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Impact of a Leadership Development Program on Perceptions of Structural Empowerment, Leadership Self-Efficacy, and Staff Nurse Clinical Leadership

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DNP Final Project

Impact of a Leadership Development Program on Perceptions of Structural Empowerment,
Leadership Self-Efficacy, and Staff Nurse Clinical Leadership

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IMPACT OF A LEADERSHIP DEVELOPMENT PROGRAM

Dedication

Work of this nature would not be possible without the constant support of family. Therefore, my dedication begins with an expression of love for my wife Lindsey, daughter Emerson, son Ellis, and Leo our canine companion. I am honored to have you on my team and I love you. I'm inspired daily by the impact of my mother and father on my life. You both are incredible role models, not because you're always right, but instead because you're willing to be wrong. You've taught me vulnerability, acceptance, dedication, compassion, and gratitude. Thank you for helping make this possible. I hope I make you proud. For all of this, and so much more, I am the luckiest man alive. I love you all.

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Abstract

BACKGROUND: In order to serve as full partners on the interdisciplinary health care team: nurses at all levels must develop essential leadership competencies. Organizations need to identify the essential leadership competencies required for bedside nursing staff and develop programs to enhance these competencies. Leadership competencies in areas such as managing change can help bedside nursing staff improve care delivery and quality outcomes.

PURPOSE: The purpose of this project was to evaluate the impact of an established leadership development program on participants' perceptions of structural empowerment, leadership self-efficacy, and staff nurse clinical leadership in one university health system.

METHODS: The pilot study was a single center, prospective pre-test, post-test design. Nurses in the 2017 Leaders in Training (LIT) program completed surveys which measured their perceptions of structural empowerment, confidence in performance of leadership skills, and ability to employ transformational leadership practices at the bedside.

RESULTS: The pre- and post-survey mean empowerment and clinical leadership findings did not differ significantly. Themes generated from the Clinical Nurse Leader Self-Efficacy Survey responses indicated participants felt high levels of confidence when performing the roles of client advocate, peer mentor, and professional practice leader. Participants reported a lack in confidence when asked to manage health of populations and for assignments requiring financial management and business skills.

CONCLUSION: This project added to our understanding of the needs of program participants, the relevance of program content, and the ability of participants to translate knowledge to action at the bedside

Keywords: leader, clinical, nurse, develop, empower, self-efficacy

Impact of a Leadership Development Program on Perceptions of Structural Empowerment,
Leadership Self-Efficacy, and Staff Nurse Clinical Leadership

Introduction

Health care in the United States (U.S.) has undergone extreme change in the modern era, sparked in 1999 by the release of the Institute of Medicine (IOM) report, *To Err is Human, Building a Safer Health System*. Since the report's demands for improved quality and safety, medical practice environments are frequent targets of heavy public scrutiny. Increased media attention, targeted legislative initiatives, and regulatory agency pressures demand improved performance of U.S. health care centers and therefore, test the professionals who provide these services (Sadaniantz, 2015). In 2010, the signing of the Patient Protection and Affordable Care Act paired additional pressures for improved outcomes with system financial reforms aimed to halt rising costs. These, along with the growing need for health care services result in a system desperate for effective leadership.

Strong leadership is important to the success of any organization. As the largest professional component in the U.S. health care workforce, nursing leadership is needed to meet the mounting pressures on the nation's healthcare system. It is imperative that all nurses, from the bedside to the boardroom, develop essential leadership competencies and serve as full partners on the interdisciplinary health care team (IOM, 2011).

Leadership training in undergraduate nursing curricula is limited; therefore, nurses may either seek graduate levels of education or rely on their employers to provide education through internal programs. Nurses who seek master's level education in nursing leadership may obtain the Clinical Nurse Leader (CNL®) distinction as established by the American Association of Colleges of Nursing (AACN). Conversely, many organizations have created independent

programs designed to enhance the leadership skills of their bedside nursing staff. The focus of these is to engage and empower bedside nurses to display Staff Nurse Clinical Leadership (SNCL) behaviors to improve care delivery and quality outcomes. It is essential that these programs be tailored to meet specific competencies required for SNCL, such as effective communication, relational coordination, innovation, change management, and collaboration (Chavez & Yoder, 2014). Effective outcome evaluations are needed to ensure program objectives are met. The leadership development program for nurses in one university health system is lacking an evaluation process. The effectiveness of the program on the perceptions of structural empowerment, leadership self-efficacy, and SNCL are unknown.

Background

Organizations traditionally identify leaders as individuals in supervisory roles who possess formal titles. These formal titles may provide operational structures; however, they have little impact on individual performance or display of leadership characteristics. The most effective and influential health care leaders often exist in the organization's micro-system and are found doing the front-line work of patient care (Bohmer, 2013). Therefore, nurses at the bedside should be viewed as challengers to the traditional assumptions of leadership. These direct care nurses are the focus for this pilot project and are referenced as SNCL. Although SNCL possess no formal authority over others, they utilize influence on the health care team to accomplish shared objectives (Chavez & Yoder, 2014).

The AACN has reserved the formal title of CNL® for the master's prepared registered nurse leader. The CNL® is expected to be an "advanced generalist" employed to directly impact the clinical, functional, satisfaction and cost outcomes of their assigned unit or setting (Stanton, Lammon, & Williams, 2011, pg. 78). Although the AACN supports formal graduate level

preparation for those seeking the designation of CNL®, many believe that all professional registered nurses should be responsible for care coordination, process improvement efforts, and outcomes management in their roles (Erickson & Ditomassi, 2005; Pearson et al., 2009).

Organizations must recognize the value and importance of leadership development programs for bedside nursing staff in achieving site-specific goals as well as professional objectives for the future of nursing.

The Leaders in Training (LIT) program is a 6-month leadership development program designed to promote leadership discovery and skill acquisition for nurses interested in leadership careers. Program objectives were formed around three logical themes; leading self, leading others, and leading organizations. Although LIT was created to advance interest in formal leadership roles, the focus of this pilot was on development of nurse leaders at the bedside. Table 2 contains a brief summary of LIT curriculum topics, themes, and primary skill types utilized.

Historically, nursing has been considered a highly technical, functional, and task-driven profession, rooted in following the orders of others (IOM, 2011). Therefore, nursing education is focused on mastery of technical abilities, referred to as cognitive skills, and less on development of the non-cognitive skills. As a result, achieving the distinction as an expert clinician has been the primary gateway to leadership emergence for nurses.

Current literature highlights the importance of possessing greater non-cognitive as compared to technical skills for nurse leaders at the bedside. Effective communication (Stanley, 2006; Chavez & Yoder, 2014; Feltner, Mitchell, Norris, & Wolfle, 2008; Patrick, Laschinger, Wong, & Finegan, 2011), establishing vision and innovation (Cook, 2001 & Davidson, Elliott, & Daly, 2006), maintaining respect and fairness (Cook, 2001; Feltner et al., 2008, and motivating

and supporting peers (Cook, 2001; Feltner et al., 2008; Davidson et al., 2006), are skills most frequently cited as important for a clinical nurse leaders to possess. The presence of these characteristics is considered an antecedent to the feelings of empowerment by staff (Patrick et al., 2011; Fardellone, Musil, Smith, & Click, 2014), unity among teams (Feltner et al., 2008), and interdisciplinary team collaboration (Davidson et al., 2006).

Theoretical Framework

The expanded workplace empowerment model by Laschinger, Finegan, Shamian, & Wilk (2001) provided the theoretical framework for this pilot project. In this model, the authors propose that perceptions of structural empowerment engages modes of psychological empowerment. In this context, psychological empowerment emerges as confidence. Perceived confidence in the work setting results in positive work attitudes and behaviors, specifically SNCL behaviors; see figure 1. Kanter (1993) describes structural empowerment as the extent to which employees perceive they have access to opportunities, information, resources, and support necessary to accomplish tasks and/or goals. Education may be considered one example of information. A consequence to structural empowerment, psychological empowerment, is defined as the “state that employees must experience for empowerment interventions to be successful” (Laschinger, et. al., 2001, pg. 261). For example, employees may experience improved confidence in skill performance after receiving this education. Positive work behaviors and attitudes are the final consequence in the model. These could be recognized in health care organizations as positive clinical outcomes and/or goal attainment. Positive SNCL behaviors align with this category and manifest as clinical achievements, efficiency, relational coordination, team facilitation, and/or job satisfaction (Chavez & Yoder, 2014).

Purpose and Objectives

The purpose of this pilot project was to evaluate the impact of a leadership development program on participants' perceptions of structural empowerment, leadership self-efficacy, and staff nurse clinical leadership in one university health system. At the completion of the program, participants will report improved perceptions of:

1. Structural empowerment in their work environment as measured by the Conditions of Work Effectiveness Questionnaire-II (CWEQ-II).
2. Confidence in performance of the 9 practice competencies of the Clinical Nurse Leader as measured by the Clinical Nurse Leader Self-Efficacy Scale (CNLSES).
3. Utilization of transformational leadership practices at the bedside as measured by the Clinical Leadership Survey (CLS).

Methods

This study employed a pre-test, post-test design in which eligible participants were surveyed prior to, and within 2 weeks of completion of the LIT program.

Setting

This project was conducted at UK HealthCare in Lexington, Kentucky. UK HealthCare is the region's largest academic referral medical center attracting patients from six states and totaling over 37,000 discharges in 2015 (UK HealthCare, 2016). With over 9,000 employees, UK HealthCare holds several prominent recognitions including U.S. News and World Report's Best Regional Hospital and Magnet® designation for nursing. Kentucky is one of the most complex health care delivery environments in the country due to its high degree of illness as evidenced by a case complexity ranking in the 75th percentile (UK HealthCare, 2016).

Consequently, strong leadership is needed at all levels in order to meet the demands of the population.

Sample

Potential participants included members of the Fall 2017 cohort of the LIT program. All nurses in the organization are eligible to apply for acceptance, either through self-nomination or supervisor recommendation. Program co-directors select LIT participants after application review and in-person interview. Study participation was limited to only employees of UK HealthCare, therefore, 4 of the 12 members of the LIT program were ineligible. The final sample size for this pilot study was 8.

Procedure

Approval from the University of Kentucky Institutional Review Board (IRB) was obtained prior to the collection of data. The eligible participants were invited to take part in the study via the employee's official university email. The survey was available online via Qualtrics software and unique identifier codes were assigned to maintain anonymity.

Measures

Demographic information. Demographic information included age categories (18-24 years, 25-34 years, 35-44 years, 45-54 years, 44-64 years, and 65 + years), gender, education level (Bachelors, Masters, or Doctoral degree), and years in practice (Less than 1, 1-3, 4-6, 7-9, and 10+).

Empowerment. The CWEQ-II consists of 19 items, which measure Kanter's six components of structural empowerment (opportunity, information, support, resources, formal power, and informal power) (Laschinger, 2012). Response options for each item follow a 5-point Likert scale ranging from 1) 'a little' to 5) 'a lot.' Each survey subscale received a score (1-5)

based on the average of subscale items. A summative score was then calculated to derive the total empowerment score (range 6-30). Higher scores indicate higher perceptions of empowerment. Scores ranging 6-13 are described as low empowerment, 14-22 as moderate, and 23-30 as high (Laschinger, 2012). The CWEQ-II has shown consistent reliability and validity in numerous nursing studies among various specialties since 2000 (Laschinger, 2012).

Self-efficacy. The CNLSES is a relatively new survey, constructed and tested in 2011 (Gilmartin & Nokes, 2015). It consists of 35 items designed to measure the respondent's confidence in performance of each of the 9 practice competencies of the CNL®, population-based care, care planning, unit-based leadership, managing financial resources, team management, continuing education, mobilizing others, professional leadership, and mentoring (Gilmartin & Nokes, 2015). The authors constructed each survey item by combining Bandura's item-stem "In your practice as CNL®, how confident are you..." with adapted items from the *AACN Performance Evaluation Tool of the Practice Setting* to assess role competency (Gilmartin & Nokes, 2015). Overall, the survey measures self-efficacy of the participant to meet each of the competencies using a 5-point Likert scale ranging from 1) 'not at all confident' to 5) 'extremely confident'. Due to a small sample size, Gilmartin & Nokes (2015), could not assess the validity and/or reliability of the CNLSES using confirmatory factor analysis. However, the instrument was determined to be reliable by alternate methods, including a Principal Component Analysis and Cronbach's coefficient analysis of the indices. Due to limited variability in responses, each item was dichotomized as 'not at all confident to somewhat confident' versus 'very confident/extremely confident' for analysis purposes.

Leadership. The CLS was derived using the five practices of transformational leadership from Kouzes and Posner (2007). This survey contains 15 items rated using a 5-point Likert scale

ranging from 1) 'strongly disagree' to 5) 'strongly agree.' The responses reflect the use or display of these leadership practices by nurses at the bedside. A similar approach to the methods used in analysis of the CWEQ-II was used to compare pre- and post-survey data obtained in the CLS. First, survey questions were organized into subscales aligning with Kouzes and Posner's (2007) 5 practices of transformational leadership; challenge the process, establish a shared vision, enable others to act, model the way, and encourage the heart. An overall CLS score was calculated for the purposes of comparison in this study. This is calculated as the sum of the five subscale means. In 2011, Patrick, et al., determined evidence of preliminary construct validity of the CLS. Although further research is needed to replicate these results, the CLS was selected for this project because of its derivation in the Kouzes and Posner components. *The Leadership Challenge* is one of the texts utilized in the program; therefore, the curriculum highlights these components of transformational leadership gauged by the CLS (Kouzes & Posner, 2007).

Data Analysis

Frequency distributions were used to describe participants' demographic characteristics. The Independent sample t-test was used to compare perception of empowerment and leadership between pre-survey and post-survey periods. Fisher's exact test compared the dichotomized self-efficacy measures over time. All analyses were conducted using SPSS version 24; an [*alpha*] level of .05 was used for statistical significance.

Results

Sample Characteristics

A 100% response rate was achieved for pre-survey, while only 7 of the 8 participants completed the post-survey (87.5%). Participants ranged in age from 25 and 44 years, but the majority were between the ages of 25-34 (62.5%; see Table 3). The majority identified with the

female gender (62.5%) and held a bachelor's degree in nursing (BSN) (87.5%). Years in practice as a registered nurse ranged from 1 to 9 years. Four (50%) reported 1-3 years, 3 (37.5%) reported 4-6 years, and 1 (12.5%) respondent reported 7-9 years of clinical practice.

CWEQ-II Results

An independent sample t-test was performed to compare the overall structural empowerment scores of participants between pre- and post-survey periods. Testing revealed an insignificant statistical difference in mean overall empowerment scores between the pre-survey ($M = 22.82$, $SD = 3.67$) and post-survey ($M = 23.81$, $SD = 2.73$) periods; $t(13) = -.58$, $p = .57$; see Table 4. Mean scores at both time points met the borderline moderate/high level of empowerment based on scale cutoffs. Although there was no statistically significant increase, mean scores increased across 5 of the 6 subscales (information, support, resources, job activity scale, and organization relationship scale) over the survey period.

CNLSES Results

Percentages of low confidence and high confidence were calculated for each of the self-efficacy items pre- and post-survey. The five highest and lowest confidence items were selected and themes identified. Table 5 contains the detailed analysis for each of these 10 questions. Thematic analysis indicated participants felt most confident in their ability to act as a client advocate, peer mentor, and professional practice leader. Conversely, participants reported lacking confidence in managing health of populations and matters requiring skills of financial and business acumen. There was no significant change in self-efficacy over time.

CLS Results

The independent samples t-test was conducted to compare the overall CLS mean scores between the pre- and post-survey periods. As with the prior surveys, there was not a significant

difference in the pre-survey ($M = 22.14$, $SD = 2.06$) and post-survey ($M = 23.00$, $SD = 2.29$) periods; $t(12) = -.735$, $p = 0.48$; see Table 6. Although statistical significance was not achieved, review of the subscale data revealed improvements in 4 of the 5 means between the pre- and post-survey periods.

Discussion

Although the results did not indicate significance based on the statistical analyses performed, for the purposes of this pilot, practical relevance was achieved. An increase in overall mean scores was obtained after completing the LIT program for both the CWEQ-II and CLS, indicating increased perceptions of structural empowerment and active engagement in transformational leadership behaviors at the bedside when comparing before and after LIT program completion.

Considerable attention should be given to the interpretation of the overall empowerment scores. As mentioned previously, higher overall empowerment scores indicate stronger perceptions of empowerment in the work environment. According to the author's scale, participants perceived moderate levels of empowerment during the pre-survey period. An increase in the post-survey overall mean indicates that respondents perceived high levels of empowerment in the same work environments on the post-survey. Analysis of the organization relationship scale of the CWEQ-II also align with increased perceptions of structural empowerment. Substantial increases in the mean score for this individual item indicated that participants had strong feelings of informal power after program completion. Kanter defines power as "the ability to mobilize information, resources, and support to get things done" (Laschinger, 2012, para. 1). Specifically, informal power relates to the personal alliances and relationships within an organization. Therefore, it is not surprising that the increased means for

the information, support, and resources subscales resulted in strong feelings of informal power by the participants at program's end. Interestingly, the mean score for the opportunity subscale decreased from pre- to post-survey. It is likely that this finding is incidental, although it may warrant further clarification in future studies. Opportunity, in this context, refers to the perceived possibility for growth within an organization (Laschinger, 2012). If LIT participants do not perceive opportunity for growth, the likelihood for recidivism may potentially increase. Trending of this item may be important in the organization when considering retention of program graduates for future positions.

The lack of confidence in the management of population health is one highly concerning theme revealed in the CNLSES. Managing health of populations may be a concept not well understood by nurses who entered professional practice, within the last 5 years. However, organizations are focusing significant resources toward implementation of various population health strategies. Strong nursing leadership is crucial to sustaining these initiatives. In relation to the future of healthcare, the nursing workforce, and nursing leadership, it is important to explore this lack of confidence. Likewise, investigating the lack of confidence in the display of business acumen should be considered with a similar sense of urgency. Understanding concepts of the health care business is necessary in order for bedside leaders to execute these strategies and impact patient outcomes.

The CLS was specifically selected for use in this project because of its close relationship to the transformational practices in *The Leadership Challenge* (Kouzes & Posner, 2007). Since statistical significance was not achieved, practical relevance must be discussed. Improvements in four of the five subscale means between the pre- and post-survey periods may indicate close association of curriculum content and practice experience. In other words, program participants

translated learned concepts from the program to the bedside and in most cases more frequently. This is extremely relevant in program evaluation.

Participants rated items in the “inspiring a shared vision” subscale most differently after completing the LIT program. Items in this category refer to the concepts of collaboration, building consensus, and effective communication. These important non-cognitive skills, identified earlier, also contribute to feelings of overall workplace empowerment and improved patient outcomes. Recent literature indicates that patients who perceive effective communication and being involved in their plans of care experience fewer hospital readmissions (Choate & McCrory, 2017). Future data trending may be expanded to attempt correlation of specific patient outcomes with nursing care received from LIT graduates.

Limitations

This project had several limitations that hindered generalization of the results, primarily the small sample size. Although, unpreventable, this small sample limits the statistical strength of the evidence in the findings. Consistent application of this evaluation model would need to be applied to future LIT participants in order for data trends to be analyzed. Another limitation of this project, which challenges the results, was the use of the CNLSES as a survey tool. The CNLSES was only validated for assessing self-efficacy of those with formal CNL® preparation and credentialing. Questions were designed to elicit responses focused specifically on the practice competencies for this role. Those without this educational preparation would likely not be familiar with these topics and therefore misinterpret items on the survey. Selection of an alternate survey to assess self-efficacy should be considered in future evaluations. Finally, due to the anonymous nature of the survey, paired-samples were not possible. Strength of evidence

would have improved with a more thorough study design aimed at measuring impact on individuals versus the overall group response.

Implications for practice

This pilot project produced relevant, practical, evidence for LIT coordinators to continue program dissemination. Although, the overall impact of this program on organizational objectives is not known, it was clear that participants experienced improved feelings of organizational empowerment and increased engagement in leadership practices at the bedside. Three major considerations are recommended for consideration during future curriculum revisions. First, non-cognitive skill development should remain a priority focus in the curriculum. Non-cognitive skills translate across all aspects of nursing practice; therefore, their importance is universal. Since these skills act as a significant contributor to feelings of empowerment and quality outcomes for both nurses and patients, the focus on the “soft skills” should remain. Next, valuable information was learned through careful evaluation of the CNLSES high and low confidence themes. The inclusion of elements that allow participants to gain more experiences with financial and business concepts is one consideration for inclusion in the LIT program. Program coordinators should carefully consider the feedback of participants to tailor programmatic elements where appropriate. However, the program objectives, if appropriately defined, should not be compromised based entirely on participant feedback. Finally, program coordinators must communicate to senior leadership that these respondents reported negative perceptions of opportunity for growth within the organization. Failure to further investigate this information may affect the ability of the organization to remain responsive and flexible in a rapidly changing market.

Conclusion

Although the results did not indicate significance based on the statistical analyses performed, for the purposes of this pilot project, practical relevance was established. Engaging LIT participants in a formalized program evaluation is an important process to ensure relevance and success of future programs. This project added to our understanding of the needs of program participants, the relevance of program content, and the ability of participants to translate knowledge to action at the bedside. Consistent evaluation of the LIT program using formalized structures is necessary to validate program success.

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Table 1

Study Variables

Variable Name	Measure	Level of Measure	Time of Measurement	Statistical Analysis	Data Source
Outcome Variables					
Staff Nurse Clinical Leadership	Clinical Leadership Survey (CLS)	Continuous	Pre & Post-intervention	Means (SD); Independent sample t-test	Survey
Leadership Self-Efficacy	Clinical Nurse Leader Self-Efficacy Scale (CNLSES)	Continuous	Pre & Post-intervention	Means (SD); Independent sample t-test	Survey
Structural Empowerment	Conditions of Work Effectiveness Questionnaire (CWEQ-II)	Continuous (6-30)	Pre & Post-intervention	Means (SD); Independent sample t-test	Survey
Demographic Variables					
Age	18-24 25-34 35-44 45-54 55-64 65+	Ordinal	Pre-intervention	Frequencies	Survey
Gender	Female Male Non-Binary/Third Gender Prefer not to say	Nominal	Pre-intervention	Frequencies	Survey
Education level	ADN BSN MSN DNP/PhD	Nominal	Pre-intervention	Frequencies	Survey
Years in practice	Less than 1 year 1-3 years 4-6 years 7-9 years 10+ years	Ordinal	Pre-intervention	Frequencies	Survey

Table 2*LIT Curriculum Summary*

Class	Topic	Theme	Skill type
1	Elements of professional practice	Leading self	Non-Cognitive
2	Self-reflection & understanding self (DISC assessment)	Leading self	Non-Cognitive
3	Project Management (8 step process)	Leading change	Cognitive
4	Educational advancement, professional development, & career planning	Leading self	Cognitive
5	Value system analysis (personal, professional, leadership style)	Leading self	Non-Cognitive
6	Managing Infrastructure (staffing, resources/demand, Using data)	Leading Orgs	Cognitive
7	Managing Infrastructure (Quality/Safety, NSI, regulatory, compliance)	Leading Orgs	Cognitive
8	Managing others (Hiring, strategy, goal setting, HR)	Leading others	Cognitive
9	Managing others (crucial conversations, Appreciative Inquiry, communication, coaching)	Leading others	Non-Cognitive
10	Managing Others (Emotional intelligence)	Leading others	Non-Cognitive
11	Managing others (meetings, collaboration, c-suite dealings)	Leading others	Non-Cognitive
12	Managing others (legal & ethical implications, culture management)	Leading others	Non-Cognitive
13	Final Class - presentations	n/a	

Table 3

Sample Demographic Characteristics (N=8)

Variable	Frequency	Percent
Gender		
Female	5	62.5
Male	3	37.5
Age Range		
25-34	5	62.5
35-44	3	37.5
Educational Degree		
Bachelors	7	87.5
Masters	1	12.5
Years as Bedside RN		
1-3	4	50
4-6	3	37.5
7-9	1	12.5

Table 4

Summary Statistics for Conditions of Work Effectiveness Questionnaire-II (CWEQ-II)

CWEQ-II Subscale	Time	N	Mean	SD	p
Opportunity	Pre	8	4.37	0.57	0.24
	Post	7	4.00	0.61	
Information	Pre	8	3.87	0.59	0.20
	Post	7	4.24	0.42	
Support	Pre	8	3.75	0.85	0.71
	Post	7	3.90	0.74	
Resources	Pre	8	3.25	0.83	0.44
	Post	7	3.57	0.71	
Job Activity Scale	Pre	8	3.42	0.97	0.60
	Post	7	3.67	0.79	
Organization Relationship Scale	Pre	8	4.16	0.75	0.38
	Post	7	4.43	0.28	
Overall Empowerment Score	Pre	8	22.82	3.67	0.57
	Post	7	23.81	2.73	

Table 5

Summary Statistics for Clinical Nurse Leader Self-Efficacy Survey (CNLSES)

How confident are you that you can:	Time	N	Count	% Low Confidence
Use information systems to track population-level clinical outcomes	Pre	8	7	87.5
	Post	7	4	57.1
Resolve population health problems	Pre	8	6	75.0
	Post	7	5	71.4
Identify opportunities for revenue enhancement to benefit clients	Pre	8	6	75.0
	Post	7	5	83.3
Create proposals to modify your unit using alternative business models	Pre	8	6	75.0
	Post	7	4	57.1
Create proposals to modify your unit incorporating return on investment analysis	Pre	8	6	75.0
	Post	7	7	100
How confident are you that you can:				
How confident are you that you can:	Time	N	Count	% High Confidence
Advocate effectively on behalf of the client with the intervention team	Pre	8	8	100
	Post	7	7	100
Mentor other CNLs	Pre	8	8	100
	Post	7	5	71.4
Represent your unit on organizational committees	Pre	8	8	100
	Post	7	7	100
Act as a leader in relevant professional organizations	Pre	8	8	100
	Post	7	5	71.4
Practice in accordance with the values of the organization.	Pre	8	7	87.5
	Post	7	7	100

Table 6*Summary Statistics for Clinical Leadership Survey (CLS)*

CLS Subscale	Time	N	Mean	SD	p
Challenge the Process	Pre	7	4.62	0.36	1.0
	Post	7	4.62	0.40	
Shared Vision	Pre	7	4.33	0.54	0.19
	Post	7	4.71	0.49	
Enable Others to Act	Pre	7	4.48	0.38	0.55
	Post	7	4.62	0.49	
Model the Way	Pre	7	4.57	0.42	0.86
	Post	7	4.62	0.56	
Encourage the Heart	Pre	7	4.14	0.72	0.42
	Post	7	4.43	0.57	
Global CLS	Pre	7	4.43	0.53	0.60
	Post	7	4.57	0.45	
CLS Subscale Total	Pre	7	22.14	2.06	0.48
	Post	7	23.00	2.29	

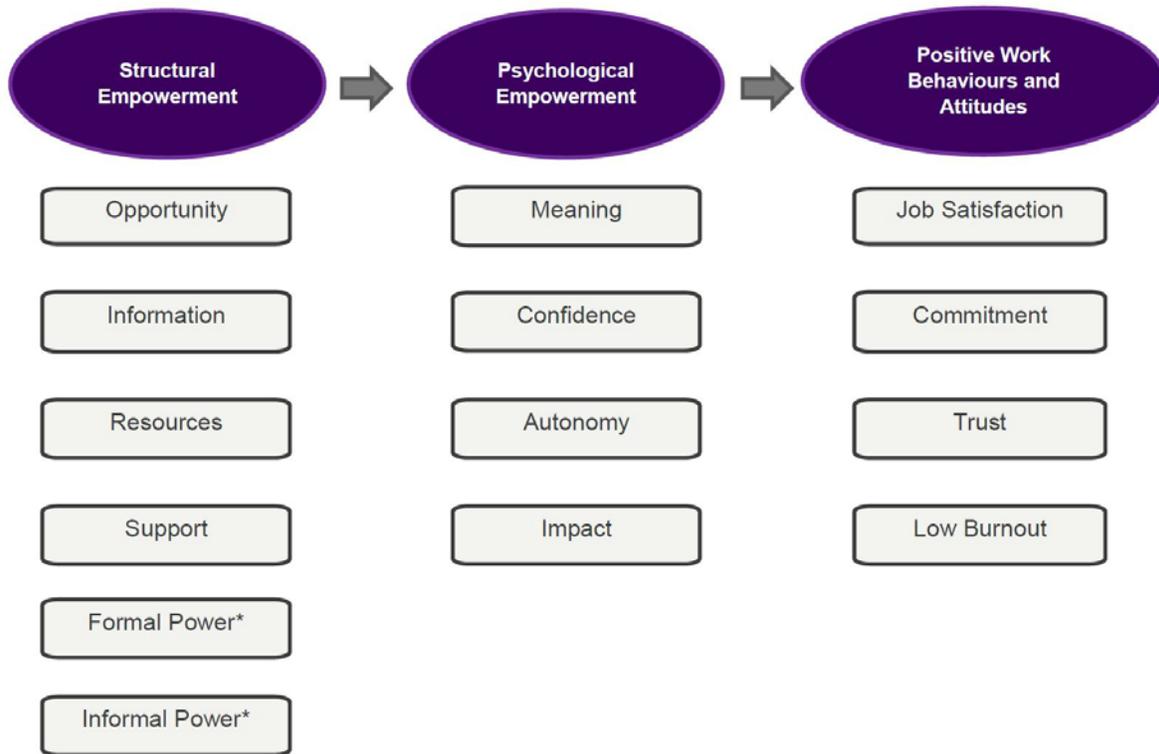


Figure 1. Expanded Workplace Empowerment Model. Graphic from Laschinger, H. K. S. (2012).

Conditions for Work Effectiveness Questionnaire I and II [User Manual]. Published instrument. Retrieved from <http://www.uwo.ca/fhs/hkl/cweq.html>