down to get a portable suction machine, and the tubing and a little basket with suction and saline. I showed the nurse how to switch him over to a ventimask so he would have humidified oxygen. Here was a man who if

> he went into respiratory distress, he would not be able to verbally alert anyone. That is what I mean about looking at the big picture.

Angela saw herself as the one "looking at the patients with a different set of eyes, making sure they get the resources they need and are moving along in the right direction." In her story about the patient with sepsis, she described working alongside a novice nurse who was concerned about her patient's change in status. Angela was able to use her knowledge and experience to pick up on the higher level of care this patient with sepsis needed. This different set of eyes seemed to see and pick up on what others did not. Moving the patients along in the right direction was her way of navigating their safe journey. She shared, "this story just happened two days ago, but it really happens daily. A lot of the role is stepping back and asking what else can we do?"

Carrie described her focus on patient safety as the most important aspect of her role, closely observing her patients and intervening when necessary:

> The most important aspect of my role is keeping on top of my patients and following them, and making sure that those high risk scenarios are not falling through the cracks, and making sure that nurses understand their role, and developing the environment where the nurses know that they have that help and support. …My role with patient safety is looking at discharge planning and skin assessment. I don't know if you consider this patient safety. But we do risk assessments, and I guess that with respiratory patients, we focus on their mental status change. Sometimes I will step in when a patient is getting confused and the nurses recognize it, but nobody is doing that close observation and I step

> forward and get that in place. I reduce the risk of blood stream infections. I step in and check IVs and PICC lines, and I work with the Blood Stream Infection committee. I standardized the PICC line kit. Those are the areas that I try to focus on all the time.

Making a Difference Evokes Pride

Participants described many situations where they made a positive difference in the care of their patients. Making a difference by implementing new processes, challenging the status quo, and not giving up until the best solutions were found turned out to be both important and satisfying aspects of their roles as leaders. Subthemes that support this essential theme include: "Having moxie, Being the get it done person, and Cultivating respect from other disciplines."

Having moxie. Participants shared stories where their assertiveness and tenacity were what it took to meet their patients' unique needs. Jeanne described a patient situation where she had to be assertive with the medical staff to make the right decision for the care of a patient.

> We had a patient we were working with one night that we were trying to get home to home hospice. The family was resistant to taking him home. They said, "He is real sick." I said yes, your father is definitely sick, and yes, he is dying. I could see their resistance although this was planned for a couple of days. I left the floor about 6:30 that night and I kept thinking about that patient…thinking about that patient all night long, wondering about whether he was going to make it or not. So I came in early the next morning, at 6:30 am, and saw the doctors and

> we started rounding and I said this patient is going to need a lot of care. They said, "We are going to move him to the ICU." I said, oh no he's not. This man is dying. The resident said, "He is not gonna die here. I've never had a patient die before." I said, well, he is going to die and he is going to die here on our floor. The family is not ready to take him home and he is not going to live long. I said he is not going to the ICU to die. We are going to take care of him right here. We are going to handle him here.

Likewise, Sue shared a story where her tenacity made a difference to her patient:

> I have showed them *(meaning the nurses)* that it is important to go above and beyond to do things for patients. For example, when a patient has been NPO for two days and the doctor writes the order to let them eat the nurse checks the order and tells the patient, "Your tray will come up in an hour." That is not acceptable. I will go down to the kitchen and get the tray and they will say, "Sue, you didn't have to that, the tray would have come up in an hour." And I said do you know what it is like to not eat for two days? Do you know what that's like? I had a patient write to me on a little piece of cardboard because he didn't have any paper. He wrote "Thank-you for the food, thank-you, thank-you for the food!" I have that up on my bulletin board and when anybody gets on my back about the doctors and having to call them about when this patient can eat, I will take that little piece of cardboard out and I will show them this is what a patient wrote to me. This means something to them.

Danita's patient was in her 37th week of gestation with twins and she needed to be

moved to a higher level of care.

> She came in with a real bad cough and difficulty breathing. We did tests, ABG's, everything looked good, but I was worried about her. One of the nurses called me to start her IV and I saw her arms were swollen, her whole body was swollen and she looked worse than the day before. I called the chief resident and checked her I's and O's and told the nurse that she is retaining fluid. I asked the chief to give her some lasix. She had a C-section that night and the next day she was still having difficulty breathing. I came in early and find her on a CPAP machine. The doctors thought she was OK to stay on this unit. I said oh no, she has got to go. She has to go to ICU, she is not doing well. I got her transferred to the ICU despite the residents wanting to keep her. She had CHF. I was right. From going in to start her IV to using critical thinking skills and making sure she got the care she needed was for me what a CNL is all about.

Susan described a patient situation where she needed to be assertive and challenge a physician for a patient that did not need additional painful intravenous interventions.

> The other week…I think it was last week…The nurse stuck this patient four times. The doctor said we are going to get a line in him. I told him, we are not sticking this patient again. We stuck him four times; I said is he on any antibiotics? Is he a diabetic? The nurse said no. I said, get that doctor on the phone and let me talk to him. So I talked to the doctor and said we are not sticking this patient any more. Either we get a PICC or central line, but right now we stuck him four times and we are not going to put him in any more distress. To

> make a long story short, the patient really didn't need that line so why stick that patient six, seven or eight times if he really doesn't need it? It's just not gonna happen….

Being the get it done person. The participants described situations where they were the "go to" persons who stepped in during critical situations and mobilized resources and their network of relationships to make things happen.

Jennifer shared a story where she not only "ran the code" in the emergency department, but made sure that the patient's family was cared for and allowed to be with the patient:

> I had a patient named Bob who came in in cardiac arrest. He was your typical middle aged American white male, overweight, worked a corporate job, in his 50's, and hypertensive. We coded him and several things happened that made this a great code. Number one was that the doctor walked out of the room. That was OK because we are ER nurses and we can run codes. So we are coding Bob. His wife and son were standing outside the room and couldn't see in. I walked out and explained to the family what was going on. He was coded from home so they knew. It was a phenomenal experience for everyone. They came in and held his hand. They were very nervous and said, "Oh, we are in your way." I said no you aren't we can walk right around you. Don't worry about it. The wife kept saying, "Come on Bob, come on Bob, come on Bob." And we had this chant going, the entire staff was just chanting, "come on Bob, come on Bob, come on Bob." …and Bob came back.

Jennifer's tenacity in making sure that the family was kept informed and then present during the code was very important to them. She continued, "It was amazing. I still see Bob every once in a while. That was really the essence. I was there. I was running the code. I was in there with the nurses. It was so great. That is my A#1 story." Jennifer went on to describe how she started her CNL® role in her hospital's emergency department with another CNL®. After demonstrating success in improving processes in the emergency department, the two CNLs® were asked to transfer to the medical surgical nursing units on a temporary basis to make similar improvements in those departments. She described her transition from the emergency department to the med surg units to facilitate process improvement in the following way:

> A couple of months ago, we were commissioned on a mission by our CNO and our Director. They discovered that our med surg floors really needed help. They were struggling with very basic things, work flow issues…not very strong managerial leadership. So, we were asked to go up there and for a lack of a better term, to tear the place apart. To go through the units to do an analysis of each unit's work flow, efficiencies, safety, clinical quality and are they doing what they say? And are they saying what they do? And we found a lot…We were told it was going to be a six to nine month project; however, I don't think that will be the case. Because when we went up and did our analysis we uncovered a lot of things and now they are thankful we are up there trying to just hack away at some of these issues. So it could be a long term temporary thing...but seeing outcomes...working hard on a project...it could take months and months and

> months, but in the end you can say that you did it.

Shaun described his experience in being the get it done person by using his critical care knowledge and skills and removing roadblocks in order for patients to receive the appropriate level of care needed:

> I take more interest in those situations that are more complex. With my background in ICU, I am often approached to evaluate the more critical patients. With this patient, the residents thought they had to build a case to move her to MICU. We called a rapid response team and made it happen just like that. With this system in place, even though you may hit a roadblock from the medical service, moving it from the nursing side, we get that patient moved a lot quicker. Nursing made it happen.

Mary shared the following story of intervening on a daily basis to not only ensure patients received the correct care, but that they also understood their care.

> The most fun of everything is my stroke patients, my neuroscience patients that I see everyday. I go in and talk to them, and do some education and ask them if they have any questions. Some don't understand the difference between a stroke and a TIA. They are always filled with question, like "I didn't really understand that." So, I go and find out some information for them and make sure that the MRI that they are supposed to get is done. I will get the time of their procedure or surgery, whether they will have an IVC filter, and explain it all.

Danita described her role in process improvement and implementing change as important aspects of the CNL® role.

> I am a person that likes to make change and make things happen. I want to look at the process and I want to fix it, and make it better….not just have meetings and do nothing about it. I would sit in these meetings and say why am I here?

Sue described how her interventions are important in getting things accomplished. The following story not only supports the theme of the CNL® being the get it done person, but also the themes of being tenacious and advocating for nurses:

> As a nurse, you tend to take no for an answer. As a CNL® you keep pounding, and going and going and going until you find the solution or find another way of looking at it. Social workers never came up to the nurses to talk to them about why the patient can't be discharged, although they *(meaning the nurses)* are here 24/7. I went to the Director of Social Services and talked to her about it and now they go to the nurses. You know how to go to the right person, and find solutions.

Susan shared a story of a 52 year old patient who had Pickwickian syndrome, was 600 lbs, had a tracheostomy, and was now to be transferred to a nursing home

> In order to get him to the nursing home, I knew I needed a current weight. So I called one PT that I know and I told him that I needed a weight on him, so he and another PT came and reset the weight on the bed scale and we got the accurate weight. I questioned if he still needed to be on CPAP and why can't he be weaned? He had been weaned before. Why can't we call pulmonary and he can be weaned and just wear it at night. So pulmonary weaned him off of CPAP and he didn't need it. When it was time to transfer him I called my PT people again to help, and when the ambulance people came they said the gurneys wouldn't hold

him. So I came up with a plan. I called my friends in the warehouse and asked if I could bring my patient there on the dock to get him into the ambulance. So that is what we did. He was in a wheelchair and they lifted him on the dock into the ambulance.

She further said:

I have all these clinical resources who come in handy. The doctor said we all deserved a gold medal since that was such a big job… I have to utilize my resources. I have a lot of them. I have created a whole list of resources so I can get things done. We had a patient who was discharged by mistake with a triple A, and the doctor wanted him to come back. He was afraid that it was dissecting. I tracked the patient down and told him we needed to have him come in to get an ultrasound done. Well he came in after Ultrasound was going to go home and I called Ultrasound to stay and he had the test done. So they said to me *(meaning the Ultrasound personnel*) "We are having a party next week. Do you think you can make us a cake?" I said you all went above and beyond, so I made them that cake.

Susan developed strategic relationships throughout the hospital that enabled her to do her work. She proceeded to tell me about housekeeping, the importance of their role and that she advocates for them when they need extra help. She said, "He (*referring to the evening housekeeper)* was working hard. I called down there and said this man needs help. And then they send him some help. I told them that you all need to give him a raise 'cause he works hard and does a good job. They really listen to me."

I noticed that Susan used the adjective "my" frequently when describing the nursing staff, the patients, physicians, and persons from other departments. She had forged a bond with them. All the persons in her world as a CNL® were linked with her in a special way.

Cultivating respect from others. Several of the participants derived pride in the relationships they cultivated with others, in particular with the physicians. Much of the respect from the nursing and medical staff developed as a result of the expert knowledge and skills that these CNLs® bring to the point of care.

Jeanne developed a close collegial relationship with the medical staff. She beamed when she shared:

> I must say that I feel extremely supported by the strong back up of the medical teams. They absolutely love having me there. We touch base continually and they know where to find me throughout the day. They hold me accountable. When I am not there they say, "Where have you been?" But they love the role and feel very supported with somebody to go to on the floor that they can go to who will help them.

Danita's relationship with the nursing and medical staff is portrayed in this story:

> My relationship with the physicians is good. I wish everybody had that relationship. My chief listens to me a lot. Sometimes they ask me "what are you thinking, what do you think is going on?" In having autonomy and making decisions, I get the respect of the physicians not that it is needed or not needed, but you get the doctors to listen to you and pay attention. Some of the attendings

> call me every weekend. If something goes wrong, they want me there. They don't care if I can do something, or can't do something; they say, "Just stand right there." I think my relationship with the docs makes it better…smoother.

In addition to the strong relationships and level of respect gained from the medical staff, Jennifer described the relationships she developed with executive leaders in the organization.

> It's great when the CEO comes up to you and says, "How much money did you just save me? Awesome!" I can plop down in my CNO's office and complain about anything...and I have relationships throughout the hospital. A big part of what I do is seek out the right people and tell them I need your expertise…When I call and say it is Jennifer the CNL®, they know me and say, "OK what do you want now?" in a friendly and teasing way.

Bringing The Bedside Point of View

The importance of being at the patient bedside or point of care rang true from each of the participants. By occupying this privileged place, these CNLs® were able to stay connected to the needs of the patients and nurses on their nursing units and bring this point of view forward when important decisions needed to be made. Subthemes that support this theme include: "Being the consistent presence, Bringing the bedside nurses' perspective, and Working hand in hand with nurses."

Being the consistent presence: Some of the participants delineated the importance of their roles at the point of care as compared to Nurse Managers who are often far removed from the bedside. Angela described the CNL role as being different than the

Nurse Manager:

> The Nurse Manager is 24/7 over all of the unit, the human resources, staffing effectiveness, all of that stuff, while I focus on the clinical outcomes of the patients…So she is helping identify those issues from a systems level from the hospital perspective, from the nursing department perspective. It is my job to implement them on the floor and make sure we are following though with the standard of care…I think what is unique, is that the CNL® is really at the patient's bedside, you are there with nursing, really at the point of care, where the Nurse Manager would not be. They are spending more of their time in operational meetings, from a different perspective. The huge difference is our impact with the patient at the bedside with that nurse.

Mary described the bedside as "my home" and that her presence at the point of care was analogous to being the needle that pulls the thread forward so that the fabric of the patient experience does not unravel. She shared:

> I am the lateral integrator and collaborate with the other health care members and coordinate the patient care and I make rounds on my set of patients. I go and see them. I pull the thread through their stay. Sometimes the nurses are different everyday, every shift. I am the person who is there Monday through Friday. They know they can get me if they need me.

Susan reiterated that it is the CNL who is positioned at the point of care Monday through Friday. She said, "The managers are out in meetings all day so they don't know what is going on. But I am out on the floor. If you call I can tell you everything that is

going on with the patients, about every patient up there."

Bringing the bedside nurse's perspective. Being at the bedside not only afforded the participants the opportunity to come to know their patients better, but it also allowed them to come to know their nursing colleagues better. Danita described that being at the point of care afforded her the view of the nurses at the bedside when she talked about her role in implementing a new clinical informatics system:

> About six months ago, I was just doing the CNL® role, and the informatics part is something new for me. Sometimes I am seen as a problem solver when sometimes there is not a problem. The informatics project was a whole other thing. From the CNL® perspective, I looked at it from the bedside nursing point of view. The way they had it set up was that the bedside nurse would fail. So I brought it to the bedside and made it applicable to the nurses there. They *(meaning managers)* have been away from the bedside for so long that they cannot see how it works for them, but I see.

When Danita talked about her role in developing the clinical informatics program for the labor and delivery unit, she described how the director of the unit did not consider what the nurses needed to do their work:

> The Director said we are going to do this and that, and I sat in the meeting shaking my head. When she went on vacation, I said this is not going to work. Let's go out on the floor and walk this floor and look at the logistics. They purchased one printer. Can you believe it? One printer for everyone when we

> have three OR rooms and a recovery room and the printer is all the way out in labor and delivery. I said you expect the nurse to walk all the way from labor and delivery to the printer? You are expecting them to walk up and down the halls? It's not gonna happen. This would have sent me out the door. I quit. So Biomed brought another printer and he said "What did you do to get my Supervisor to give you all another printer?" They see I really come from the nurse's point of view, from the people who are doing the work. They think she really does care about those nurses, she's going to break her neck to get what they need.

Danita commented on the "levels of hierarchy" in management and that the higher up the rungs you go, the less connected you are with the realities at the point of care, and the less you are able to accomplish.

> I think that the layers in the hospital are bad. Staff have ideas and it just doesn't go anywhere. It feels a little... it is frustrating when you want to make a change. I am a person that likes to make change and make things happen. I like to feel that there is progress. In my institution, they don't bring all the layers to the table all of the time...You need to be out there seeing what is going on, rather than sitting the meeting...The director and manager haven't worked the floor in years...They wonder why we don't have much buy in on things. It is because we all don't sit down as a group and collaborate.

Mary believed that managers who were no longer close to the point of care were not able to effectively understand the bedside nurses' perspectives. She shared the following comment related to middle management decision making:

> At the surface level they look like they are getting along but they are not. They don't come down to get the information. They are not at the point of care. They are making assumptions. They don't spend enough time on the units to really see what is going on, so bad ideas are shared upwards and the executives make decisions and the staff nurses say, "Who the hell made that decision. That is the dumbest thing I have ever heard." I think the Clinical Nurse Leader is a practical position, who is there at the point of care and can say, "That is not going to work."

Working hand in hand with nurses. Participants voiced satisfaction by working with fellow nurses. Phrases such as "working hand in hand" and "I keep my hands in patient care" were often mentioned. Carrie described what she liked about being a CNL®:

> It's an interesting position and I really like it because I am not pulled away from patient care completely. I am able to, how can I say; really, look at patient care from a perspective of how we can improve it … and it also puts you in a role of leadership and I really like that.

I asked her to tell me more about her comment about not being completely pulled away from patient care. She replied:

> I keep my hands in patient care and I think that is really important, and I think that the nurses see the importance of that because then it gives them the guidance, and it's not guidance that is just coming out of an office somewhere, it is guidance that is coming from an individual who is out there on the unit working hand in hand with them.

Danita shared the following example of working with the nurses:

> I round with the nurses and go through the charts with them to make sure they are picking up on everything, to see if they are missing anything. I like to go in and talk with the patients with them, to see what the patients are asking for.

Collette shared an example of how working with the nursing staff on her unit facilitated a decrease in patient falls.

> I asked the team to debrief in the moment right after the fall. The team did it but it was hard. We had to stop and talk and see what we could have done differently and really get to the root of why these falls were happening. We would share and learn from it and I would email it to those who weren't there, so we could prevent this from happening again. Together we looked at processes to protect the patient. You know, nurse empowerment and being engaged in process redesign and doing the work together...I spend five to seven minutes each morning with the staff to have a safety huddle.

Susan described herself as a "team player" by supporting and working with the nursing staff.

> I am a team player. I will do what I can to help people and I know our unit is a high volume unit, and the nurses are very stressed. We're swamped half the time and it is very hard. I am not the type of person to be sitting behind a desk anyhow... to be sitting behind a desk and know that people are running around, and hear patients gurgling, and hear IVs beeping would be terrible.

Knowing Patients as Caring Persons

The quantity and quality of time spent with patients afford the CNL® the opportunity to come to know patients as persons and to respond to that which matters most to them. This essential theme is reflective of the meaning of CNLs® living caring. Subthemes that support this theme include "Dancing with patients, Authentic listening, and Bringing the truth to light for patients and families."

Dancing with patients. Jeanne described the importance of her role at the bedside as being the one who comes to know the patient. When I asked her to explain what she meant, she shared her perspective on being a consistent presence and included the phrase "constant dancing with the patients":

> Oh Lordy, sure. You know the patients, you know their…being there on the floor, getting to know the patients, you know their behavior and you know when they are not feeling well and can't verbalize it, you know when they are escalating, and when things are going wrong. You have a Nurse Manager who is responsible for the scheduling, disciplinary actions, incident reports, meetings, and off the floor the entire day, pretty much. I am the person out there. Everybody sees me as the one in charge of the floor…I know…I have my finger on the pulse of the floor. I know where people are, consultants are looking, they find me, they find out where the patient is…it's you know, constant dancing with the patients, you figure out where they are and get them to where they need to be.

Authentic listening. The concept of authentic listening combines authentic presence with active listening to the patient's calls for nursing. Collette shared a story of a 35 year old male patient admitted to her unit after having been to the emergency

department eight times in the past year for abdominal cramping and vomiting. She began:

> He was miserable. I heard from the nursing staff that he was upset and was talking about a lawsuit. So I went in to see him. We talked about what was bothering him. He felt that no one was listening to him, and no one knew what was wrong with him. No one told him his test results; no one sat down and explained things to him. He saw multiple physicians and nobody really knew him. He had only seen his primary doctor once. He never had follow-up after each of his ER visits, he just kept coming back again and again. I knew he was depressed. I told him that it must be very difficult for you to be going through this all… He knew that there was someone now who was in charge of taking care of him. By knowing his story, knowing his history, what was going on, hearing what the issues were, taking the time to hear him and plan together with him.

Bringing truth to light for patients and families. Multiple examples were provided by the CNLs® that highlighted their role in seeing situations from the perspectives of patients and families. Being at the bedside or point of care, and coming to know their patients as persons and hearing their calls for nursing afforded them the opportunity to provide honest information, serving in the role as truth teller.

Jeanne's story about the patient who was dying and the family needing to know this truth is an example of the CNL® speaking the truth.

> We had a patient we were working with one night that we were trying to get home to home hospice. And the family was very resistant to it. They said, "he is real sick." I said, yes, your father is definitely dying...I sensed that the family didn't

> want him to die at home. They couldn't handle it, so I said we are going to take care of him right here. We know him and we will handle him here.

In a story mentioned earlier in the chapter, Sue described caring for a patient with CHF. In this situation, she spoke the truth about a patient's condition; words that no one had voiced and in this case, it was directly to the patient:

> When I went in to talk to him about CHF, nobody ever said the words, congestive heart failure to him. After the whole time I went in with the brochure and taught smoking cessation and watching his weight and taking his medicine, he said to me "heart failure? You mean I have heart failure?" I said yes and it will get worse before it gets better unless you do something. But the good news is that we know about it and you are in the best preventative medicine system that you can possibly be in. I spent an hour with him going over things, contacted Dietary; Home Based Telehealth, the Respiratory Nurse Practitioner and got BIPAP for his sleep apnea. About two weeks after his discharge I saw him at work walking up the stairs. He said, "Hey Sue, look….I am walking up the stairs, look at me."

Living Caring With Nurses

The participants lived caring and saw themselves as effective leaders through mentoring and helping nurses to grow. They viewed this as being a central aspect of their role in order to be able to deliver safe and appropriate patient care. Participants described serving as role model and mentor to the nursing staff, and being available to help develop their critical thinking and assessment skills. Subthemes that support this theme include: "Developing their best, and Advocating for nurses."

Developing their best. Mary claimed that her work with applying evidence-based practice at the point of care, educating the nurses in Joint Commission Stroke Center Accreditation standards and advancing their practice to achieve certification as neuroscience nurses represented for her an important essence of being a CNL®. She described the following situation:

> I have been pushing for the nurses to join the Association of Neuroscience Nurses. I offered to start study groups and I spoke to one of the neurosurgeons about one of my goals to get certified neuroscience nurses, and the doctor is like, "Great. If the hospital doesn't cover it, we'll sponsor them." And as it turns out, I will use the physician money to purchase the videos, and then we will be able to have the nurses move forward…I am going to raise the bar.

Jeanne shared a similar view about the importance of her work supporting the nursing staff:

> A big part of my job is supporting the nurses and what their function is. I help them to think critically. How they go about doing their job. I constantly say I am one person. I can't do this alone; I am here to help you do your job better, so I really put the onus back on them. You see it would be easy for me to take over since I am a take charge kind of person, but I try to put that back on them and say, oh, see I had to go to a meeting and you were able to do this yourself…great job! I go in with them to assess a patient and say let's go together. I say OK what are you going to do now? This is what I think, yes, I agree with you, but what are you going to do now?

When I asked Danita about the most important aspects of her role she said, "Guiding the nurses, mentoring them… and the critical thinking piece are most important." She shifted in her seat, her face brightened and she grinned when she said:

> I like it when the nurses get it. When I see the light bulb goes off, I love it. They come to me and say, "I had this happen yesterday and I was right on top of it." I like when they actually get it. I like it when actually everything comes together for them.

Carrie related the most important part of her role as making sure that nurses understand their role and developing the environment where the nurses know that they have help and support.

> A lot of nurses come to me...especially novice nurses and I am able to help them problem solve and that gives me a lot of reward. And of course when I implement changes that actually impact the care delivery of all and I actually see that improvement happens, it gets me, it makes me very excited that there is a way to change care delivery for nurses, and that the future looks much brighter for the nursing profession.

Carrie shared the following example of helping the nurses to grow to be more autonomous and confident in their skills:

> With the respiratory issues, we were at 100% failure at identifying early signs of respiratory deterioration. It's true. Now that I have integrated into the orientation process for every nurse, I don't care if it is RN or LVN, every nurse that comes into this unit… There are like four different educational modules that I go through

> for them to understand the importance of those early signs and to act on them, and what they can do to act on them. Many of these nurses were new or novice nurses and now these nurses are very independent with that and challenge those physicians now in an appropriate way, to utilize these standards of care. They will say "Carrie, I think he needs a blood gas, or I am calling that doctor, I don't like the way he is breathing…I don't like the way his lungs sound. " So they are becoming very independent in their care delivery and pushing care delivery forward to protect that patient.

Angela acknowledged that there are several novice nurses on her unit and viewed her role helping them to grow as being an essential aspect of her role stating, "We see nurses on the younger sides of their careers so my role is to develop their skill, and develop their expertise as an RN." She shared the following story to illustrate this point:

> I was called into a patient's room. Sharon *(the patient's nurse)* said, "Angela heads up, this patient in 15, we think he is septic and we need your help." Sharon is a novice nurse of about six months and I go in and see what is going on. I was there as a coach and mentor for this nurse who was doing a great job. In helping her with this patient, I interacted with the patient's family and got the patient down to ICU. I stayed with her a total of about two hours. My role was to help guide her to continue her assessments, validate her assessments, help her to be the voice to get what she needed for the patients… Really be her back up. I think it is important not to overtake what the nurse is doing. She stayed with me the entire time. I helped guide her and made sure the patients were safe. The

patient passed and I asked Sharon on Monday about the patient situation. She said she called the family at home and gave them her sympathies and came to closure by reaching out to the family. She did a great job and a lot of my job is to recognize that and provide feedback and support for them.

Jennifer described her work with the nursing staff as being a very important part of what she did as a CNL®:

I partnered with another CNL®, and we were requested to work in the Emergency Department and we walked into chaos. Our Nurse Manager had been fired, and uhhm…morale was low. There were safety issues, clinical practice issues. We started with the very, very basic things. We had to regain trust with the staff, to make it clear to our staff that we are not your boss. We are not your disciplinarians. We are here to help you, not just an extra set of hands. We are here to move your professional practice forward, and help you have a better work day, a better work week, and overall have better patient outcomes.

Jennifer created a "15 minute rule". She told the nurses "if it hits the fan in your section, call me, grab me. I will give you 15 minutes of my time. You delegate to me. I will do anything you need me to do."

Advocating for nurses. Advocacy for nurses occurs in the form of helping them with their work, illuminating the value of nursing, encouraging nursing autonomy and self respect. Jeanne shared:

I am their helper. I hear all the time, "Jeanne, thank you so much. You help me so much." I constantly emphasize team work and good patient care. We say

> that so many times and we really believe it. The nurses are happier, are now doing their own scheduling of time and feel they are supported and valued. Having the staff feel good about themselves. I thank them everyday for the care that they give. We can't do it without teamwork and I emphasize that. Instead of them all being beaten down and feeling they are the lowest of the low, we have raised it up. We have instituted our motto on the floor, "Welcome to 4-West. We are the best." People were laughing at first and now they are saying "We are the best" and they have a lot of pride in themselves. The staff have taken the motto further and now say, "Welcome to 4-West. We are the best. We strive for success." People have seen remarkable changes and we are the poster child from being the step child. It's not easy being a nurse. I'm proud of them. We've turned that unit around and we are very proud of it. I have really turned it around and I am very proud of that.

Collette also believed that her work was important in assisting other nurses to do their best and being recognized for their achievements.

> We have really improved our care. I don't think they (*meaning the nurses*) had the pride before that they have now in their unit. I have done a lot of work in recognition because we have done great things. I've shown them (*meaning the nurses)* the evidence that the work we are doing is making a difference, and they should promote their work. They were really not recognized before. They didn't have someone there to show them the way and help them to understand the importance of things to help them to be successful. This is what we have to do,

> here is how we do it, recognize what you are doing, recognize those who are doing it, and that you can do it. And look, we did it!

Susan shared that she viewed by the nursing staff as being their advocate and helper.

> I am a big advocate for the nursing staff, assist in patient care, I am the clinical resource on the unit, I am the educator. I implement all of these processes to improve care. My staff says, "Call on Susan and she is right there. If you need help or get stressed out, just call her and she'll help you"…and I do, you know.

Needing to Be Known, Understood and Affirmed

Perceptions that the CNL® role and contributions were not fully appreciated by others were shared by most of the participants. Their roles were neither well understood nor embraced when they started, which presented them with barriers to overcome. Participants also shared concern about their future and did not want the work they were doing to be lost. Subthemes that support this theme include: "Breaking through the barriers, Needing support from middle management, Justifying their existence, and Fearing an uncertain future."

Breaking through the barriers. The phrase "Who are you?" was a common thread mentioned by a few of the participants as they described the staff nurses' original reaction to them. Jeanne described what it was like for her when she started in her CNL® role. Although Jeanne was accepted early on by the medical staff, it was not so with the nursing staff. She shared:

> I came to this unit which had the worse reputation in the hospital. It was horrible. No one wanted to go here. They are like "Why would you ever want to go to that

> floor?" The staff turnover rate was 40% and the Head Nurses would last a year to a year and half…maybe…and people were unhappy, overworked and miserable. The new Head Nurse and I came at the same time. The staff thought that I was put there as a spy *(chuckles)*, sent by the Director to make them work harder and to see how come things were so bad on the floor. I was not well received. People didn't know what to make of me and it took some time before they realized that she can help us, and maybe something is going to work out of this and it really evolved within three months time.

Susan shared, "At first there was no concept of what the role was to be. Nobody there knew what we were supposed to do, so we were pulled into different areas, but as time goes on, it's been clearly defined. So I am now enjoying the role more."

Collette expressed concern over the lack of pre-planning for her role, with little preparation and education of the nursing staff; and that her role was an add-on to the existing care delivery model. Collette stated:

> Let me tell you, the first year, I felt I was butting my head against the wall because I was trying…I think I recognized that until they changed the care delivery model that we were going to continue to have the same outcomes that we always had. I was told to go out there and do what a CNL® does. So, I got on the units and I knew what I was there to do…to improve patient care outcomes, to round on patients and to make a difference, be a support and partner with nursing. It was up to me to communicate that, help it to be understood, to put it into practice, to fit into the team. So away I went…and I think they all looked at me,

> like “Who are you?” Sometimes people would say, “What are you doing messing with my stuff? Who are you and what are you doing?” At first, I was thought of as the documentation police.

Danita shared her experience with others having expectations of her that were not reasonable:

> In the CNL® role, people had a lot of expectations. They wanted you to produce things quickly, they want it done quickly, but they don’t understand that it takes time to gather the information; it takes time to really look at the data to see if there is really something there.

Jennifer also experienced being pulled in many different directions. She described some of the barriers she was facing:

> The biggest barrier…and while my organization is very supportive of the CNL® role, they block the resources to have other people do these things. Right now I am starting a joint replacement center, I’m starting a stroke center, I’m starting a peer review council…uhhm, the other CNL® and I are starting a patient satisfaction council, and these are things that are not the way the role of the CNL® was defined. I have multiple roles at once.

Needing management support. Some of the participants shared that they did not receive the level of support they needed from their managers. Mary described the relationship with her Nurse Manager as being tenuous.

> She just didn’t want anyone on her units. Actually the day I started, sight unseen, she left me standing …she wouldn’t even talk to me…left me with my

pocketbook on my shoulder for two hours. The Chief Nursing Officer came up and got me and hooked me up with another Nurse Manager who showed me around. I have to tell you that you go through life as a nurse; take care of your patients. You come in and you go out. You do your work happy as a clam. And, when you go to the next step, when you go beyond staff nurse, when you pull up the curtain and see the inner workings of management… there is a lack of camaraderie. There is this…like a disease that executives don't get a view of. They don't see it. And staff nurses don't see it. But there is this… it is hard to describe…but now, I have seen it at two hospital systems that when you go above staff nurse level, at the Nurse Manager level there is back biting. There is too much cover your butt, a general lack of teamwork, a general lack of watching out for each other at that middle management level…like a middle management sickness that spreads throughout this level.

Mary also stressed how important it is to have executive support from the Chief Nursing Officer.

The CNO needs to truly believe and say that this role is a proven benefit to patient outcomes, reduces patient length of stay, improves Press Ganey scores (a *patient satisfaction measure)* and I support it and I expect you to support the role too.

Mary acknowledged that she felt supported by her CNO which enabled her to succeed in her role and get past the barrier that her Nurse Manager had initially erected.

I mentioned that the Nurse Manager that I am working with is a barrier in and of herself. When you have people who have their own little niches and are trying to

> protect their own little zone, it's a barrier. But I have been given the heads up from the CNO. That's the reason why you have to have an executive level support, who says they know what you can do. It really starts with the CNO or Assistant VP or Director...at the institutions, the CNO's create the position.

Shaun shared that he is working on his Doctorate in Nursing Practice (DNP) and would like to move into a "higher role" since he is experiencing some barriers with his current CNL® role. He stated:

> When I first started, I felt I had a lot more support in what the role is going to bring and in what I am going to do. I am a strong leader, and the Nurse Manager is a strong leader, so our visions don't exactly meet up. I think that because she is the manager she is going to win out. The interaction has gone south a little bit. I feel I have had to bring myself down a little bit instead of moving forward. I am getting a lot of roadblocks to even doing my DNP clinicals there. This is the same Nurse Manager who groomed me in SI. When I left SI *(meaning the surgical intensive care unit),* she said to me, "You know you are competition now." So I think that is how a lot of them view me. I have been very successful, but I think getting my DNP is very threatening at some level.

Sue talked about the lack of support she received from her manager:

> I was the first one in this role and nobody knew where to put me and what my role should be. The manager didn't really understand and in retrospect was not very supportive of the role. She always felt like she had to give me a task. That created friction between us because I did not have the time to develop my role because

> she always kept saying to me “I don’t know what to do with you…what am I supposed to do with you?” I kept telling her that you don’t have to do anything with me. I know what I am supposed to do but I need the ability to do it. I need to have an unencumbered role so that I can go to various places, meet various people. I know what to do and know where to go. After three months, I was far, far beyond what she was capable of knowing what to do after having been there for eight years.

Jennifer felt supported in her role and stated:

> Let me say first that I have tremendous support from my organization, from administration. They back the role and the future of the role 100%, so for me, being accepted was very easy. I was joking with my husband just a little while back. He was talking about that he has all these ideas and nobody listens to him, and I said, well its funny, because at work I have the exact opposite problem...because every time I open my mouth, somebody says, “well, that is a great idea, do it!”

Justifying their existence. Participants acknowledged that the economy has affected their organizations, necessitating scrutiny of every dollar spent and saved. Angela shared her concerns about practicing within the constraints of the current economy:

> There is a tendency as a CNL® to feel you need to prove your worth …so you load up your plate with all these initiatives to feel that you are not just a staff nurse with a master’s degree. But at the end of the day, you need to look at what

> you have done and know that you have made a difference. It needs to be cost neutral and I think that is the problem. When I started, the economy was different. Now there is so much instability nationwide, so the new CNLs® will have that added burden that I didn't have. I mean I think I paved the way to show we have improved outcomes, but I think that they will be challenged.

Like Angela, Mary recognized the important role that economics plays in the organization and prided herself in reducing organizational expenses while improving the care of patients. Although Mary joked about the cost savings "covering her pay," her concern about the constant need to demonstrate her worth to the organization was real.

Fearing an uncertain future. As a result of economic constraints and lack of support from some in their organizations, CNLs® were concerned about their future and that their work and successes may not continue on. Collette said:

> I'm so sad. At our facility, the people who were the champions of the Clinical Nurse Leader moved onto other positions so it left the base of support as being very minimal. I have been watching. I can see what's going on and with the economic downturn in September. I'm watching the writing on the wall and realizing that there just isn't the support in the system for the Clinical Nurse Leader to be successful where I am working. I see the writing on the wall. I talked to my boss and I know they will be making cuts. I ended up accepting an interim Nurse Manager position because I knew that there wasn't going to be a spot for a Clinical Nurse Leader.

She continued:

How can I be a manager and still be this *(referring to her CNL® role)*? My boss came to the unit and said to the staff "Collette will be taking off her Clinical Nurse Leader hat and will be putting on her Nurse Manager hat." I hated it. I am afraid that I am going to lose that connectedness with the patients. I don't know who is going to be able to see the big picture and help the staff to see it. I don't know who it would be. I know that there is just a major void in their care from day to day. But…who is going to take care of that?

Danita shared concerns about the future of her role.

I don't see any more CNL® roles the way the economy is going. As far as my role, I don't know where I see myself in a year. I have a lot of things that I would like to get accomplished but they get pushed to the wayside because of this hot spot, and that hot spot. I don't feel secure. There are always vicious rumors and things that go on. I feel insecure that people don't really value it. They don't see that the bedside nurses need, that the patients need, and that those needs are not being met. The staff is so stretched out. I am trying to make sure the patients are getting good quality care. You want to make sure that somebody is looking over the nurses, the physicians, to make sure the care is not fragmented and I don't think that is valued.

Carrie described feelings of being alone since she was the only CNL® in her hospital, with no one to advocate for her:

There are things that sometimes as a CNL® you know…the politics that override everything. Especially in a bureaucratic system. Sometimes I feel like I don't have

> anybody to provide leadership for me. Perhaps because I am the only one. I am afraid that there will be this gavel that comes down and says stop what you are doing and go take patients. It is a continual fear that everything that I am trying to do will be unimportant and actually, it is having a good impact. And that personally is pretty disappointing. I go to work everyday and just continuously collaborate…and politically let them know how different my role is. Because they are so distant from what is happening at the point of care…I try to be out there, to be visual from a political aspect.

Mary described the following discussion she had with her CNO:

> I have been given a heads up by my CNO. She says, “I don’t know. you are a luxury right now.” I let her say that, but then I came back to her with my data and said, I am not a luxury. I am a necessity, and I am going to continue on in that vein. I think she is trying to get me to be a nurse manager, but if I wanted to be a nurse manager, I would have been a nurse manager. I want to be a CNL®.

Chapter Summary

The purpose of this study was to gain understanding about the meaning that leading at the bedside has for CNLs®. This chapter presented six essential themes that emerged as a result of hermeneutic interpretation of the data. Participants’ statements were selected from the data and included to provide the reader with greater insight and understanding of each of the themes.

CHAPTER 5

DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

Introduction

The findings from Chapter 4 answered the research question, "What is the meaning of leading at the bedside to CNLs®?" This chapter presents the study findings within the context of the theoretical frameworks of Ray's (2006) Holographic Theory of Bureaucratic Caring, and Boykin and Schoenhofer's (2001) theory of Nursing as Caring. Findings are also linked with the current literature. Implications for nursing practice, nursing administration, nursing education, and recommendations for additional research are identified. In conclusion, a poem written by this researcher which was inspired by the lived experiences of these CNLs® is offered as an aesthetic understanding of leading at the bedside.

Discussion of Findings within the Context of the Theoretical Frameworks

Ray's Holographic theory of Bureaucratic Caring (2006) and Boykin and Schoenhofer's theory of Nursing as Caring (2001) frame the context of this study. These theories were selected for the context they provide in understanding how nursing and nursing leadership's values of caring can successfully flourish within the complex acute

care hospital system; and for the importance that the nursing situation, and stories of nursing have for understanding caring relationships and advancing the knowledge of nursing.

Ray's (2006) Holographic Theory of Bureaucratic Caring. Ray theorizes that acute care hospitals are complex bureaucratic organizations, presenting nurses with the challenge of providing high quality nursing care. Leadership models remain fundamentally hierarchical and the understanding of bureaucracy, politics, power, technology and economics are important domains of knowledge for nurses. This theory proposes that all nurses serve as leaders in the organization regardless of their position by advocating for patients, maintaining the organization's viability, and balancing ethical caring with ethical economics (Ray, 2006).

Through the lens of this framework, although not holding hierarchical positions of leadership, CNLs® serve as important leaders in their organizations in an elite role, holding positions of power to "broker" for patients and families. Professionals, patients and families exhibit a position of power in the health care organization, manifesting political caring (Ray, 2010). The CNLs® in this study exhibited an understanding of how their organization worked, established networks with different disciplines, and were often seen by others as being the go to persons in the organization. CNLs® shared the following sentiments made by other care providers in their stories: "You are the best thing that ever happened to this unit. Thank God you are here," and "The care is 100% better since you got here." These statements exemplify how CNLs® established positive relationships and were seen as valuable leaders at the point of care in their organizations. The CNLs®

valued their work with others to achieve positive patient outcomes, deriving satisfaction and pride in the networks of relationships they cultivated, as well as from the respect garnered from the executive level of the organization. Findings support the political caring of the CNL® within their organizations.

Although hospitals are fundamentally bureaucratic organizations, they are complex adaptive systems with interrelated systems and dynamics (Ray, 2006). Through building relationships and interconnections throughout the organization, CNLs® were able to optimize the care of patients. CNLs® described their role as being one of many in the acute care setting. Nurses, physicians, therapists, consultants, and other health care providers were described as “coming and going”, adding layers of complexity to what was happening with the patient; with each provider only knowing a piece of the patient’s story. CNLs® were able to see the big picture, and at the same time the fine details of what was important for their patients. They came to know their patients’ stories.

The participants described many occasions of protecting patients from medical error and catching what could have “fallen through the cracks”. A major threat to patient safety occurs as a result of fragmentation of care and lack of communication between care providers. The CNLs® saw themselves as being the connectors with health care providers from different departments, and that serving in this role was integral to the safety of their patients. Jeanne described her role in bringing the care providers together for the good of the patient as being a “lateral integrator”. Jennifer viewed garnering and sharing knowledge with other health care providers to keep patients safe an example of the CNL® being a “connector”, describing herself as being a “knowledge broker.” Angela

described working with other disciplines to pull together all the pertinent information as "connecting the dots."

Findings included situations where participants advocated for patients, even when the medical staff was initially at odds with their position. Jeanne's story exemplifies how a CNL® advocated for a patient's care and facilitated this patient's peaceful death with nurses caring for him who knew and cared about him. Danita's story of advocating for a patient whose status was deteriorating to be moved to a higher level of care, despite the assertion of the medical residents that she didn't need to be transferred, is another example. On occasions such as these, ethical and spiritual caring were employed to advocate for patient and family choices, supporting the assertion that nurses at the point of care advocate for patients through caring approaches (Turkel & Ray, 2000).

Susan described calling on her "friends in respiratory, social work and the warehouse" to pull together to get a patient with complex co-morbidities into an ambulance to be transferred to an extended care facility. Her story illustrates the CNL® being known in the organization as someone who knows the right people, and the person who gets results; exemplifying Ray's (2006) assertion that nurses' knowledge of organizational dynamics and power are important domains of knowledge.

CNLs® described being respected and valued by physicians for their knowledge and ability to get results. Angela's comment, "Physicians see me a little bit differently. If they are having problems or issues, they come to me to see what we can do about this," and Jeanne's experience of the medical staff asking her, "Where have you been? We need you here" are just two of several examples from the data that exemplify CNLs® being

respected for their knowledge and ability to effect change. Garnering this respect and support contributes to building relationships with the medical staff and their ability to advocate for care of patients.

Participants' concerns about the economic pressures facing hospitals, having to earn their keep and justify their existence were common with the concerns expressed by other CNLs® in this researcher's pilot study (Sorbello, 2007). Participants often referred to the need to demonstrate improvement in patient outcomes related to economics, having to save the hospital money. Susan's comment, "The big part of what I do is focus on where is the money shot? And the money shot is in CHF patients. And the money shot is in keeping CHF patients out of the unit *(meaning the ICU)* and I think that is where I need to concentrate" exemplifies this understanding. Mary acknowledged the importance of the CNL® contributing to the bottom line when she shared, "I reduced that length of stay through coordination of his care, the services, I talked to the doctors. It's actually a savings of $300,000. He was a no pay patient, and it was really a cost savings. I saved the hospital $300,000 so I think that covers my pay." Understanding the nature of the acute care hospital as a bureaucratic organization where there are competing priorities for resources are important in order for CNLs® to effectively practice within this environment. Within the reality of the current economic pressures that acute care hospitals are facing, CNLs® realize that the future of their role is tied to the economic viability of the organization.

Several of the participants experienced professional jealousy from their direct managers as a result of competition for power. Their experiences and views about the

middle management layer in organizations coincide with the notions that organizations remain fundamentally hierarchical where decision making is centralized within hierarchical silos, and support Ray's (2006) assertion that the understanding of bureaucracy, power, politics, technology and economics are important domains of knowledge for nurses (Ray, 2006). Practicing within this environment can be challenging for a CNL®. Carrie's statement, "There are things that sometimes as a CNL® you know…the politics that override everything. Especially in a bureaucratic system. Sometimes I feel like I don't have anybody to provide leadership for me." is a poignant example of a CNL recognizing the dynamics at play within her practice environment. Mary identified her nurse manager as "a barrier... in her little niche trying to protect her own little zone. This individual didn't want anyone on her unit. Actually the day I started, sight unseen, she left me standing for two hours." Shaun described the conflict he was experiencing, "I feel like I am getting a lot of roadblocks. The nurse manager said to me, you know you are competition now." Ray (2006) posits that it is within these complex circumstances that these CNLs® practice nursing and are challenged to live caring and come to know others as caring persons.

Within this complex environment, it is important for nurse administrators to recognize the importance of their role in advocating for the resources and personal support needed for CNLs® to bring ethical and spiritual caring to the organization. Providing an open door where support is generated by the nurse administrator and experienced by the CNL® is important, especially where individuals in middle management roles may not be supportive. After Mary described her nurse manager

ignoring her on her first day, she described how her chief nursing officer intervened; "The chief nursing officer came up to get me and hooked me up with another nurse manager who showed me around...Fortunately for me, I had executive level support, who knew what I could do. It really started with the CNO."

Boykin and Schoenhofer's (2001) Theory of Nursing as Caring. The fundamental assumptions of this theory are that each person is caring and lives and grows in caring throughout life; persons are whole or complete in the moment; caring is lived moment to moment; the process of living caring is enhanced through being in relationships with other persons, and nursing is a discipline and a profession. Relationships between persons are viewed as opportunities to be authentic and "draw forth caring possibilities" and through "entering, experiencing and appreciating the world of the other, the nature of being human is more fully understood" ((Boykin & Schoenhofer, 2001, p. 4-5).

Boykin and Schoenhofer (2001) posit that living and knowing the value of nursing occurs within the context of the nursing situation. The nurse's intention in a nursing situation is to be authentically present to know the other as caring person. Through being with patients at the point of care, the participants were authentically present, heard calls for nursing and created nursing responses. In coming to know the patient as caring person, the participants were able to bring esthetic, personal, empirical and ethical ways of knowing to the nursing situation (Carper, 1978).

Susan heard her patients' calls for nursing, whether unspoken like in her story of the patient with a laryngectomy, or in the face of a patient who hadn't eaten for two days. That scrap of cardboard with the note of appreciation for the food served as a constant

reminder for her that we must never lose sight of what is important to patients. Susan demonstrated the qualities of being a strong and persistent advocate, going down to the kitchen to get the patient's meal tray and asking the nurses to think about what it must be like for the patient. She stated, "What is that patient feeling, thinking, experiencing? If nurses really understood what was important to patients, they would not hesitate in doing whatever was necessary." Boykin and Schoenhofer (2001), describe this understanding and response to the call for nursing as "a situated expression of caring and a call for an explicit caring response…a reaching out for the other." (p.18).

Coming to know the patient as caring person and his/her calls for nursing were important to the participants. Their stories illuminated that patients may be vulnerable with many care providers involved in their care who are often pressed for time, with no one pulling it all together and helping patients fully participate in and understand their care and what is happening to them. Collette's story about a patient who had visited the emergency department eight times in the past year and who was very unhappy with his care, illustrated how a CNL® can make a difference in a patient's well being by taking time to be authentically present, to come to know him as caring person and his unique calls for nursing. Collette stated, "knowing his story, knowing his history, what the issues were, taking the time to really hear him and plan together the with him" made that difference."

Establishing relationships and staying connected with patients were very important aspects of the CNLs®' practice. Boykin and Schoenhofer (2006) posit that the process of living caring is enhanced through being in relationships with other persons,

and it is “within the nursing situation that the nurse comes to know the other as caring person, expressing unique ways of living and growing in caring” (p.17). Participants told stories where they made time to develop caring relationships with patients and authentically listen to their stories. Jeanne lived caring with her patient who was dying through her concern about him. She stated, “I kept thinking about that patient...thinking about that patient all night long...wondering about whether he was going to make it or not.” She described coming in early the next morning to see him before the start of her shift.

CNLs® described expressions of caring as living honesty, trust, hope and courage. Jeanne’s story exemplifies her living caring through her honesty, tenacity and courage to advocate for a patient and family’s right to know the truth about the dying process so that they can more fully live their caring in the time they had left. She stood up to the medical staff and insisted on supporting the patient and caring for him where he was known; demonstrating Mayeroff’s (1971) caring ingredient of honesty and the courage to care.

Susan lived caring by helping a patient to honestly look at his health; sharing the good news and the bad, and helping him to optimally care for himself through providing the contacts, equipment and knowledge needed. Mayeroff (1971) posits that persons grow by becoming more honest with themselves through awareness of their situations “with a minimum of illusion” (p.14). Susan helped this patient see his situation realistically so that he could grow in caring for his health. She was honest with the patient, explaining his diagnosis to him, sharing information he had a right to hear, but that no one else had told him.

Susan's story about encouraging a patient diagnosed with Pickwickian syndrome to regain mobility despite the deterioration of his status exhibited living caring through inspiring hope. She arranged for the therapy and resources that he needed to regain his strength. She stated, "I wanted to see him up and walking before he left the hospital because he wasn't getting up at all and I told him that. After he left, he called me and said, "Susan, I'm up." It took him a while but he did it." Jennifer's story about caring for Bob and his family during the patient's resuscitation, and the staff's chant "Come on Bob, Come on Bob", demonstrated how this CNL® and nurses lived caring through maintaining hope with the family for this patient's recovery.

Through mentoring fellow nurses and advocating for their professional growth and autonomy, CNLs® demonstrated Mayeroff's (1971) caring ingredient of helping the other to grow and actualize self through "encouraging and assisting him to find and create areas of his own in which he is able to care" (p.13). Examples of CNLs® living caring with nurses include Mary's story about advocating for and helping the nurses on her unit to attain neuroscience certification; Jeanne's story about rebuilding nurses' self confidence and self esteem through working hand in hand and providing them with positive feedback; and Danita's story about spending time with nurses to "help make their lives easier; keeping them at the bedside so that they can pay attention to their patients."

Several of the participants shared how important it is to develop relationships with others; mostly with patients and family members, but also with other members of the health care team. Through these relationships, the participants experienced living caring

and growing in caring, and were able to align, motivate and inspire others through a leadership style grounded in respect and honoring persons. Jennifer demonstrated Mayeroff's (1971) caring ingredient of trust through building relationships based upon honesty and trust with nurses. She stated, "We had to regain trust with the staff, to make it clear to our staff that we are not your boss. We are not your disciplinarians. We are here to help you..."

A conceptual representation of the shared lived experience between nurse and nursed is described by Boykin and Schoenhofer (2001) as the Dance of Caring Persons, where all persons involved in the caring relationship are honored, known and valued. Jeanne likened her interactions with patients as being in a constant dance with them; moving with them in synchrony, to facilitate their care. She described the other members of the health care team, including consultants, as a part of this dance; exemplifying how each dancer "moves within this dance as called forth by the nature of the nursing situation" (p. 36-37).

While the participants experienced living caring through helping others to grow, they expressed an unmet need for being cared for, understood and affirmed. Within their bureaucratic organizations, they felt their roles were not well understood or valued by others. Mayeroff (1971) likens the need to feel understood as like being in-place in a world that makes sense; having a feeling of belonging and being needed. In order to find one's place, one needs to care for and be cared for by others (p. 104). In this study, I heard the participants' call for caring. In order for them to continue to grow as caring persons and more fully live a life of meaning, they need to be known as caring persons

and mutually cared for.

Boykin and Schoenhofer (2001) posit that in bureaucratic organizations, there is competition and positions of power, conceptualized as residing on the rungs of a vertical hierarchical ladder. Those who cling to this ladder may not fully come to know self and others as living caring and growing in caring. The experience of having managers that were not supportive of the participants may be a manifestation of these managers clinging to the rungs of the ladder. In this study, one of the participants described “dancing with patients” and other participants explained being authentically present with their patients and colleagues, which is analogous to the “dance of caring persons” (Boykin & Schoenhofer, 2001, p. 36-37). A preferred conceptualization of the relationship between CNLs® and others in the organization would be that of caring persons in a dance. In this image, all persons in the circle are important, honored, viewed as special and caring. Through being at eye level with each other, as opposed to the vertical view of the ladder, all are able to come to know and appreciate each other more fully.

In summary, both Ray’s (2006) theory of Holographic Bureaucratic Caring and Boykin and Schoenhofer’s (2001) theory of Nursing as Caring provide a lens for understanding how CNLs® lead and live caring within the bureaucratic acute care setting. Their stories illustrate how CNLs® bring spiritual and ethical caring to their organizations as leaders at the bedside, while acknowledging that the hierarchical, political and economic dimensions directly influence their practice. Their stories also show how incorporating caring ingredients, establishing authentic presence, coming to know others as caring persons, and nurturing caring relationships with others, CNLs® live caring in

their roles as leaders.

Findings Linked to Current Literature

This study's findings draw a parallel with the synthesized definition of *"leading at the bedside"* developed by this researcher through concept analysis. Leading at the bedside, or bedside leadership was defined as a way of being there, being with the patient, using influence, advocacy and expertise to facilitate and coordinate care through collaboration. The bedside leader also serves as mentor and role model for others (Sorbello, 2005). Being at the bedside and coming to know the patient as person, working alongside and mentoring nursing colleagues, using influence, collaboration and advocacy were important meanings CNLs® derived from their leadership. What emerged from the study that was not included in this researcher's initial definition of bedside leadership, were the importance of *navigating safe passage for the patient, being the voice of truth and bringing the bedside point of view to decision making.*

The CNL® role was conceptualized to be unit based, or practicing at the point of care to provide, oversee and coordinate the care for a cohort of patients (Begun, Tornabeni & White, 2006; Hall, 2007; Harris, Tornabeni & Walters, 2006; Hartranft, Garcia & Adams, 2007). Being at the bedside affords the CNL® the opportunity to identify changes in patient condition, communicate with other care providers, educate staff and patients and evaluate interventions and outcomes. Participants viewed their presence at the bedside as imperative in order for them to come to know their patients, know what is transpiring on the nursing unit, and be effective in implementing change.

Several CNL® stories demonstrated how their presence at the point of care allowed them to pick up on things others missed, see things from the vantage of the clinical nurse, prevent medical error, and use clinical situations as learning opportunities to mentor nurses.

The theme that emerged from the data of CNLs® helping nurses to grow supports what has been published in the literature about the importance of CNLs® working with the nursing staff to improve patient care. Angela's comment about "impacting patient care at the bedside with the nurses," and Carrie's remark about "keeping her hands in patient care to give guidance from an individual who is out there on the unit working hand in hand with nurses," and Angela's assertion that her role is to help novice nurses "to develop their skill and develop their expertise as an RN," exemplify CNLs® helping nurses to grow. These findings support the CNL® role in mentoring and role modeling critical thinking, problem solving, clinical and leadership skills, with positive patient outcomes as a result (Bowcutt, Wall & Goolsby, 2006; Brown, 2008; Drenkard, 2004; Gabuat, Hilton, Kinnaird & Sherman, 2008; Hartranft, Garcia & Adams, 2007).

The ability to understand and apply informatics coupled with the ability to view technology from the vantage of the clinical nurse to not only benefit the nursing staff, but also support the nurse's role in protecting patient safety were viewed by participants as important aspects of the CNL® role. Danita's story of leading the computerized documentation implementation for her department, and insisting upon enough printers to support nurses' work is an excellent example of the CNL® applying informatics technology at the point of care and bringing the nurses' perspective to this project.

Competencies in information technology support Warren and Connors (2007) claim that the CNL® positively impacts patient safety through the application of informatics competencies, which supports Institute of Medicine (IOM) recommendations. The CNL's®' distinctive position at the point of care, technological competency and role in implementing technology support Ray's (1987, 1998, 2001), Swinderman's (2005) and Locsin's (2001) assertions that technological competency is an expression of caring, that nurses play a key role in facilitating the use of technology to enhance the caring of persons and uphold ethical caring within complex systems.

Findings from this study support Benner (2001) and Perra's (2001) assertion that building a network of relationships, knowledge of the clinical specialty, and technological skills are necessary in order for nurses to effectively lead and collaborate with others to advance the care of patients. Several CNL® stories demonstrated how their assessment skills and knowledge of organizational and community resources were important in caring for patients. Additionally, CNLs® viewed their role as being a resource for patients and other health care providers, incorporating research based findings into the clinical setting; supporting the work of Stetler, Brunell, Giuliano, Morsi, Prince and Newell-Stokes, (1998) and Ingersoll (2000).

CNL® experiences of developing and sustaining relationships with other disciplines, and bringing them together to facilitate care of patients emerged as important aspects of leading at the bedside. This subtheme supports Hay's (2004) assertion that nurses at the point of care lead by facilitating the participation of others while anticipating what it takes to deliver high quality care. The relationships they nurture with

others are not only important in their role as bedside leaders, but are also a source of satisfaction for them. CNLs® provided several examples of making connections and building relationships across the organization, and were known by individuals in other departments as the ones “who would get the job done.” Susan’s references to calling upon her “friends” in PT, housekeeping, pulmonary, radiology and the warehouse exemplify the strong relationships that CNLs® cultivate to get things accomplished for patients.

Participants described nursing situations where their clinical expertise not only facilitated change for the care of patients, but also fostered credibility with nursing and medical staff. According to Angela, physicians took management problems to the Nurse Manager, but when there were clinical issues, they took them to the CNL®. Shaun described how his background in ICU enabled him to care for the patients with acute and complex needs, which was valued by both nursing and medical staff. Jeanne and Danita’s stories of insisting upon a particular level of care for patients exemplified their clinical expertise and ability to facilitate change for care of patients. Physicians and other care providers saw the CNLs® as the “go to persons”, supporting Iacono (2003) and Peters (2007) assertions that nurses serving as leaders work within and affect change in systems, and earlier work on the credibility that nurses garner through their clinical expertise (Spitzer-Lehman, 1993; Warfel, Allen, McGoldrick, McLane & Martin, 1994).

Findings included CNLs® not accepting the status quo. Rather, they sought opportunities to make positive changes by using their influence and resources to benefit the organization and patients served. This finding supports Cook’s (2001) typology of an

effective clinical leader being a *discoverer,* looking for new possibilities and striving for ways to improve care. Additionally, this finding supports Cook's (2001) attributes of effective clinical leaders *influencing* others to see things from a different perspective, *highlighting* the value of changing the status quo, and *supporting* others through the change process.

Often times CNLs® bucked the system and challenged physicians to achieve what was best for the patient. Taking risks by being assertive and tenacious; yet also using their influence to work with and through others, affirms Anderson and McDaniel's (2000) depiction of successful leaders working within complex organizations.

Participant experiences of being the "go to" people in their hospitals support Iacono (2003) and Peters (2007) assertions that informal nursing leaders who can mobilize energy, talent and overcome resistance to change are the "go to" people in their practice environment. Their authority is not based upon a hierarchical position, but by their knowledge, skills and actions. Shaun provided an example of using the rapid response system to assemble clinical resources needed quickly for a patient; circumventing delays from the medical staff. CNL® descriptions of improving processes such as documenting of PRN medications, implementing new reporting processes that follow the Institute of Health Care Improvement (IHI) guidelines, identifying vital signs parameters for the nursing support staff to report, starting weekly huddles between day and night shifts, and aggregating medication errors with the Safety Officers exemplify the CNL® improving processes to create safe patient outcomes.

The findings from this study echo the CNL® as being in a unique position at the

point of care to manage a patient's care throughout the patient's length of stay at the microsystem, with leadership skills such as systems thinking, interdisciplinary collaboration, and knowledge about health care systems, patient outcomes, and evidence-based practice identified as being important components of the role (Brown, 2008; Drenkard & Cohen, 2004; Dzurec et al., 2006; Hartranft, Garcia & Adams, 2007; Picard & Henneman, 2007; Quataro & Reid, 2006; Tornabeni, Stanhope & Wiggins, 2006).

Although the participants derived satisfaction and pride in their nursing practice and accomplishments, they experienced stress and concern over being pulled in too many directions, job insecurity, not being supported by management, and an overall feeling that their role was not fully understood. These experiences are of concern since they have been associated with nurses choosing not to seek and reasons to leave leadership positions (Rudan, 2002; Sherman, 2005; Skytt, Ljunggren & Carlsson, 2007). If these concerns are not validated and addressed, nurses may not choose to pursue CNL® roles and current CNLs® may not choose to continue to practice in this role. Caring is a reciprocal process, thus, the CNL® needs to experience the caring and respect consistent with both Ray's (2006) and Boykin and Schoenhofer's (2001) theory used to guide this research.

Study findings included several of the participants starting their role with very little pre-planning, preparation of the staff and re-design of the care delivery system. This presented them with challenges and barriers to fully practicing within the CNL® role. Both Susan and Jeanne shared that when their roles were introduced into the hospital, they were misunderstood, mistrusted, and asked, "Who are you? What is it that you do?"

Collette stated that she felt that she was butting her head against the wall during her first year practicing as a CNL, and that "until they recognized that they need to change the care delivery model, we are going to continue to have the same outcomes that we always had." The literature supports that the CNL® role should not be an add-on to the existing staff or care delivery system. All of the roles and processes in the practice environment must be reviewed and potentially revised to support success of this new CNL® role and reduce role confusion (Bartels & Bednash, 2005; Begun, Tornabeni & White, 2006; Goudreau, 2008), and nurse administrators must create an environment of trust and caring in order for caring leadership to flourish (Boykin & Schoenhofer, 2001; Hilsenbeck, 2006).

Implications for Care of Patients

As leaders at the bedside, CNLs® are expected to improve patient care by collaborating with others, facilitating and coordinating care, implementing evidence based practice, and advocating for the patient. In addition, CNLs® are depicted as being the role models for novice nurses, and as a result, positively impacting nurse retention (AACN, 2003; AACN, 2007a; AACN, 2007b).

Through practicing as CNLs®, the participants described being able to make a difference in the care of patients. They saw improved continuity of care, clinical outcomes and patient safety, as well as development of critical thinking and fine tuning clinical skills of the novice nurses on their nursing units. They brought evidence and best practices to the bedside, and challenged substandard practices. Their relationships with nurses and other health care professionals improved interdisciplinary collaboration and

nurses' self esteem.

The participants described occasions where they facilitated the patient receiving a higher level of care; thereby, preventing further deterioration of their condition. Clarke (2004) reports that close surveillance and preventative actions by experienced nurses who are permanent staff members, who serve as mentors for others are key to preventing failure to rescue events. Study findings support this assertion, where the CNLs® served as the permanent presence, providing close observation and mentoring, and as a result initiating rescue activities. The subtheme of seeing the big picture echoes what other CNLs® have experienced (Brown, 2008); likened to acquiring a more global knowledge base of their institution from what others call the "view from 40,000 feet" (Poulin-Tabor, Quirk, Wildon, Orff, Gallant, Swan, et al., 2008, p. 624). Clarke (2004) recommends further study of nursing factors and failure to rescue; which could be fertile ground for future research of the CNL® role and patient rescue (p.71).

Challenging the status quo requires risk taking. Perhaps, because CNLs® work "outside the line hierarchy", they are more open to questioning, testing decisions and accomplishing change than those that occupy roles within the hierarchy. Hernandez, Spivack and Zwingman-Bagley (1997) contend that many leaders in hierarchical positions will not or cannot take the risk of challenging the status quo. Bachtel (2006) posits that nurses need to have courage to follow their heart and do what has to be done with self-confidence. Similarly, Clancy (2003) asserts that in order to be an effective leader, one must have the courage to face tough choices as well as overcoming the fear associated with them. Having the courage to care and overcome barriers supports

Mayeroff's (1971) caring ingredient of courage, and confidence which is one of Roach's (2002) 6 C's of caring; both being essential to living and growing in caring.

In addition to being courageous risk takers, an important leadership principle for nurses to demonstrate includes having the voice of nursing heard, "because nurses understand what is required in delivering high-quality patient care" (Hay, 2004, p. 76). Likewise, Scoble and Russell (2003), include the abilities to communicate, ask provocative questions, act in the face of ambiguity or chaos and be assertive as some of the necessary competencies needed for successful nursing leadership at all levels of the organization. They referred to this demonstration of tenacity and assertiveness as "having moxie" (p. 328).

This study's findings support the literature that CNLs® play a positive role related to protecting patient safety by assessing patient risk, advocating for patients, providing lateral integration of care and implementing evidence-based practice (Peters, 2007, Picard & Henneman, 2007; Stanley, Hoiting, Burton, Harris & Norman, 2007; Stanton, 2006; Tornabeni, 2006; Tornabeni, Stanhope & Wiggins, 2006; Woods, 2003). According to Leape and Berwick (2005), health care is the most complex industry in terms of the numbers of different health professionals interacting with each other. With these multiple interactions, important information can get lost in translation and fragmentation of care occurs. The CNLs® in this study have been effective as the communication links that prevent important pieces of information from being missed, and as the connectors who coordinate care.

Hughes and Clancy (2005) posit that nurses have a critical role in patient

advocacy, and that “the total number of errors would be greater if nurses did not intercept 86% of all potential errors that could result in patient harm” (p.289). These CNLs® shared stories of patient advocacy and saw being an advocate as important aspect of their role. Clearly, the CNLs® found meaning in and were effective in protecting their patients from harm. It would appear that having the CNL role in the acute care setting does positively impact the care of patients.

In order for CNL®s to be successfully recruited, retained and effective in their roles, they must be supported to fully live the meaning of their roles as leaders by being known and affirmed. Care delivery models must also be evaluated and redesigned to integrate this new role.

Implications for Nursing Administration

With many hospitals setting a goal for nursing excellence through applying for ANCC magnet status, and where nursing theory must be used to guide nursing excellence in practice, caring theories should be encouraged to promote and support the CNL® role and the overall practice of nursing. This study has import for nurse administrators who have CNLs® or are considering incorporating the CNL® role into the care delivery model by linking caring theories to the practice and role of the CNL® within the complex hospital setting. Understanding what is meaningful to CNLs® in their practice and how they experience living caring within their role enables the nurse administrator to create and support an environment for the CNL® to grow and be successful. With this understanding, the nurse administrator can examine and redesign care delivery models with CNL® role responsibilities that incorporate what is meaningful to them; namely

protecting patient safety, advocating for patients and nurses, and remaining at the bedside.

Understanding what motivates CNLs® and the value and meanings they derive from their roles, as well as what dissatisfies them are important in creating job descriptions and role relationships that are synergistic and not antagonistic. Some of the participants experienced barriers due to their role not being planned for or understood. They viewed their role as being an add on to an already ineffective care delivery system. The literature supports examining and redesigning care models for integration of this new role (Rusch, 2004) and including the stakeholders in this planning in order to be successful (Rusch & Blakewell-Sachs, 2007).

Some of the participants experienced unrealistic demands on their time, and concern over their role becoming diluted by being pulled away from the point of care as obstacles to overcome. The participants in this study experienced role overload and concerns about being taken away from the bedside by the number of special projects given to them. In order to not dilute the role and overburden the CNL®, nurse administrators must be cautious about what and how much is delegated to the CNL®.

Participants were concerned about the impact of economic constraints facing their organizations on their role viability. Not having the organizational and economic support to continue in her role, one participant described having to give up what she loved doing and leave the sacred place of being at the bedside with her fear of "losing that connectedness with the patients" becoming a reality in the near future. Will there be anyone who will be able to fill this void? The question is left unanswered, although the

look on this participant's face seemed to say, "I am afraid no one will be there." Nurse administrators must create ways to support CNLs® and other nurses at the bedside by advocating for the economic resources needed to support nurse patient relationships.

Nurse administrators can promote a culture where nursing and caring are valued and lived. Role modeling and encouraging CNLs® and other nurses to share their stories are two strategies administrators can employ to reflect their commitment to living caring in nursing practice (Boykin & Schoenhofer, 2006; Ray, 1997; Sorbello, 2008).

Introducing the CNL® into the care delivery model has the potential to contribute significantly to patient and nursing satisfaction, patients' clinical outcomes, and improved interdisciplinary relationships that support a healthy work environment. These outcomes result in cost savings which contribute to the organization's bottom line and can be used by the nurse administrator in a business case for implementation of the CNL® role (Harris & Ott, 2008).

The nurse administrator's ongoing involvement in and support for the implementation of the CNL® role is an important determinant of the success of the role, as evidenced in this study and in the literature (Sherman, 2008). Several participants in this study experienced pride and satisfaction from being known and appreciated by the nurse administrator. Findings from this study include the need for management and executive support for implementation of the CNL® role, supporting the literature (Gabuat, Hilton, Kinnaird & Sherman, 2008; Poulin-Tabor, Quirk, Wilson, Orff, Gallant, Swan & Manchester, 2008; Rusch, 2004). Participants who experienced lack of management support were unable to be fully live caring and grow as CNLs® in their organizations. In

particular, those who had tenuous relationships with their direct managers, experienced role dissatisfaction and mistrust of middle management, and a desire to never occupy a middle management role, supporting the research on trust and trusting relationships by Hilsenbeck (2006) and Ray, Turkel and Marino (2002).

Implications for Nursing Education

The stories and meanings that emerged from the experiences shared by these CNLs® provide a method for studying nursing. Through understanding the stories of CNLs®, students can discern important aspects of being a leader at the point of care and develop an understanding of unique ways to live caring in practice. Faculty may also use knowledge gained through the stories of these CNLs® into nursing curriculums to invite dialogue and help students gain new understandings. Other CNLs® and nurses can learn from these stories through “enter[ing] into this shared lived experience of nursing” (Boykin & Schoenhofer, 2001, p. 20), where calls for nursing are heard and caring responses are created.

Navigating safe passage for patients, deriving satisfaction and pride in making a difference through collaborating with and being respected by others, bringing the bedside point of view to decision making, being at the bedside, knowing the patient as caring person, and helping nurses to grow are meaningful aspects of the CNL® role and should be included in CNL® curricula. The concerns and barriers that CNLs® experience might also be included in the CNL® role courses, so that students and faculty can discuss ways to mitigate these from happening.

Topics such as change implementation theory and strategies, understanding

complex bureaucratic organizations, conflict management, communication skills, evidence-based practice, patient safety principles, and economic principles to support cost benefit analyses should remain in the CNL® graduate curriculum since these are important aspects of the CNL® role. In addition, competencies in team building, leading and working within committees, and project management should be included in the curriculum, as these also surfaced as being important aspects of their roles. Lastly, the role of the CNL® in honoring the wholeness of persons and creating environments grounded in caring values is essential in the curriculum in order to ground nursing practice in caring principles (Touhy & Boykin, 2008).

Implications for Nursing Research

This phenomenological study informs our understanding of what CNLs® find meaningful about their roles as bedside leaders. The meanings that emerged from this study may be shared by other CNLs® working in acute care settings. In phenomenology, there is a unity of meaning illuminated that represents the experiences of CNLs®. Additional qualitative studies are needed to determine whether other CNLs® share these same experiences and meanings in order to create practice settings and care delivery systems where the CNL® role is fully understood, planned for and supported. Since CNLs® work in many different settings, it would be beneficial to conduct studies to gain understanding about the meaning of leading with CNLs® who practice in areas outside of acute care, such as in schools, clinics and long term care. Longitudinal studies are also recommended to ascertain whether CNL® views and experiences change over time.

Research is needed to study the experiences of having been cared for by a CNL®

in order to determine whether the CNL® role is meeting the expectations and expressed needs of patients. By gaining understanding of patient perceptions, CNLs® and nurse administrators can plan patient-centered care delivery systems and create an environment grounded in caring values while minimizing aspects of care that are dissatisfiers to them. By seeing the health care experience through the patient's eyes, the CNL® gains knowledge about how to help build trusting relationships with the ingredients of caring in order to help patients to grow. Researching the CNL® and patient dyad to understand the value experienced from the practice of the CNL® would also be beneficial.

Research with other health care providers that work with the CNL® role, such as novice nurses, physicians, nurse administrators and managers is needed to gain understanding about the nature of the relationship they experience and the meanings and value they believe the CNL® brings to the health care organization and to their practice. By gaining this knowledge, stronger collaborative interdisciplinary relationships can be created where all members of the team can practice optimally and synergistically.

Lastly, since the CNL® is a new role, both qualitative and quantitative research is needed to study how this role impacts many of the current issues in health care, including but not limited to the economic impact, failure to rescue, nursing sensitive indicators, patient satisfaction and readiness to care for self, patient readmission rates, nursing satisfaction and turnover, and physician satisfaction. The literature is replete with studies of how evidence-based practice has improved patient outcomes. Further research is needed to explore the CNL® involvement in evidence-based practice from a human perspective rather than just from an empirical point of view.

This study included participants who have been in practice between six months and two and a half years; and several of them were concerned for the future of their role. One participant had already accepted a position change to be a nurse manager. Studies are needed to look at retention rates of CNLs®; and for those who choose to leave the role, the reasons for making this decision.

Chapter Summary

This chapter provided the reader with the findings situated within the context of Ray's Holographic theory of Bureaucratic Caring (2006) and Boykin and Schoenhofer's theory of Nursing as Caring (2001). These theories offered a framework for understanding how CNLs'® caring values flourish within the complex acute care hospital system; as well as the barriers they experience to fully living caring. Findings were then linked with the literature. Implications for the care of patients, nursing administration, nursing education, and recommendations for additional research were then described.

Concluding Thoughts

The purpose of this hermeneutic phenomenological study was to gain understanding about the meaning of leading at the bedside from the perspective of the CNLs®. Ten CNLs® were interviewed, and as a result of hermeneutic interpretation of the data, six essential themes emerged. These themes were synthesized to create an overall understanding of the meaning of leading at the bedside for CNLs® which includes navigating safe passage for patients; making a difference and being recognized for their knowledge, skills, accomplishments and respect earned from others; and the experience of knowing patients and other nurses as caring persons and helping them to grow.

CNLs® value their position at the bedside, close to the patients, families and their nursing colleagues. Through coming to know patients' stories, they understand what is most important to them. Through establishing relationships throughout their organization and by virtue of their clinical expertise, they are able to advocate for the care of patients. Sadly, many CNLs® fear that their role will be taken away from the bedside, diluted with additional projects, or eliminated as a result of economic constraints within their organizations.

Aesthetic expressions offer a way to understand meanings and re-present the whole of situations. Boykin and Schoenhofer (2001) posit, "aesthetic knowing is the integration and synthesis of all knowing...." (p.42). The concluding poem was written to capture the pride CNLs® experience in living caring with patients, and their need for affirmation.

Poem

Who Am I?

I am one who sees

What is most important to you now.

I am one who hears

What you say and what is left unsaid.

I am one who shields

You from the stormy seas of error and harm.

I am one to go to

Just call on me and I will get it done.

I am one who stands firm

For what is right, and for what you choose.

I am one who cares.

I am present.

I hear you.

I see you.

I know you for who you are.

Who am I?

I am one who needs to be known.

I have much to give.

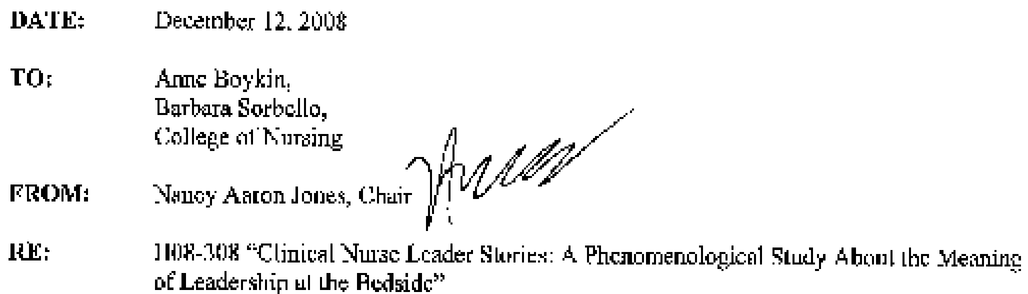
Hear my stories and come to know me for all that I am and all that I can be.

APPENDIX A

Institutional Review Board Approval

Division of Research
Institutional Review Board
777 Glades Road
Boca Raton, FL 33431
Tel: 561.297.0777
Fax: 561.297.2319
www.fau.edu/research/ric

MEMORANDUM



DATE: December 12, 2008

TO: Anne Boykin,
Barbara Sorbello,
College of Nursing

FROM: Nancy Aaron Jones, Chair

RE: H08-308 "Clinical Nurse Leader Stories: A Phenomenological Study About the Meaning of Leadership at the Bedside"

The Institutional Review Board (IRB) has reviewed the above protocol. Under the provisions for expedited review, the proposed research has been found acceptable as meeting the applicable ethical and legal standards for the protection of the rights and welfare of the human subjects involved.

This approval is valid for **one year from the above memo date.** This research must be approved on an annual basis. It is now your responsibility to renew your approval annually and to keep the IRB informed of any substantive change in your procedures or of any problems of a human subjects' nature.

It is important that you use the approved, stamped consent documents attached.

Please do not hesitate to contact either myself (6-8632) or Elisa Gaucher (7-2318) with any questions.

NAJ:eeg
Final Expedited Review Category: B7

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APPENDIX B

Consent to Participate in the Study

Consent Form

1) Title of Research Study: Clinical Nurse Leader^{SM} Stories: A Phenomenological Study About the Meaning of Leadership at the Bedside

2) Investigator: Barbara Sorbello, PhD(c), RN-BC, NEA-BC. Responsible faculty member and Committee Chair, Dr. Anne Boykin, Professor and Dean, Christine E. Lynn College of Nursing at Florida Atlantic University.

3) Purpose: The purpose of the study is to gain an understanding of the meaning of bedside leadership as experienced and explicated by CNLs assuming this new role within the bureaucratic acute care hospital setting. This study is significant so that a better understanding can be gained about the experiences of the CNL, the context in which these experiences occur, and the meanings these events and experiences have to CNLs.

4-A) Procedures:
a) You will be asked a number of open ended questions about your role. Interviews will be tape recorded and coded in order to protect your privacy and confidentiality. Text will be analyzed for emerging themes. You will participate in co-interpretation of the text to assure it accurately reflects your experiences and views.
b) Each interview will be limited to one hour. Subsequent contact through email and phone will be used for you and the investigator to co-interpret the text. Your involvement in the study will entail interaction with the investigator for one face to face interview and one to two email or phone sessions over a 1-2 month period.
c) Interviews will be conducted in a private location, such as a conference room in the hotel setting where you will be attending the annual CNL conference.

5) Risks: Risks associated with participation in this study are minimal. "Minimal" risk means that the probability and magnitude of harm or discomfort anticipated in the research is not greater than is ordinarily encountered in daily life or during the performance of routine activities. Risks to you include the potential to experience fatigue, as in-depth interviews often require much emotional energy. You may also experience emotions and feelings that may be uncomfortable when answering and reflecting upon the research questions.

6) Benefits: Potential benefits to the participants include:

- The opportunity to reflect upon and appreciate the value of your role in the care of patients and in the organization.
- The opportunity to improve your leadership and clinical practice as a result of reflection, and as a result, improve care of patients.
- The opportunity to influence future CNL education.

Additionally, you may benefit from participating in this study in knowing you have contributed to benefiting society and adding to the body of nursing knowledge by informing our understanding of:

Initials: ______

- The impact of the CNL role on the nursing care delivery model
- The views and experiences of what it is like being a CNL.
- The importance of organizational support, process improvement, and the creation of a culture of caring where nursing is valued.
- The implications that change in care delivery methods and interdisciplinary collaboration have in improving patient care.
- Future curriculum planning to meet the unique needs of the nurses in this role, as the health care system continues to evolve.

You may refuse to participate and also withdraw from the study at any time without penalty.

7) <u>Data Collection & Storage:</u>
a) Interviews will be tape recorded and transcribed into text. Interviews will be coded and restricted for use only by this authorized investigator, to maintain participant confidentiality. You will participate in co-interpreting the text to assure that it accurately reflects your experiences. Data will be kept locked in the investigator's locked file cabinet and shredded within two years of the conclusion of the study.
b) Results will not be released in any way that might allow the identification of the participants without your agreement, unless disclosure is required by law.

8) <u>Contact Information:</u> For related problems or questions regarding your rights as a subject, the Office of Sponsored Research at Florida Atlantic University can be contacted at (561) 297-0777. For other questions about the study, you should call the principal investigator, Barbara Sorbello, PhD(c), RN-BC, NEA-BC at (772) 214-2344 or Dr. Anne Boykin at (561) 297-3206.

9) <u>Consent Statement:</u> I have read or had read to me the preceding information describing this study. All my questions have been answered to my satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the study at any time. I have received a copy of this consent form.

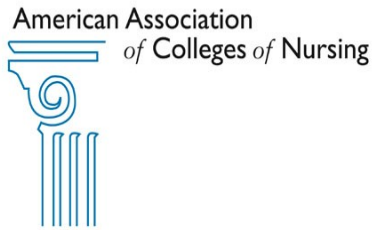
Signature of Subject: ________________________________ Date:______________

Signature of Investigator: ______________________________ Date: ____________

IRB
Approval Date: 12/2/08
Initials:
Expiration Date: 12/1/09

APPENDIX C

Letter of Support from the AACN to Conduct the Study



October 19, 2008

Barbara Sorbello, PhD(c), RN-BC, NEA-BC
Doctoral Student
Christine E. Lynn College of Nursing
Florida Atlantic University
777 Glades Road
Boca Raton, FL 33432

Mrs. Sorbello,

This letter is written to acknowledge support for you to conduct data collection for your dissertation study, "Clinical Nurse Leader stories: A phenomenological study about the meaning of leadership at the bedside" with Clinical Nurse Leaders attending the AACN Clinical Nurse Leader conference in January 2009.

I understand that your data collection will entail conducting tape recorded interviews of Clinical Nurse Leaders in a private location, such as a conference room, after informed consent is obtained. The AACN will look forward to the results of your study to advance understanding of the Clinical Nurse Leader role.

Sincerely,

Joan M. Stanley

Joan Stanley, PhD, RN, FAAN
Senior Director of Education Policy
American Association of Colleges of Nursing

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www.aacn.nche.edu

APPENDIX D

Communication to CNLs® to Recruit Participants

Greetings Clinical Nurse Leaders,

My name is Barbara Sorbello. I am an Administrative Director for Acute Care Nursing in a not for profit health care system in Virginia, and PhD Candidate at Florida Atlantic University. I have been interested in the CNL® role since its inception, co-directed and taught in the CNL program at Florida Atlantic University, and am planning on implementing the role in my hospital system.

I am sending this email to CNL's® on the AACN list serve to recruit volunteers to participate in my dissertation research which focuses on the CNL role. Participants must have:

- Graduated from a CNL® masters curriculum,
- Be practicing as a CNL® in a hospital setting for at least 6 months

The dissertation is titled "**Clinical Nurse Leader℠ Stories. A Phenomenological Study About the Meaning of Leadership at the Bedside.** The purpose of this qualitative phenomenological study is to gain understanding about the meaning of leadership at the point of care; to discover the unique expressions of living caring that CNL's® experience as they embark upon this new role in the acute care hospital setting. In this study, CNL's® will be asked to reflect upon and share unique nursing situations and other experiences at the point of care that have special meaning for them that contain the essence of what is means to be a CNL®.

I will be conducting tape recorded interviews for data collection at the January 2009 CNL conference in New Orleans; therefore, I am recruiting participants from those of you who will be attending the conference.

Interviews will be scheduled both before and after conference sessions so as not to interfere with the conference. If you are interested in participating in this research study to further our knowledge about the CNL® role, please contact me and I will provide you with further information.

Thank-you.

Barbara Sorbello, PhD(c), RN-BC, NEA-BC
Administrative Director Acute Care Services, St. Francis Medical Center
PhD Candidate, Florida Atlantic University
Email: Barbara_Sorbello@bshsi.org
Office phone: (804) 594-7557
Or
Email: Bsorbell@fau.edu

APPENDIX E

Participant Demographic Data Collection Form

Participant Code:__________
To be completed by the researcher

CNL Participant Demographic Data Form

Name	
Age	
Taken/passed the CNL certification exam?	
Length of time working as a CNL	
Length of time working as an RN prior to working in the CNL role	
Type of hospital	
Type of nursing unit/dept.	
Number of beds in unit	
Are there any other CNLs in your hospital?	

APPENDIX F

Participant Demographics

CNL Participant Demographics

Age	Range from 37-55
Taken/passed the CNL certification exam?	All participants had passed the CNL certification exam
Length of time working as a CNL	Range from 6 months to 2.5 years
Length of time working as an RN prior to working in the CNL role	Range from 2 years-26.5 years
Type of hospital	• Five participants worked at Veterans Administration hospitals • Five participants worked at non- profit medical centers •
Type of nursing unit/dept.	• Eight participants worked in medical surgical units with or without telemetry monitoring • One participant worked in a mother baby unit • One participant worked in an orthopedic-neurology unit
Number of beds in unit	Range from 20-44 beds
Are there any other CNLs in your hospital?	Seven out of ten participants were the only CNLs in their hospitals

References

Aiken, L., & Patrician, P. (2000). Measuring organizational traits of hospitals: The revised nursing work index. *Nursing Research,* 49(3), 146-153.

Allan, J. D., Stanley, J., Crabtree, M.K., Werner, K.E., & Swenson, M. (2005). Clinical prevention and population health curriculum framework: the nursing perspective. *Journal of Professional Nursing*, *21*(5), 259-267.

American Association of Colleges of Nursing. (2003). *Working paper on the role of the clinical nurse leader.* Retrieved March 17, 2006 from http://www.aacn.nche.edu/CNL/cnlpubs.htm

American Association of Colleges of Nursing. (2006). *CNL curriculum framework for client-centered healthcare, April 2006.* Retrieved October 12, 2007 from http://www.aacn.nche.edu/CNL.htm

American Association of Colleges of Nursing. (2007a). *White paper on the education and role of the Clinical Nurse Leader, July 2007.* Retrieved May 24, 2008 from http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader07

American Association of Colleges of Nursing (2007b). *CNL. Frequently asked questions, November, 2007.* Retrieved May 24, 2008 from http://www.aacn.nche.edu/CNL/faq.htm

American Association of Colleges of Nursing (2009a). *CNC. Commission on Nurse*

Certification. Retrieved January 9, 2010 from http://www.aacn.nche.edu/CNC/cnlcert.htm

American Association of Colleges of Nursing (2009b). *CNL. Clinical Nurse Leader Certification.* Retrieved January 9, 2010 from http://www.aacn.nche.edu/CNC/cnlcert.htm

American Nurses Association News (Jan-March 2006). ANA joins the AACN Clinical Nurse Leader implementation and evaluation task forces. *The New Mexico Nurse*, 51(1), 13.

Anderson, R.A., & McDaniel Jr., R.R. (2000). Managing health care organizations: Where professionalism meets complexity science. *Health Care Management Review,* 25(1), 83-92.

Antrobus, S., & Kitson, A. (1999). Nursing leadership: Influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing,* 29(3), 746-753.

Arndt, M., & Bigelow, B. (2000). Commentary: The potential of chaos theory and complexity theory for health services management. *Health Care Management Review,* 25(1), 35-38.

Bartels, J.E. (2005). Educating nurses for the 21st century. *Nursing and Health Sciences, 7,* 221-225.

Bartels, J.E., & Bednash, G. (2005). Answering the call for quality nursing care and patient safety. *Nursing Administration Quarterly, 29*(1), 5-13.

Batchtel, I. (2006). Be still and listen, be still and know The essence of leadership during career path transitions. *Nurse Leader, 2,* 20-36.

Begun, J.W., Tornabeni, J., & White, K.R. (2006). Opportunities for improving patient care through lateral integration: The Clinical Nurse Leader. *Journal of Healthcare Management, 51*(1), 19-25.

Benner, P. (2001) *From Novice to Expert. Excellence and Power in Clinical Nursing Practice, Commemorative Edition.* Upper Saddle River, NJ: Prentice Hall Health

Bleich, M.R., & Hewlett, P.O. (2004). Dissipating the "perfect storm"- Responses from nursing and the health care industry to protect the public's health. *Online Journal of Issues n Nursing, 9*(2), 1-16.

Bowcutt, M., Wall, J., & Goolsby, M.J. (2006). The Clinical Nurse Leader. Promoting patient-centered outcomes. *Nursing Administration Quarterly, 30*(2), 156-161.

Boykin, A., & Schoenhofer, S. (1997). Reframing outcomes: Enhancing personhood. *Advanced Practiced Nursing Quarterly, 3*(1), 60-65.

Boykin, A., & Schoenhofer, S. (2001). *Nursing as Caring: A model for transforming practice.* Sudbury, MA: Harper Perennial.

Brown, A.B. (2008). Understanding the role of the Clinical Nurse Leader. *American Nurse Today, 3*(6), 40-41.

Brown, C.L., Holcomb, L., Maloney, J., Naranjo, J., Gibson, C. & Russell, P. (2005). Caring in action: The patient care facilitator role. *International Journal for Human Caring,* 9(3), 51-58.

Bryant, L. (2009). The art of active listening. *Practice Nurse, 37*(6), 49-52.

Burke, L.E., Schlenk, E.A., Sereika, S. M., Cohen, S.M., Happ, M.B., & Dorman, J. S. (2005). Developing research competence to support evidence-based practice.

Journal of Professional Nursing, 21(6), 358-363.

Burns, J.S. (2002). Chaos theory and leadership studies: Exploring uncharted seas. *Journal of Leadership & Organizational Studies,* 42(15). Retrieved November 9, 2005 from Thomson Gale, Florida Atlantic University.

Burns, J., & Grove, S.K. (1997). *The Practice of Nursing Research. Conduct, Critique and Utilization* (3rd ed.), Philadelphia: W.B. Saunders.

Capuano, T., Bokovoy, J., Hitchings, K., & Houser, J. (2005). Use of a validated model to evaluate the impact of the work environment on outcomes at a magnet hospital. *Health Care Management Review,* 30(3), 229-237.

Carnohan, M. (May 21, 2007). Letter to the editor. Taking care of nurses…"Clinical nurse leader; new role focuses on big picture," April 9. *Nurseweek, 20*(11), 4.

Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Clancy, T.R. (2004). Navigating in a complex nursing world. *Journal of Nursing Administration, 34*(5), 274-282.

Clancy, T.R. (2008). Directing: A complex systems perspective. *Journal of Nursing Administration, 38*(2), 61-63.

Clarke, S.P. (2004). Failure to Rescue: Lessons from missed opportunities in care. *Nursing Inquiry, 11*(2), 67-71.

Clarke, S.P. (2006). Challenge: New educational levels. *Nursing Management, 37*(5), 56.

Connelly, L.M. (2003). A qualitative study of charge nurse competencies. *MEDSURG Nursing, 12*(5), 298-306.

Cook, M. (2001). The attributes of effective clinical nurse leaders. *Nursing Standard, 15*(35), 33-39.

Crist, J.D., & Tanner, C.A. (2003). Interpretation/Analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52*(3), 202-205.

Cronin, S., & Harrison, B. (2002). Caring behaviors assessment tool. In J. Watson (Ed.), *Assessing and measuring caring nursing and health science.* New York: Springer.

Drenkard, K.N. (2004). The Clinical Nurse Leader: A response from practice. *Journal of Professional Nursing, 20*(2), 89-96.

Drenkard, K., & Cohen, E. (2004). Clinical Nurse Leader: Moving toward the future. *Journal of Nursing Administration, 34*(6), 257-260.

Duffy, J. (2003). The Quality Caring Model ©: Blending dual paradigms. *Advances in Nursing Science,* 26(1), 77-88.

Dzurec, L.C., Allchin, L., Engler, A.J., Szarlan, J., Polifroni, E.C., & Brewer, T. (2006). Toward a qualified yes: Personal characteristics of post baccalaureate nursing students and implementation of the Clinical Nurse Leader role. *Journal of Professional Nursing, 22*(1), 15-22.

Eisenstadt, S.N. (1959). Bureaucracy, bureaucratization and Debureaucratization. *Administrative Science Quarterly, 4*(3), 302-320.

Endacott, R. (1999). Roles of the allocated nurse and shift leader in the intensive care unit: Findings of an ethnographic study. *Intensive and Critical Care Nursing,* 15, 10-19.

Erickson, J.I., & Ditomassi, M. (2005). Guest editorial. The Clinical Nurse Leader. New

in name only. *Journal of Nursing Education, 44*(3), 99-100.

Finch, L.P. (2004). Understanding patients' lived experiences: the interrelationship of rhetoric and hermeneutics. *Nursing Philosophy, 5,*251-257.

Foley, B.J., Kee, C.C., Minick, P., Harvey, S.S., & Jennings, B.M. (2002). Characteristics of nurses and hospital work environments that foster satisfaction and clinical expertise. *Journal of Nursing Administration,* 32(5), 273-282.

Gabuat, J., Hilton, N., Kinnaird, L., & Sherman, R. (2008). Implementing the Clinical Nurse Leader role in a for-profit environment: A case study. *Journal of Nursing Administration, 38*(6), 302-307.

Gage, G. (1998). From independence to interdependence. Creating synergistic healthcare teams. *Journal of Nursing Administration, 28*(4), 17-26.

Gilmartin, G. (1998). The nursing organization and the transformation of health care delivery for the 21st century. *Nursing Administration Quarterly,* 22(2), 70-87.

Girard, N.J. (2005). Editorial. Possible new career options. *AORN Journal, 81*(5), 961-963.

Gibbons, C. & Krajnak, S. (1989). The coalignment model and its usefulness for nurse administrators and educators. In Beverly Henry, Clara Arndt, Marie DiVincenti and Ann Marriner-Tomey (Eds.), *Dimensions of Nursing Administration* (pp 183-194). Cambridge, MA: Blackwell Scientific Publications.

Glazer, G. (2005). JAN Guest Editorial. Higher education for lower patient risk? *Journal of Advanced Nursing, 52*(4), 345-346.

Globerman, J., Mackenzie Davies, J., & Walsh S. (1996). Social wok in restructuring

hospitals: Meeting the Challenge. *Health & Social Work, 21*(3), 178-189.

Goldblatt, H., Granot, M., Admi, H., & Drach-Zahavy, A. (2008). The experience of being a shift-leader in a hospital ward. *Journal of Advanced Nursing, 63*(1), 45-53.

Goleman, D. (1998). What makes a leader? *Harvard Business Review.* Nov/Dec, 93-102.

Goudreau, K.A. (2008). Confusion, concern, or complimentary function. *Nursing Administration Quarterly, 32*(4), 301-307.

Grazier, K.L. (2006). Editorial. *Journal of Healthcare Management, 51*(1), 1.

Grindel, C. (2005). AACN presents the Clinical Nurse Leader and the Doctor in Nursing Practice roles: A benefit or misfortune? *MEDSURG Nursing, 14*(4), 209-210.

Haase-Herrick, K.S., & Herrin, D. S. (2007). Clinical Nurse Leader. Evolution of a revolution. The American Organization of Nurse Executives' Guiding Principles and American Association of Colleges of Nursing's Clinical Nurse Leader. A lesson in synergy. *Journal of Nursing Administration, 37*(2), 55-60.

Harman, W. (1992). 21st Century business: A background for dialogue. In J.D. Renesch (Ed.), *New Traditions in Business. Spirit and Leadership in the 21st Century* (pp. 11-22). San Francisco, CA: Berrett-Koehler.

Harper, J. (1995). Clinical leadership-bridging theory and practice. *Nurse Educator, 20*(3), 11-12.

Harris, J.L., & Ott, K. (2008). Building the business case for the Clinical Nurse Leader role. *Nurse Leader, 6*(37), 25-28.

Harris, J.L., Tornabeni, J., & Walters, S.E. (2006). Clinical Nurse Leader. The evolution

of a revolution. The Clinical Nurse Leader. A valued member of the healthcare team. *Journal of Nursing Administration, 36*(10), 446-449.

Hartranft, S.R., Garcia, T., & Adams, N. (2007). Clinical Nurse Leader. Evolution of a revolution. Realizing the anticipated effects of the Clinical Nurse Leader. *Journal of Nursing Administration, 37*(6), 261-263.

Hay, C.J. (2004). Leading towards the future: Implementing nursing leadership principles at the front line. *Nursing Leadership, 17*(2), 681.

Hernandez, D.B., Spivack, L.B., & Zwingman-Bagley, C. (1997). Nurse Leaders: Roles driving organizational transition. *Nursing Administration Quarterly, 22*(1), 38-46.

Hilsenbeck, J.R. (2006). Unveiling the mystery of covenantal trust: The theory of the social process between the nurse manager and the chief nursing officer. (Doctoral Dissertation. Florida Atlantic University, 2006). *Proquest Dissertations and Theses,* (UMI No. 3244888).

Holden, L.M. (2005). Complex adaptive systems: Concept analysis. *Journal of Advanced Nursing, 52*(6), 651-657.

Hooper, V.D. (2006). The back page. What are the roles of nursing? *Journal of Peri Anesthesia Nursing, 21*(4), 298-300.

Hughes, R.G., & Clancy, C.M. (2005). Working conditions that support patient safety. *Journal of Nursing Care Quality, 20*(4), 289-292.

Iacono, M. (2003). Leadership at the bedside. *Journal of PeriAnesthesia Nursing, 18*(5), 348-351.

Ingersoll, G.L. (2000). Evidence-based nursing. What it is and what it isn't. *Nursing*

Outlook, 48(4), 151-152

Ingersoll, G.L., Wagner, L., Merck, S., Kirsch, J.C., Hepworth, J. T., & Williams, M. (2002). Patient-focused redesign and employee perception of work environment. *Nursing Economics, 20*(4), 163-187.

Jacques, E. (2000). Associations and bureaucracies. *Physician Executive, 26*(3), 6-12.

Karshmer, J., Seed, M., & Torkelson, D. (2009). The Clinical Nurse Leader. How will the role affect psychiatric nursing? *Journal of Psychosocial Nursing, 47*(10), 8-9.

Kennedy, M.S. (2004). AJN News. Introducing the Clinical Nurse Leader. *American Journal of Nursing, 104*(10), 22.

Kennedy, M.S. (2007). On the road with AJN. Clinical Nurse Specialists celebrate new highs. *American Journal of Nursing, 107*(5), 87.

Kerfoot, K. (1998). Leading change is leading creativity. *Pediatric Nursing,* 24(2), 180-182.

Koloroutis, M., Manthey, M., Felgen, J., Person, C., Kinnaird, L., Wright, D., et al. (2004). *Relationship based care: A model for transforming practice.* Minneapolis, MN: Creative Health Care Management, Inc.

Kowalski, K. (2008). HRSA funds frontline nursing leadership project for Colorado, *Colorado Nurse, June,* 11.

Kramer, M., & Schmalenberg, C.E. (2003). Magnet hospital nurses describe control over nursing practice. *Western Journal of Nursing Research,* 25(4), 434-42.

Kupperschmidt, B.R., & Barnhouse, J. (Dec. 2005-Jan., Feb. 2006). The Clinical Nurse Leader (CNL): Staying at the bedside; filling in the gap; and impacting patient

and staff outcomes. *The Oklahoma Nurse,* 50(4), 16, 18.

Laverty, S.M. (2003). Hermeneutic Phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 1-29.

Lavoie-Tremblay, M., Wright, D., Desforges N., Gelinas, C. Marchionni & Drevniok, U. (2008). Creating a healthy workplace for new-generation nurses. *Journal of Nursing Scholarship, 40*(3), 290-297.

Leape, L.L., & Berwick, D.M. (2005). Five years after To Err is Human: What have we learned? *Journal of the American Medical Association, 293*(19), 2384-2390.

Lee, H., & Cummings, G.G. (2008). Factors influencing job satisfaction of front line nurse managers: A systematic review. *Journal of Nursing Management, 16,* 768-782.

Locsin, R.C. (2001). Practicing Nursing: Technological Competency as an Expression of Caring. In R.C. Locsin's (Ed.) *Advancing Technology, Caring and Nursing* (pp.88-95). Westport, CT: Auburn House.

Long, K.A. (2004). Preparing nurses for the 21st century: Reenvisioning nursing education and practice. *Journal of Professional Nursing, 20*(2), 82-88.

Maag, M.M., Buccheri, R., Capella, E., & Jennings, D.L. (2006). A conceptual framework for a clinical nurse leader program. *Journal of Professional Nursing, 22*(6), 367-372.

MacPhee, M., McLean, G., & Woo, C. (2005). Editorial. The nursing "leadership" evolution: Just another label? *Journal of Pediatric Nursing, 20*(4), 231-233.

Manojlovich, M. (2005). Predictors of professional nursing practice behaviors in hospital settings. *Nursing Research, 54*(4), 41-47.

Mayeroff, M. (1971). *On caring.* New York: Harper Perennial.

McCabe, S. (2006). What does it take to make a nurse? Considerations of the CNL and DNP role development. *Perspectives in Psychiatric Care, 42*(4), 252-255.

McWilliam, C.L. & Wong, C.A. (1994). Keeping it secret: the costs and benefits of nursing's hidden work in discharging patients. *Journal of Advanced Nursing, 19,* 152-163.

Medical News Today (Dec. 31, 2007). AACN establishes the commission on nurse certification to oversee the credentialing of Clinical Nurse Leaders. Accessed on Jan. 6, 2008 at http://www.medical newstoday.com.

Meyer, H.D. (1995). Organizational environments and organizational discourse: Bureaucracy between two worlds. *Organization Science, 6*(1), 32-43.

Microcosm. (2008). In *Merriam-Webster Online Dictionary*. Retrieved September 1, 2008, from http://www.merriam-webster.com/dictionary/microcosm.

Miller, P. (2008). Clinical Nurse Leader. A new nursing role. *The Tennessee Nurse, 71(*2), 4.

Mitchell, G.J., & Bournes, D.A. (2000). Nurse as patient advocate? In search of straight thinking. *Nursing Science Quarterly, 13*(3), 204-209.

Munhall, P. L. (2001). *Nursing Research. A Qualitative Perspective (3rd ed.).* Sudbury, MA: Jones and Bartlett.

Murray, T.A. (2007). Innovation in nursing education: Which trends should you adopt?

Nurse Educator, 32(4), 154-160.

National Association of Clinical Nurse Specialists (2004). NACNS position statement on the Clinical Nurse Leader. Accessed on Jan. 6, 2008 at http://www.nacns.org

National Association of Clinical Nurse Specialists (2005). NACNS update on the Clinical Nurse Leader. Accessed on Jan. 6, 2008 at http://www.nacns.org

Nelson, R. (2005). AJN Reports. The Clinical Nurse Leader-needed or not? Opinions vary; results still out. *American Journal of Nursing, 105*(12), 24-25.

Newkirk, D. (Dec. 2005-Jan., Feb. 2006). Nurse Manager response to the Clinical Nurse Leader initiative. *The Oklahoma Nurse,* 50(4), 20.

Norris, T.L., & McKeon, L. (2008). The Clinical Nurse Leader: Transforming care in the microsystem. *The Tennessee Nurse, March, April, May,* 10.

Nyberg, J. (1991). The nurse as professnocrat. *Nursing Economics, 9*(4), 244-247,280.

Omery, A. (1983). Phenomenology: a method for nursing research. *Advances in Nursing Science, 5*(2), 49-63.

Palmier, D. (1998). How can the bedside nurse take a leadership role to affect change for the future? *ConceRN,* 27(1), 16-22.

Perra. B.M. (2001). Leadership. The key to quality outcomes. *Journal of Nursing Care Quality, 15*(2), 68-73.

Peters, M.A. (2007). Clinical Nurse Leader: A “Go to Person”. *Pennsylvania Nurse, 3,* 17.

Picard, C., & Henneman, E.A. (2007). Theory-guided evidence-based reflective practice: An orientation to education for quality care. *Nursing Science Quarterly, 20*(1),

39-42.

Pink, D. (2005). *A Whole New Mind. Moving from the Information Age to the Conceptual Age.* New York: Penguin Group.

Porter-O'Grady, T. (2004). Overview and summary: Shared governance. Is it a model for nurses to gain control over their practice? *Online Journal of Issues in Nursing,* 9(1): Retrieved March 17, 2006 from http://www.nursingworld.org/ojin

Poulin-Tabor, D., Quirk, R.L., Wilson, L., Orff, S., Gallant, P., Swan, N., & Manchester, N. (2008). Pioneering a new role: The beginning, current practice and future of the Clinical Nurse Leader. *Journal of Nursing Management, 16,* 623-628.

Quataro, B., & Reid, K. (Nov.-Dec. 2005, Jan. 2006). VNA working for you. Developing Clinical Nurses Leaders at the University of Virginia. *Virginia Nurses Today, 15.*

Radzyminski, S. (2005). Advances in graduate nursing education: Beyond the advanced practice nurse. *Journal of Professional Nursing, 21*(2), 119-125.

Ray, M.A. (1987). Technological caring: A new model in critical care. *Dimensions in Critical Care Nursing, 6*(3), 165-173.

Ray, M.A. (1997). The ethical theory of existential authenticity: the lived experience of the art of caring in nursing administration. *Journal of Nursing Research, 29*(1), 111-126.

Ray, M.A. (1998). The interface of caring and technology. A new reflexive ethics in intermediate care. *Holistic Nursing Practice, 12*(4), 69-77.

Ray, M.A. (2001). Complex Culture and Technology: Toward a Global Caring Communitarian Ethics of Nursing. In R.C. Locsin's (Ed.) *Advancing Technology,*

Caring and Nursing (pp.41-52). Westport, CT: Auburn House.

Ray, M.A. (2006). Marilyn Anne Ray's Theory of Bureaucratic Caring. In M.E. Parker (Ed.), *Nursing Theories and Nursing Practice* (2nd ed.) (pp. 360-368). Philadelphia: F.A. Davis Co.

Ray, M.A. (2010). *Personal communication received January 7, 2010.*

Ray, M.A., Didominic, V.A., Dittman, P.W., Hurst, P.A., Seaver, J. B., Sorbello, B.C., & et al. (1995). The edge of chaos. Caring and the bottom line. *Nursing Management,* 26(9), 48-50.

Ray, M.A., Turkel, M.C., & Marino, F. (2002). The transformative process for nursing in workforce redevelopment. *Nursing Administration Quarterly, 26*(2), 1-14.

Reineck, C., & Furino, A. (2005). Nursing career fulfillment: Statistics and statements from registered nurses. *Nursing Economics, 23*91), 25

Roach, C. (2002). *The human act of caring.* Ottawa, Canada: Canadian Hospital Association.

Rogers Gibson, S. (Nov.-Dec. 2005, Jan. 2006). VNA working for you. Clinical Nurse Leader. The value to an organization: Perspective from nurse administrators. *Virginia Nurses Today, 16.*

Rudan, V.T. (2002). Where have all the nursing administration students gone?: Issues and solutions. *Journal of Nursing Administration, 32*(4), 185-188.

Rusch, L. (2004). Supporting clinical nursing leadership and professional practice at the unit level. *Nursing Leadership Forum, 9*(2), 61-66.

Rusch, L., & Blakewell-Sachs, S. (2007). The CNL: A gateway to better care? *Nursing*

Management, 38(4), 32-40.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Schmalenberg, C., & Kramer, M. (2008). Clinical units with the healthiest work environments. *Critical Care Nurse, 28*(3), 65-77.

Schmalenberg, C. & Kramer, M. (2009). Nurse manager support: How do staff nurses define it? *Critical Care Nurse, 29*(), 61-69.

Scoble, K.B., & Russell, G. (2003). Vision 2020 Part 1. Profile of the future nurse leader. *Journal of Nursing Administration, 33*(6), 324-330.

Scott, E.S., & Cleary, B.L. (2007). Professional polarities in nursing. *Nursing Outlook, 55*(5), 250-256.

Senge, P. (1990). *The fifth discipline. The art & practice of the learning organization.* New York: Doubleday.

Shaver, J. (2004). Envisioning novel and meaningful collaborations: Crucial leadership needed. *Nursing Outlook, 52*(5), 223-224.

Sherman, R.O. (2005). Growing our future nurse leaders. *Nursing Administration Quarterly,* 29(2), 125-133.

Sherman, R.O. (2008). Factors influencing organizational participation in the Clinical Nurse Leader™ project. *Nursing Economics, 26*(4), 236-242.

Sherman, R.O., Edwards, B., Giovengo, K., & Hilton, N. (2009). The role of the Clinical Nurse Leader in promoting a healthy work environment at the unit level. *Critical Care Nursing Quarterly, 32*(4), 264-271.

Skytt, B., Ljunggren, B., & Carlsson, M. (2007). Reasons to leave: The motives of first-line nurse managers' for leaving their posts. *Journal of Nursing Management, 15,* 294-302.

Smith, D.S., & Dabbs, M.T. (2007). Clinical Nurse Leader. Evolution of a revolution. Transforming the care delivery model in preparation for the Clinical Nurse Leader. *Journal of Nursing Administration, 37*(4), 157-160.

Smith, M.J., & Liehr, P.R. (2003). *Middle range theory for nursing.* New York: Springer Publishing.

Smith, S.L., Hagos, O., Harriss, J., Claus, K., Thompson, D., & Young, J. (2006). Hospital use of a modified Clinical Nurse Leader. *Med-Surg Matters, 15*(3), 1, 12-14.

Smith, S.L., Manfredi, T., Hagos, O., Drummond-Huth, B. & Moore, P.D. (2006). Application of the Clinical Nurse Leader role in an acute care delivery model. *Journal of Nursing Administration,* 36(1), 29-33.

Sorbello, B. (2005). *Bedside leadership. Nursing influence at the crossroads.* Unpublished manuscript.

Sorbello, B. (2007). *What do Clinical Nurse Leaders perceive to be the value that their new roles bring to the acute care hospital setting?* Unpublished manuscript.

Sorbello, B.C. (2008). The nurse administrator as caring person: A synoptic analysis applying caring philosophy, Ray's ethical theory of existential authenticity, the ethic of justice and the ethic of care. *International Journal For Human Caring, 12*(1), 44-49.

Sorrells-Jones, J. (1997). The challenge of making it real: Interdisciplinary practice in a "seamless" organization. *Nursing Administration Quarterly,* 21(2), 20-30.

Spitzer-Lehman, R. (1993). Front-line ambassador. *Hospital Management Quarterly, 2nd Quarter.*11-15.

Stanley, D. (2006). In command of care: Clinical nurse leadership explored. *Journal of Research in Nursing, 11*91), 20-39.

Stanley, J.M., Gannon, J., Gabuat, J., Hartranft, S., Adams, N., Mayes, C., et al. (2008). The Clinical Nurse Leader. A catalyst for improving quality and patient safety. *Journal of Nursing Management, 16,* 614-622.

Stanley, J.M., Hoiting, T., Burton, T., Harris, J., & Norman, L. (2007). Implementing innovation through education-practice partnerships. *Nursing Outlook, 55*(2), 67-73.

Stanton, M. (2006). Editorial. The health care quality challenge and the Clinical Nurse Leader role (CNL). *Online Journal of Rural Nursing and Health Care,* 6(1), 2-3.

Stetler, C.B., Brunell, M., Giuliano, K. K., Morsi, D., Prince, L., & Newell-Stokes, V. (1998).

Evidence-based practice and the role of nursing leadership. *Journal of Nursing Administration, 28*(7), 45-53.

Stordeur, S., Vandenberghe, C., & D'hoore, W. (2000). Leadership styles across hierarchical levels in nursing departments. *Nursing Research,* 49(1), 37-43.

Stringer, H. (April 9, 2007). Clinical Nurse Leader. New role focuses on big picture. *Nurseweek (Mountain West), 8*(8), 10-11.

Swinderman, T. D. (2005). The magnetic appeal of nurse informaticians: Caring attractor for emergence. (Doctoral Dissertation. Florida Atlantic University, 2005). *Proquest Dissertations and Theses,* (UMI No. 3162666).

Tachibana, C., & Nelson-Peterson, D.L. (2007). Clinical Nurse Leader. Evolution of a revolution. Implementing the Clinical Nurse Leader role using the Virginia Mason Production System. *Journal of Nursing Administration, 37*(11), 477-479.

Tappen, R.M., Weiss, S.A., & Whitehead, D.K. (2004). *Essentials of nursing leadership and management* (3rd ed.). Philadelphia: F.A. Davis.

Thompson, P., & Lulham, K. (2007). Clinical Nurse Leader. Evolution of a revolution. Clinical Nurse Leader and Clinical Nurse Specialist role delineation in the acute care setting. *Journal of Nursing Administration, 37*(10), 429-431.

Tornabeni, J. (2006). Clinical Nurse Leader. Evolution of a revolution. The evolution of a revolution in nursing. *Journal of Nursing Administration 36*(1), 3-6.

Tornabeni, J., Stanhope, M., & Wiggins, M. (2006). Clinical Nurse Leader. Evolution of a revolution. The CNL vision. *Journal of Nursing Administration, 36*(3), 103-108.

Touhy, T., & Boykin, A. (2008). Caring as the central domain in nursing education. *International Journal for Human Caring, 12*(2), 8-15

Tourangeau, A.E., & McGilton, K. (2004). Measuring leadership practices of nurses using the leadership practices inventory. *Nursing Research,* 53(3), 182-189.

Turkel, M.C., & Ray, M.A. (2000). Relational complexity: A theory of the nurse-patient relationship within an economic context. *Nursing Science Quarterly, 13*(4), 307-313.

Ulrich, B.T., Lavandero, R., Hart, K.A., Woods, D., Leggett, J., Friedman, D., & et al. (2009). Critical care nurses' work environments 2008: A follow-up report. *Critical Care Nurse, 29*(2), 93-102.

United American Nurses (2006). The United American Nurses' position on the Clinical Nurse Leader. Accessed on Jan. 6, 2008 at http://www.kentucky-nurses.org.

Upenieks, V. (2002). What constitutes successful nurse leadership? A qualititative approach utilizing Kanter's Theory of Organizational Behavior. *Journal of Nursing Administration,* 32(1), 622-632.

Van Manen, M. (1990). *Researching Lived Experience*. New York: State University of New York Press.

Warfel, W., Allen R., McGoldrick, T., McLane, S., Marin, S. G. (1994). Organizational innovations that nourish staff leadership. *Holistic Nursing Practice 9*(1), 58-67

Warren, J., & Connors, H.R. (2007). AAN News & Opinion. Health information technology can and will transform nursing education. *Nursing Outlook, 55*(1), 58-60.

Weinberg, N. (2003). Healing thyself. *Forbes, 171*(6), 64-68.

Wheatley, M. (1999). *Leadership and the New Science: Discovering Order in a Chaotic World.* San Francisco, CA: Berrett-Kohler Publishers.

Wieck, L., Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in its leaders. *Journal of Nursing Scholarship,* 34(3), 283-289.

Wiggins, M.S. (2006). Clinical Nurse Leader. Evolution of a revolution. The partnership

care delivery model. *Journal of Nursing Administration, 36*(7/8), 341-345.

Witt, C. (2004). Editorial: Leadership at the bedside. *Journal of PeriAnesthesia Nursing,* 4(6), 321-322

Wood, D. (2004). Clinical nurse leader role moves into pilot phase. Retrieved January 6, 2007 from http://www.nursezone.com/job/Medicial

Woodring, B.C. (2004). Commentary. Clinical Nurse Leaders: New roles, new responsibilities, new preparation. *Journal for Specialists in Pediatric Nursing, 9*(4), 129-133.

Woods, N.F. (2003). Leadership-not for just a few! *Policy, Politics & Nursing Practice, 4*(4), 255-256.

Zaleznik, A. (2004). Managers and leaders: Are they different? *Harvard Business Review,* May/June, 171-177.

Zimmerman, B., Lindberg, C., & Plsek, P. (2001). *Edgeware. Insights from Complexity Science or Health Care Leaders* (2nd ed.). Irving, TX: VHA Inc