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Action-logics of Veterans Health Administration Magnet nurse executives and their practice of supporting nurses to speak up

Bonnie R. Pierce

Pepperdine University

Graduate School of Education and Psychology

ACTION-LOGICS OF VETERANS HEALTH ADMINISTRATION MAGNET NURSE

EXECUTIVES AND THEIR PRACTICE OF SUPPORTING NURSES TO SPEAK UP

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Bonnie R. Pierce

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Susan Nero, Ph.D. – Dissertation Chairperson

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Bonnie R. Pierce

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

Doctoral Committee:

Susan Nero, Ph.D., Chairperson

Kay Davis, Ed.D.

Kent Rhodes, Ed.D.

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DEDICATION

I dedicate this dissertation to the numerous people I have the great fortune to love. The ones I will name here are my husband, Robert Gay Guthrie; my parents, Reverends Nolan and Barbara Pierce; my daughter, Andrea Janeé Austin and her husband Jarrett; my step-children Ann Enseñat Delozier and Paul Guthrie; my brothers, Larry and Harvey Pierce; my grandchildren Kaienta Marie Enseñat Delozier, Nicholas Kaden Austin, Sofia Enseñat, and Sydney Austin; and my best friend forever Lea Denise Cain. You have sacrificed and supported me while I have gone through the incredibly challenging and transformational process of doctoral work. You have touched me with your love, kindness and understanding. You also inspired me to do the doctoral work, and now you inspire me to work hard to make a difference. I dedicate the rest of my career to the pursuit of improving health care quality and helping front-line staff and you, my loved ones, speak up so that you can get the care you deserve.

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VITA

Bonnie R. Pierce

Education

Doctor of Education in Organization Change   2015
Pepperdine University, Malibu, California

Master of Science in Nursing with a focus in Administration   2000
California State University, Dominguez Hills, California

Bachelor of Science in Nursing   1996
California State University, Dominguez Hills, California

Diploma in Nursing   1977
Methodist Hospital School of Nursing, Lubbock, Texas

Experience

Associate Director Patient Care Services/Nurse Executive   2008 to present
Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

Associate Chief Nursing Service Financial Management Program   2005 to 2008
VA Greater Los Angeles Healthcare System, Los Angeles, California

Assistant Chief Nursing Service Geriatrics and Extended Care   2001 to 2005
VA Greater Los Angeles Healthcare System, Los Angeles, California

Nurse Manager, 4W Medicine and Oncology   2000 to 2001
Jerry L. Pettis VA Medical Center, Loma Linda, California

Nurse Manager, 1 South Nursing Home Care Unit   1994 to 2000
Jerry L. Pettis VA Medical Center, Loma Linda, California

Staff Nurse, Perioperative Care   1990 to 1994
Jerry L. Pettis VA Medical Center, Loma Linda, California

Psychiatric Inpatient and Short Stay Surgery Staff Nurse   1987 to 1989
St. Mary's Hospital, Enid, Oklahoma

Office and Scrub Nurse   1983 to 1987
Terry L. Carlberg, D.M.D, Santa Fe, New Mexico

Operating Room Staff Nurse   1980 to 1983
St. Vincent Hospital, Santa Fe, New Mexico

ABSTRACT

Health care organizations typically have a hierarchical structure, with physicians dominant and nurses subordinate. The challenge to open and honest communication between doctors and nurses is real, and communication errors contribute significantly to undesirable patient outcomes. Nurse executives (NEs) have a responsibility to help lead transformation of health care organizations to support nurses to speak up and communicate all critical information.

NEs are challenged to improve safety and quality, decrease costs and increase access to care. Combining health care expertise with business ability can support these goals. Rooke and Torbert found correlations between successful business leaders and postconventional action-logics, or world-views. Action-logics can be developed to make leaders increasingly effective.

The Magnet Recognition Program recognizes health care organizations that have achieved high quality care and excellence in nursing practice. The purpose of this study was to determine what action-logics the NEs demonstrate who have led their organizations to Magnet designation or re-designation in the Veterans Healthcare Administration. The study also sought to determine what actions NEs took to support nurses speaking up about their concerns, the barriers that impede those efforts, and the sources of influence these NEs implemented to support   nurses speaking up. This exploratory study used a mixed methods design and each participant completed the Maturity Assessment Instrument (MAP) and an interview.

The study demonstrated, in contrast with other business leaders, that conventional action-logic was sufficient for the NE to bring an organization to Magnet status. However, the study found specific limitations those possessing conventional action-logic have to support speaking up, and that those possessing postconventional action-logic have transcended these limitations. This strength of the postconventional action-logic is very important to support speaking up in

health care. The use of multiple sources of behavioral influence by Magnet NEs was confirmed, as was the existence of a culture of organizational silence. Multiple speaking up behaviors were required to address every single barrier encountered to speaking up, and strong emotion routinely accompanied speaking up. The absence of sources of behavioral influence in an organization was determined to be a barrier to speaking up.

Chapter 1. Health Care Challenges, the Nurse Executive, and Adult Development

Introduction

Health care is at a turning point in the United States. The role of leadership in health care is receiving more attention, as the focus has become the need for quality care at an affordable price for as many people as possible. In Britain, the National Health Service (NHS) faces problems similar to that of the Veterans Health Administration (VHA) in the United States. In Ireland, health services were reorganized to increase access, efficiency, and effectiveness, by launching a transformation program in the late 1990s (Jarman, 2007). The U. S. health care system is funded at the will of the politically powerful and must provide quality while responding to ever-increasing demands for care (Jasper & Jumaa, 2005). This convergence of increased demand within an environment in which the competition for resources is intense has brought both the NHS and VHA into an era in which combining health care expertise with business acumen will be important to their continued success. The need for reform in health care has been apparent for decades, and Welford (2007) emphasized that health care professionals must understand theories of transformational leadership to ensure success in the changes to come.

Health care reform has become a topic that is frequently and hotly debated in the United States. In March 2010 President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. This legislation is the most sweeping change in health care law since 1965 (Institute of Medicine, 2010). In November 2010 over 58 members of Congress who voted for reform were voted out of office. The new health care law was cited as one of the principle reasons voters made significant changes in the makeup of Congress in the mid-term elections (Zeleny, 2010). In March 2012 the Supreme Court heard arguments for and against the

constitutionality of the PPACA. The ruling came on June 28, 2012. The Supreme Court

supported the constitutionality of the act, including the individual mandate, a provision that

requires Americans to buy health insurance or be subject to a penalty (Negrin & Vogue, 2012).

Key reasons that health care reform has become an urgent issue have to do with health care costs,

health care quality, and the unequal access to health care in the United States.

Health Care Cost Challenges

Health care costs in the United States have increased from 9 percent of the gross

domestic product (GDP) in 1980 (Stanton & Rutherford, 2006) to 17.90 percent of the GDP in

2011 (Central Intelligence Agency, 2014). Although there are some economists who have stated

that this level of spending, along with continued increases with health care costs at 1% greater

than the GDP, is affordable through 2075 (Chernew, Hirth, & Cutler, 2003), the most common

interpretation is that this rate of increase and level of spending on health care is unaffordable and

unsustainable (Skeen, 2007). In 2007, the Congressional Budget Office (CBO) estimated that

health care would consume 25% of the GDP by 2025 and 37% of the GDP by 2050. These

estimates were based on historical growth patterns in health care spending as well as historical

actions by Congress (Skeen, 2007). The PPACA, if fully implemented, would decrease the

budget deficit by $210 billion in the 10-year period between 2012 and 2021. The passage of HR

2, the Repealing the Job-Killing Health Care Law Act of 2011 would increase the federal budget

deficit by $210 billion over the same 10-year period (Congressional Budget Office, 2011). The

debate continues.

Health Care Quality Challenges

Although the United States spends 17.90 percent of its GDP on health care, the quality of

health care is poorer than in many industrialized nations who spend much less of their GDP on

health care. Although spending on health care as a proportion of our GDP is third in the world, the United States ranks 42nd in healthy life expectancy internationally (Central Intelligence Agency, 2014). Healthy life expectancy is an important indicator of health in a country.

The challenges within the U. S. health care system for achieving high quality became the focus of the Institute of Medicine (IOM) in the late 1990s. The IOM published a ground-breaking report entitled *To Err is Human* on the prevalence of medical errors in the United States (Institute of Medicine Committee on Quality, 1999), stating that at least 44,000 and up to possibly 98,000 people die in the this country per year due to preventable medical errors. This report made recommendations for creating a safe health care system, including building leadership's focus on the importance of safety and creating safe practices at the point of care. More recently, James (2013) performed a review of articles reporting medical errors in hospitals in the United States. James estimated that at least 210,000 deaths occur per year in hospitals that are associated with medical errors. He further estimated that the actual number of premature deaths associated with medical errors is approximately 440,000 per year. James estimated the higher number due to limitations in the Global Trigger Tool that he used for the review, as well as the incompleteness of the medical records reviewed.

In 2001 the IOM urged reinvention of the health care system (Institute of Medicine Committee on Quality, 2001), stating that incremental change could not produce the needed improvements in health care delivery. The IOM stressed the importance of achieving six aims in health care: to make it safe, effective, patient-centered, timely, efficient, and equitable. These aims should be accomplished through imagination and innovation at all levels, not through one prescribed method (Institute of Medicine Committee on Quality, 2001).

The Department of Health and Human Services (DHHS) asked the IOM to study important elements of the working environment of nurses that impact patient safety and to study potential improvements in that environment that could improve patient safety. This study recognized that how nurses care for patients impacts the health of patients and can determine whether they live or die (Committee on the Work Environment for Nurses and Patient Safety, 2004). This study urged fundamental changes throughout health care organizations that will require transformational leadership to change physical environments, beliefs, and practices of nurses and multiple other disciplines and the mindsets of health care leaders and managers (Committee on the Work Environment for Nurses and Patient Safety, 2004).

Quality outcomes in health care are assessed by The Joint Commission (TJC), a non-profit agency (The Joint Commission, 2011a). TJC certifies health care organizations that have high quality procedures and outcomes, and it maintains a database on sentinel events. A sentinel event is an "event in which death or serious harm occurred" (The Joint Commission, 2015a, para. 6). Ongoing review of sentinel events has revealed that communication breakdown is commonly one of the fundamental reasons for the failure or inefficiency of processes and contributes to sentinel events (The Joint Commission, 2011b).

Health Care Access Challenges

One possible contributor to the United States' poor health care outcomes relative to cost may be limited access to care for many U.S. citizens. Prior to the implementation of the Affordable Care Act, over 50 million Americans were uninsured and at risk of financial ruin if they experienced a serious illness. Because they engaged in very little preventative care, when they do seek care their illnesses are more advanced and more expensive to treat (The Kaiser

Commission on Medicaid and the Uninsured, 2010). If the health care reforms passed in 2010 are fully implemented, an additional 32 million Americans will be insured by 2019.

The World Health Organization (Evans, Elovainio, & Humphreys, 2010) promotes universal coverage for health care and recognizes several challenges to achieving this goal:

1. How is such a health system to be financed?

2. How can they protect people from the financial consequences of ill health and paying for health services?

3. How can they encourage the optimum use of available resources? (p. 7)

Further discussion about the optimum use of resources focuses on several opportunities for increasing efficiency:

- Get the most out of technologies and health services.

- Motivate health workers.

- Improve hospital efficiency.

- Get care right the first time by reducing medical errors.

- Eliminate waste and corruption.

- Critically assess what services are needed.

Conservatively speaking, about 20–40% of resources spent on health are wasted, resources that could be redirected towards achieving universal coverage (Evans et al., 2010, p. 15).

Nursing Initiatives Making a Difference

Although current health care costs, quality, and access present significant challenges to health care providers and consumers, a large segment of the health care workforce is working on

solutions. Nurses are the most numerous health care practitioners in the country (Bureau of Labor Statistics, 2010), and the nursing profession already has begun many initiatives.

Nurses have formed their own Clinical Scene Investigation (CSI) academy, using resources from *Partners Investing in Nursing's Future* (a collaboration between The Robert Wood Johnson Foundation and the Northwest Health Foundation) and local hospitals and health care foundations in the Kansas City area (Robert Wood Johnson Foundation, 2011). Nurse leaders designed the CSI academy and got engagement and support from seven local hospitals with the goal of improving outcomes for patients in their facilities. This nurse-led initiative was intended to empower nurses to make changes they saw were needed at the point of care delivery. This effort succeeded in reducing the incidence of pressure ulcers, reduced medical errors at shift handoff, and improved pain management in pediatric patients. These accomplishments both improved quality and saved costs. One hospital estimates savings of over $250,000 per year (Robert Wood Johnson Foundation, 2011).

Two separate studies in Missouri found positive results using nursing care coordination (NCC) for elders living in the community who had qualified for nursing home care but stayed at home receiving care coordination by registered nurses. One study found that NCC saved $686 in monthly Medicare costs while increasing monthly Medicaid costs by $203 compared to a control group without nursing care coordination (Marek, Adams, Stetzer, Popejoy, & Rantz, 2010). Including the costs of nursing care coordination, the overall savings was $350 per month per patient. The other study on patient outcomes found that patients receiving NCC had no statistically significant improvements at eight months, but did have statistically significant improvements in pain, dyspnea, and activities of daily living after the intervention had been in

place for 12 months (Marek, Popejoy, Petroski, & Rantz, 2006). The authors recommend further study of NCC for community care for the elderly.

The Robert Wood Johnson Foundation reviewed their grant-supported research in 2010 and selected research on the role of nurse practitioner (NP) in primary care as one of the five most influential research articles on the field of health care in 2010. Naylor and Kurtzman (2010) found that 70 to 80% of patients have greater satisfaction with NP care than physician care and better results when NPs provide assessment, screening, follow-up, and counseling. This improved level of care was produced at 20 to 35% less cost than for a physician visit. Indeed, nurses have the opportunity to have an impact on lowering cost, improving quality, and improving access (Fateux, 2009).

Health Care Quality and Communication Breakdowns

Existing health care organizations involve the work of multiple disciplines, each with its own distinct knowledge base, that work together on behalf of the patient. The differences in thinking that are inherent in each discipline can and do result in difficulties in communication and the working together upon which the patient relies (Marshall, 2011). Additionally, the tendency to have a hierarchical structure in health care, with physicians at the top of the hierarchy, creates a power differential in which the nurse commonly holds less power in interactions than physicians and other doctorally prepared team members. The nurse will often have to speak up to someone with more power in the culture than she or he has been given, and when this speaking involves addressing inappropriate behavior, it can be extremely uncomfortable to do so. Yet nurses are responsible for providing direct care as well as observing and maintaining safe care practices regardless of the discipline engaged in the practice. The

potential challenge to open and honest communication is real, as is the potential threat to the patient if all health care staff do not use safe practices.

Communication within health care has been increasingly studied because it contributes significantly to sentinel events and other undesired outcomes. A recent study (Maxfield, Grenny, Lavandero, & Groah, 2011) revealed that there are two types of communication breakdowns: honest mistakes and undiscussables. The honest mistakes happen spontaneously and are true human error. The undiscussables are deliberately not discussed (Argyris, 1999) because people feel unsafe or unmotivated to do so. The three most common undiscussables are dangerous shortcuts, incompetence, and disrespect. Maxfield et al. (2011) claimed this silence keeps safety tools from working. Safety tools are checklists, protocols, and warning systems that are used to standardize work into evidence-based practices that research has demonstrated will result in optimal outcomes. Maxfield et al. (2011) found that over 17% of nurses used safety tools that had warned them of a dangerous situation a few times a month, yet they were unable to speak up and get anyone to listen. They were unable to speak up or be heard because they lacked the personal motivation or ability, the social motivation or ability, or the structural motivation or ability established in their work environment to support speaking up.

In another study involving over 1700 health care respondents (including nurses, physicians, clinical care staff, and administration), a majority of them observed incompetence, willful disregard for rules, or human error on a frequent basis and did not say anything to the offender (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005). This same study revealed that between 5% and 15% of health care workers do speak up and produce good results for their patients and their hospitals.

Maxfield et al. (2011) gave an example of a nurse using checklists and protocols and a surgeon disregarding both:

> A special graft was ordered and due to arrive at 10:00. The surgeon insisted the day before he had to have this particular graft. The day of surgery the graft was not yet physically in the building but the surgeon insisted we put the patient to sleep. My stand was that unless you were prepared to use something else we should wait until it arrived. All of our checklists and protocols require that all implants and necessary items are available before the case begins. The surgeon said he would [get the graft] if necessary. I felt we were jeopardizing patient care, setting a poor example to the staff and why do we go through all these things in the first place? (p. 3)

The concern of the nurse in this instance was to protect the patient from increased anesthesia time and from possibly receiving the wrong implant. However, the nurse felt unable to discuss the problem with the surgeon or administrative staff who might have been able to intervene. Because the nurse was unable to speak up, it was not possible to prevent the surgeon from taking the shortcut of anesthetizing the patient before the surgical case preparation was complete.

However, some nurses do speak up. The *Silent Treatment* study (Maxfield et al., 2011) revealed that 21% to 31% of nurses spoke up. Maxfield et al. (2011) gave an example of speaking up:

> [I] described [to a colleague] the potential interaction between an antihypertensive drug and an over-the-counter drug the patient was taking. The colleague had not taken a full history of drug exposures, and was grateful for the reminder, agreed the interaction was important to note, and warned the patient not to take this class of over-the-counter medication. (p. 6)

The nurses who did speak up demonstrated several successful methods for doing so. The particular method nurses used to speak up varied depending on the level of urgency of a given situation. If time permitted they collected data, piloted an alternative, and quietly worked out solutions to address the issue, in reality avoiding speaking up but addressing the issue after the fact. In urgent situations they may have just spoken up. However, speaking up requires at least one and usually a combination of skills, including:

- explaining one's positive intent;

- making it safe for the other caregiver;

- using data;

- diffusing or deflecting the other person's negative emotion;

- not engaging in negative stories or accusations (Maxfield et al., 2011).

Nurses who spoke up held three things in common: none of them used threats, none showed their frustration or anger, and they all kept their own feelings in check (Maxfield et al., 2011). Several existing conditions helped the nurses to speak up:

- They had spoken up in the past and a patient had been protected.

- A patient had already been harmed and the incident was being reviewed.

- They had a strong trusting relationship with the person they needed to confront.

- One or more physicians had made it clear that they appreciate it when nurses speak up. (p. 6)

The examples above illustrate the nurses' personal motivation and personal ability to speak up. As the low number of nurses who do speak up in the current research suggests, organizations cannot rely on personal attributes of nurses alone to promote speaking up. In order to make undiscussables discussable, organizations will have to establish social and structural

elements to influence behavior to support speaking up (Maxfield et al., 2011). Sources of

behavioral influence described by Maxfield et al. (2011) are the following:

Source 1. Personal Motivation, a personal attribute in which a person wants to speak up

because they think it is a moral obligation.

Source 2. Personal Ability, a personal attribute in which a person has the knowledge and

skills they need to handle the toughest challenges of speaking up.

Source 3. Social Motivation, which includes one or more of the following: The people

around them (physicians, manager, and co-workers) encourage them to speak up when

they have concerns. The people they respect model speaking up.

Source 4. Social Ability, which includes one or more of the following: Others step in to

help people when they try to speak up. Others support them afterward so the risk doesn't

turn against them. Others around them offer coaching and advice for handling the

conversation in an effective way.

Source 5. Structural Motivation, which includes one or more of the following: The

organization rewards people who speak up and does not punish them. Speaking up is

included in performance reviews. Managers are held accountable for influencing these

behaviors.

Source 6. Structural Ability, which includes one or more of the following: The

organization establishes times, places, and tools that make it easy to speak up (surgical

pauses, Situation Background Assessment Recommendation –SBAR- handoffs, read back

policies, etc.). There are times and places when caregivers are encouraged to speak up.

The organization measures the frequency with which people are holding or not holding

these conversations, and uses these measures to keep management focused on speaking

up for patient safety. (p. 8)

Due to the magnitude of the existing problem of communication breakdowns that

contribute to poor outcomes and sentinel events, establishing organizations that have sufficient

psychological safety, competence in the workgroup, and respect for nurses to speak up is

required (Maxfield et al., 2011; Maxfield et al., 2005). The American Organization of Nurse

Executives (AONE) noted that it is the role of nurse executives (NEs) to help lead transformation

of health care organizations so that patient safety principles and practices are established across

multiple disciplines. Establishing an environment that supports nurses speaking up to

communicate critical information is part of this transformation (American Organization of Nurse

Executives, 2007).

The Role of the Nurse Executive

NEs lead nurses in every clinical setting. In their now expanded role, NE's also lead other

heath care staff, which may include chaplains, dieticians, social workers, pharmacists, and sterile

processing personnel. NEs may lead thousands or a few, but they are responsible for obtaining

resources and creating an environment that is healthy for nurses to work within and that is

healing for their patients (American Organization of Nurse Executives, 2011). The NE reports to

the health care organization's chief executive officer (CEO). As a member of the senior

leadership team, the NE role has expanded from a focus on the practice of nursing to encompass

accountability for the provision of patient care services across the entire health care continuum

(Nurses for a Healthier Tomorrow, 2006). The NE collaborates with all disciplines to design

patient care delivery systems, promotes and advances the practice of nursing, builds relationships

within organizations across multiple disciplines, makes connections and advocates for improved

outcomes across the spectrum of health care, and is a steward of human and financial resources. They are role models for nurses. NEs have the competency to address clinical care issues as well as to create and administer multi-million dollar budgets. They are corporate executives. They are thought leaders in advancing new ways of achieving excellence in nursing practice to provide health care that is safer, more cost-effective, and more accessible than ever before (American Organization of Nurse Executives, 2007, 2011; Nurses for a Healthier Tomorrow, 2006; Robert Wood Johnson Foundation, 2011).

Magnet Recognition as a Model for Excellence

The American Nurses Credentialing Center (ANCC) developed the Magnet Recognition Program to recognize health care organizations that have achieved high quality care and excellence in nursing practice (American Nurses Credentialing Center, 2005). Magnet designation is considered a benchmark by which consumers can expect to receive high quality care. The goals of the Magnet Recognition Program are to promote quality care through developing settings in which nurses engage in professional practice, excellence in care delivery, and the creation of best practices (American Nurses Credentialing Center, 2011). The vision of the ANCC for Magnet-recognized organizations is:

> ANCC Magnet-recognized organizations will serve as the fount of knowledge and expertise for the delivery of nursing care globally. Grounded in core Magnet principles, they will be flexible and constantly striving for discovery and innovation. They will lead the reformation of health care, the discipline of nursing, and the care of the patient, family, and community (American Nurses Credentialing Center, 2013, para. 2).

Magnet designation is achieved through years of work and transformation. These years and the effort undertaken in the process are commonly known as the magnet journey. This

journey requires that a facility develop, document, and demonstrate the 14 forces of magnetism.
The forces of magnetism are clearly defined so that each force describes an attribute of the
organization that supports a healthy and creative environment for providing nursing care. The
original 14 forces of magnetism are now arranged into five components that comprise the
Magnet Recognition Program model. A description of the Magnet model that includes the 14
forces of magnetism follows (American Nurses Credentialing Center, 2013).

Transformational leadership (TL) is the first of five components of the model. The
ANCC (2008) defined *transformational leadership* as "Leadership that identifies and
communicates vision and values and asks for the involvement of the work group to achieve the
vision" (p. 45). This model component includes forces (1) quality of nursing leadership and (3)
management style (items in a list in Chapter 2). Magnet facilities must have a strong and
visionary NE who guides and supports excellence in nursing practice in a professional
environment. These leaders and the professional practice they develop elevate the standards of
the nursing profession (American Nurses Credentialing Center, 2011). Additionally, Maxfield et
al. (2011) noted that magnet organizations use a multifaceted approach to improve patient care,
and they use more sources of influence to support speaking up than are typically found in health
care organizations. In the current health care environment, transformational leadership is
necessary to create new ways of delivering care that are more efficient, safe, and accessible. This
level of innovation requires strategic thinking and sound implementation of change. The
remaining model components and the 14 forces of magnetism are described in Chapter 2.

The Role of the Nurse Executive in Achieving Magnet Recognition

The NE's role performance as an exemplary leader is critical for becoming recognized as
a magnet organization. The high-quality NE attracts high-quality middle managers, who then

create the environment that attracts and retains staff nurses. Elements necessary for the NE to attract and retain staff include enhanced nurse-patient ratios, clinical autonomy, and control over nursing practice, good nurse-physician relationships, support for education and professional development, and administrative support for decision-making at the bedside (McClure & Hinshaw, 2002).

The path a particular NE takes along the magnet journey is unique for the NE and the facility she or he leads. It requires years of strategic planning and implementation to put all 14 forces into place and demonstrate creative nursing interventions and outcomes that benefit the patients, the communities they serve, the profession of nursing, and the health care system (McClure & Hinshaw, 2002). The NE must provide strategic vision and a well-articulated philosophy that demonstrates advocacy for the staff and the patient, with the definitive goal of high-quality patient care (American Nurses Credentialing Center, 2005).

Initial designation as a Magnet facility focuses primarily on whether the 14 forces are in place, along with structures and processes to lay a solid foundation of support for the forces. Only one force of magnetism focuses on quality outcomes (Wolf, Triolo, & Ponte, 2008). After a facility has been designated as Magnet, re-designation is possible in five years. For a facility to be successfully re-designated, it must produce data that shows positive outcomes related to nursing-sensitive indicators. Nursing-sensitive indicators are patient outcomes that are strongly influenced by nursing care as well as nursing structures and processes. Patient outcomes include:

- patient falls, and falls with injury;
- hospital–acquired pressure ulcers;
- catheter-associated urinary tract infection;
- central line-associated bloodstream infection;

- ventilator-associated pneumonia;

- physical restraints.

Nursing structures and processes are factors affecting the nursing environment, including nurse staffing, nurse satisfaction, and nurse turnover (The American Nurses Association, 2014).

Becoming re-designated can be even more demanding than the initial designation, in that the processes must result in improvements in patient care (Lowe, 2010). The ANCC made this change intentionally in 2007 to propel the quest for excellence toward a quest for excellence and innovation, as the rapidly occurring changes in patient populations, providers, technology, pharmaceutical companies, and scientific knowledge demand (Wolf et al., 2008). In the Magnet Recognition Program model, the five components are weighted differently in initial designation and re-designation. TL is weighted more heavily in initial designation, as is *structural empowerment*. The thinking of the ANCC was that once these components are well established, they would yield visible outcomes. For re-designating organizations exemplary professional nursing practice, new knowledge, innovations and improvement, and empirical quality results are weighted more heavily (Wolf et al., 2008). TL also remains an essential component for re-designation. This is consistent with Torbert and Cook-Greuter's (2004) action-logics, as will be explained below.

NEs must be both personally and professionally competent and must have the support of the hospital's chief executive officer and governing body to achieve the transformation to Magnet status (McClure & Hinshaw, 2002) and sustain the designation. The highly competent NE would have undergone personal development to attain these skills and to gain the support of the hospital executive leadership. The possible role of developmental theory and its applicability to the growth and achievements of the NE will be explored in this study.

Developmental Theory

Developmental theorists (Gilligan, 1993; Jensen & Wygant, 1990; Loevinger, 1976; Torbert & Cook-Greuter, 2004; Wilber, 2000a) describe human maturation as development through stages that can be defined and occur through a predictable sequence. Importantly, maturing through these stages can be achieved by anyone capable of abstract thought. Therefore, leaders can be developed through intention by engaging in practices and receiving support that fosters their growth to the next level. The growth does not automatically take place but can occur if the individual is diligent about increasing self and other awareness.

The developmental stages are hierarchical. Each successive stage builds on the previous stage and the stages occur in an invariant order so that skipping stages is not possible. Each successive stage is more complex than the one before it (Loevinger, 1966). Each stage has its own inner logic that becomes the world view for the person while the person is in the stage (Torbert & Cook-Greuter, 2004).

Action-logic as a developmental theory. Torbert and Cook-Greuter (2004) used the term *action-logic* to describe developmental stages. Action-logics are "strategies, schemas, ploys, game plans, typical modes of reflecting on experience" (Torbert & Cook-Greuter, 2004, p. 22). According to Torbert and Cook-Greuter, the ability to create and implement strategy requires a highly developed action-logic.

Leaders display one of seven action-logics Rooke and Torbert (2005). The stages are grouped into subcategories called pre-conventional, conventional, and postconventional (Torbert & Cook-Greuter, 2004). The pre-conventional stage found in leaders is called Opportunistic and is typical early in life. Most people transcend this stage during adolescence. The conventional stages are called Diplomat, Expert, and Achiever. Persons in the conventional stages take for

granted that a stable reality is created through the use of social structures, norms, and power structures. Persons in these stages place a high value on similarity and stability. The postconventional action-logics are called Individualist, Strategist, and Alchemist. Persons reaching these action-logics appreciate diversity and participate in ongoing creative personal transformation (Torbert & Cook-Greuter, 2004). The leader of the Strategist action-logic creates organizational and personal transformation using a powerful combination of mutual inquiry, vigilance, and vulnerability. The Alchemist creates society-wide transformation by integrating the material and spiritual concerns of the members of the society, especially in unique and important moments in the history of the organization.

Rooke and Torbert (2005), as well as other leadership researches and consultants, implemented survey-based consulting at numerous American and European companies, including nonprofits and governmental agencies, including Deutsche Bank, Harvard Pilgrim Health Care, Hewlett-Packard, Trillium Asset Management, Aviva, and Volvo. They worked with thousands of executives to help them develop their leadership skills. Part of the process included the use of a 36-item sentence completion test: the Leadership Development Profile. The sentences in the profile begin with a phrase like, "A good leader…" (Rooke & Torbert, 2005, p. 68). The participant is instructed to complete the sentence. The responses are quite varied, are interpreted by highly skilled evaluators, and are coded by the action-logics the participant describes. The action-logic in the profile is representative of the leader's current way of thinking and responding, especially when challenged or under stress.

Action-logic as a predictor of success. Rooke and Torbert (2005) saw a correlation between a leader's action-logic and the leader's business' success. They discovered that businesses led by people who had achieved conventional action-logics were not as successful as

businesses led by people who had achieved postconventional action-logics. Rooke and Torbert found that success in business is associated with the leaders' ability to transform themselves and their company. They discovered below-average performance is associated with leaders displaying Opportunist, Diplomat and Experts action-logics. For example, leaders of the energy company Enron engaged in the self-centered, win-lose, rule-breaking behavior of the Opportunist. They described a Diplomat in a senior position who failed due to his inability to deal with conflict. They also described an Expert who drove away numerous senior managers due to his failure to collaborate.

Additionally they found that organizations led by leaders displaying the Achiever action-logic were able to implement organizational strategies. They were more able to resolve clashes in the workplace and be a positive influence on others. This type could lead a team to accomplish both short and long-term goals and have lower staff turnover and increased revenues more than Experts who run similar businesses. However, only organizations with leaders displaying individualist, strategist, or alchemist action-logics were consistently able to transform sufficiently to become and remain successful. Individualists are known to use their enhanced awareness to deliver services ahead of schedule and under budget. Strategists become the master of creating a vision that can be shared by people with all action-logics, encouraging personal and corporate transformation.

It has yet to be determined what action-logics these successful NEs who have brought their facilities to Magnet designation or re-designation demonstrate. It is unknown whether the same correlation between postconventional action-logics and increased success in creating transformation would apply in the field of nursing. If NEs with postconventional action-logics are more successful in transforming their organizations, then to develop and choose nurses with

postconventional action-logics for the NE role could have a significant effect on transforming our health care system.

Purpose of the Study

The purpose of this study was to determine what the action-logics the NEs demonstrate who have led their organizations to Magnet designation or re-designation. The study also was designed to determine what actions NEs took to support nurses speaking up about their concerns and the barriers that impede those efforts. The sources of influence these NEs implemented to support nurses speaking up were also explored.

The research questions are

1. What action-logics are demonstrated by the NEs who have brought their organizations to Magnet designation or re-designation, as measured by the MAP sentence completion test?

2. What actions have these NEs taken to support nurses speaking up about their concerns?

3. What barriers exist that impede these NEs' efforts to support nurses speaking up?

4. What sources of behavioral influence have these NEs implemented as part of their professional practice to support nurses speaking up?

Target Population and Study Sample

In the Veteran Health Administration (VHA), five hospitals have attained Magnet status. The researcher works as a NE in the VHA and had access to a convenience sample of four NEs who are the subjects of this study. These NEs demonstrated a level of success in professional nursing practice that confirmed that they possessed advanced skill sets. Learning more about their thinking and professional practice is the primary focus of the study.

Methods

The four NE participants have been given the Leadership Maturity Assessment Instrument (MAP) sentence completion test (formerly known as the Leadership Development Profile), the instrument used to profile action-logics. This is an expanded and refined instrument based on the Washington University Sentence Completion Test (WUSCT; Cook-Greuter, 2012).

Additionally, each NE participated in an interview to explore the actions she has taken to establish an environment that supports nurses speaking up and the challenges she has faced when nurses speaking up has been a concern. These interviews were intended to illustrate the professional practice of these NEs by describing specific outcomes they have achieved in practice and the barriers to achievement. Additionally, the study explored sources of behavioral influence these NEs have implemented that support nurses to speak up.

Significance of the Study

Nurses comprise the largest segment of the health care workforce and are led by NEs. NEs have already supported numerous programs in which nurses demonstrate that they can improve cost, quality, and access for health care. Magnet hospitals are leaders in excellent health care delivery, and their NEs provide a population that is known to exhibit transformational leadership. If the ability to be a transformational leader in business requires postconventional action-logics, then the same may hold true in health care.

The significance of the study is to determine whether post conventional logics correlate with transformational leadership abilities in Magnet NEs as they do in business leaders. Additionally, the study examines the sources of behavioral influence these NEs have implemented in these Magnet organizations, transforming the environment to become more favorable for nurses to speak up about their concerns. A premise of the study is that if the action-

logics of these NEs are consistent with successful leaders in business, the action-logic of NEs will provide valuable guidance for the choosing and training of NEs. A second premise of the study is that, if these NEs have implemented multiple sources of behavioral influence that support speaking up, the study will provide additional evidence demonstrating how Magnet NEs support nurses to speak up. This information could be used by other NEs so they can support their staffs to speak up and give higher quality health care in hospitals.

The focus on action-logics for NEs is unique, as this is the first study to apply action-logics to NEs (Marshall, 2011). By studying NEs who are presumed to possess transformational leadership by virtue of the Magnet designation process, and by using the MAP instrument to determine their action-logics, this study may demonstrate whether the action-logic of these NEs is postconventional, which would be consistent with the results for transformational leaders in business. Additionally, this study explored the actions the NEs took and the barriers they faced in promoting speaking up among the nurses in their organizations. Also, the study examined what sources the behavioral influence these NEs have implemented to transform the environment in their organization to one that is more favorable for nurses to speak up. This line of thought goes through Chapter 2.

Limitations of the Study

This study will focus on NEs of Magnet-designated organizations in the VHA. A convenience sample of NEs who brought their facility to achieve Magnet status or re-designation within the VHA was used for this study. The nature of the VHA may or may not impact the action-logic of those nurses. The VHA is both bureaucratic and an exceptional resource that promotes education and growth and hence it may not be fully comparable to other hospital settings. Other limitations are (a) the small sample size, (b) the focus on the NE without any

corresponding data from nurses under her leadership, (c) reliance on self-report data without any directly observable or measurable behaviors, (d) some of the NEs in the sample are retired and hence are not currently in an NE role and hence their recall may be diminished, (e) use of interviews to collect data instead of using a more specific tool with established validity and reliability, and (f) the focus on the NE without assessment of action-logics of the entire executive leadership team.

Key Definitions

The following are key terms used in this dissertation and their respective definitions.

Gross domestic product: "the total value of the goods and services produced by the people of a nation during a year not including the value of income earned in foreign countries"(Gross domestic product, 2015).

Sentinel event: "an event in which death or serious harm occurred" (The Joint Commission, 2015a, para. 6).

Undiscussables: "Risky and threatening issues, particularly issues that question underlying organizational assumptions and policies, that people and/or organizations do not have the ability to discuss" (Argyris, 1980, p. 205).

Nurse executive: "The nurse who is responsible for organized nursing services and manages from the perspective of the organization as a whole. Her/his five primary domains of activity are leading, collaborating, facilitating, integrating, and evaluating" (American Nurses Credentialing Center, 2005, p. 33).

Magnet Nursing Services Recognition Program: "The program developed and administered by the American Nurses Credentialing Center (ANCC) to recognize excellence in

nursing services of health care organizations. The ANCC is a separately incorporated entity of the American Nurses Association" (American Nurses Credentialing Center, 2002, p. 199).

Developmental theory: Developmental theorists (Gilligan, 1993; Jensen & Wygant, 1990; Loevinger, 1976; Torbert & Cook-Greuter, 2004; Wilber, 2000a) have described human maturation as development through stages that can be defined and occur through a predictable sequence. Maturing through these stages can be achieved by anyone capable of abstract thought.

Abstract thought: "the ability to use internal symbols or images to represent reality" (Christie & Viner, 2005, p. 302).

Ego development theory: Loevinger (1966) described the transformations in a person's life to which the self is subjected or voluntarily submits itself. The transformations occur in an unvarying sequence. She articulated the major elements as milestones and polar aspects and described their manifestations. Milestones are observed as one demonstrates a particular behavior. Polar aspects are inferred from patterns of observed behavior and decrease as ego stages increase.

Milestone sequences: "Observable behaviors that tend to rise and then fall off in prominence as one ascends the scale of ego maturity" (such as conformity to generally accepted social standards; Loevinger, 1966, p. 202).

Polar aspects: "Ratings of the amount of a trait present" (such as the tendency to stereotype; Loevinger, 1966, p. 202).

Action-logics: "strategies, schemas, ploys, game plans, typical modes of reflecting on experience" (Torbert & Cook-Greuter, 2004, p. 22). "An overall strategy that so thoroughly informs our experience that we cannot see it" (p. 66).

Specific action-logics: Implusive, Opportunist, Diplomat, Expert, Achiever, Individualist, Strategist, Alchemist, from Torbert and Cook-Greuter (2004, pp. 126 - 127).

Impulsive: "Impulses rule behavior" (p. 126).

Opportunist: "Needs rule impulses" (p. 126). Dominant task is to gain power to have desired effects on the outside world.

Diplomat: "Norms rule needs" (p.126). Dominant task is to understand others' expectations and molding own action to succeed in their terms.

Expert: "Craft logic rules norms" (p. 126). Dominant task is intellectual mastery of systems outside the self.

Achiever: "System effectiveness rules craft logic" (p.126). Dominant feature is triangulation among plan, implementation, and outcome. Takes corrective action unsystematically but regularly.

Individualist: "Reflexive awareness rules effectiveness" (p. 126). Experiments with new awareness that diverse assumptions may complement one another for learning and for achieving productivity goals.

Strategist: "Self-amending principle rules reflexive awareness" (p. 127). Self-conscious philosophy, sense of time and place, invites conversation among multiple voices as well as reframing of boundaries. Acts to support organizational learning.

Alchemist: "Process (interplay of principle/action) rules principle" (p.127). Cultivates interplay and reattunement among mind and matter as well as love, death and transformation. Constantly promotes and creates cultural transformation.

Contingent reward: "proactive and exchange-related behavior, in which leaders employ goal setting to help clarify what is expected and what the followers will receive for accomplishing the goals" (Kanste, Kääriäinen, & Kyngäs, 2009, p. 775).

Relatability scale: a sequence of levels of increasing differentiation of the self from others, and the increasing affective appreciation of the delineation of others (Isaacs, 1956).

Equilibrium: "the active state of balance between the cognitive system and the demands of the environment" (Alexander & Langer, 1990, p. 6).

Team psychological safety: "a shared belief that the team is safe for interpersonal risk taking" (Edmondson, 1999, p. 354).

Team learning behavior: "activities carried out by team members through which a team obtains and processes data that allow it to adapt and improve" (Edmondson, 1999, p. 351).

Team efficacy: "the team's potential to perform" (Edmondson, 1999, p. 356).

Context support: "adequate resources, information and rewards" (Edmondson, 1999, p. 356).

Sources of behavioral influence, according to Maxfield et al. (2011) are Personal Motivation, Personal Ability, Social Motivation, Social Ability, Structural Motivation, Structural Ability (p. 8).

Personal Motivation: People want to speak up because they think it is a moral obligation (p. 8).

Personal Ability: People "have the knowledge and skills they need to handle the toughest challenges of speaking up" (p. 8).

Social Motivation includes one or more of the following: The people around them (physicians, manager, and co-workers) encourage them to speak up when they have concerns. The people they respect model speaking up.

Social Ability includes one or more of the following: "Others step in to help people when they try to speak up; others support them afterward so the risk doesn't turn against them; those around them offer coaching and advice for handling the conversation in an effective way" (p. 8).

Structural Motivation includes one or more of the following: The organization rewards people who speak up and does not punish them. Speaking up is included in performance reviews. Managers are held accountable for influencing these behaviors.

Structural Ability: The organization establishes times, places, and tools that make it easy to speak up (surgical pauses, Situation Background Assessment Recommendation [SBAR] handoffs, read back policies, etc.). There are times and places when caregivers are encouraged to speak up. The organization measures the frequency with which people are holding or not holding these conversations, and uses these measures to keep management focused on speaking up for patient safety.

Organization of the Study

The study is organized into five chapters. Chapter 2 is a literature review. Chapter 3 describes the research design and methods. Chapter 4 presents the data, analysis of the data, and a discussion of the findings of the study. Chapter 5 summarizes the study, gives conclusions drawn from the findings, and recommends future research and actions pertaining to the conclusions.

Chapter 2 begins with a review of the literature on the role of the NE, Magnet recognition as a model for excellence, and the role of the NE in achieving Magnet recognition;

transformational leadership and the NE as a transformational leader; and developmental theory and its application to transformational leadership. In addition, the literature on speaking up behavior and the environment that supports speaking up is reviewed as well as the potential relationship between Magnet designation and speaking up behavior. Finally, the chapter presents a review of the measurement of adult development.

Chapter 2: Review of the Literature

This research focuses on the following questions:

1. What action-logics are demonstrated by the NEs who have brought their organizations to Magnet status, as measured by the MAP sentence completion test?

2. What actions have these NEs taken to support nurses speaking up about their concerns?

3. What barriers exist that impede these NEs' efforts to support nurses speaking up?

4. What sources of behavioral influence have these NEs implemented as part of their professional practice to support nurses speaking up?

This chapter is a review of the literature. The chapter begins with an overview of the role of the nurse executive, Magnet recognition as a model for excellence, and the role of the NE in achieving Magnet recognition. This is followed by a review of the literature on transformational leadership (TL) and the NE as a transformational leader. Developmental theory and its application to TL are also reviewed. Next, the literature that addresses speaking up, the sources of behavioral influence that support speaking up and the potential relationship between Magnet designation and speaking up is reviewed. Finally, the measurement of adult development is discussed.

The Role of the Nurse Executive

The role of the NE is described by nursing professional organizations, nursing professional organizations in collaboration with other health care disciplines, and by the Joint Commission on Accreditation of Health Care Organizations. As noted above, the definition of NE, by the American Nurses Association through the ANCC (2005) is, "the nurse who is responsible for organized nursing services and manages from the perspective of the organization

as a whole. Her/his five primary domains of activity are leading, collaborating, facilitating, integrating, and evaluating" (p. 33).

Another nursing professional organization is the American Organization of Nurse Executives (AONE). AONE collects positions descriptions for use in the field of nursing. The AONE posts a position description for a chief NE on their website as a model that can be used for the role. This role is referred to in this paper more simply as the NE. The position summary in the chief NE position (CNO/CNE) description as posted by AONE (American Organization of Nurse Executives, 2012) follows:

> This position has overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities and clinical education and development, including continuous improvement of nursing services and staff to meet the needs and expectations of those served by the System, at assigned facility or campus while maintaining a high level of visibility at the facility, region and system levels. Ensures the realization of quality and economical health care services within facility and system guidelines and philosophies. This position is responsible for driving, supporting and modeling a service-oriented culture focused on employee engagement, quality, patient safety, service excellence, fiscal responsibility, and the overall patient experience. Serves as a member of the executive leadership team at the facility and system levels, building and supporting effective collegial relationships with applicable internal and external constituents and stakeholders and ensuring optimal operating effectiveness and strategic positioning. (para. 1)

Nurses for a Healthier Tomorrow (2006) noted the evolution of the role of the nurse in executive practice from a focus on nursing services to one that is accountable for patient care in multiple disciplines across the continuum of care. Nurses for a Healthier Tomorrow is a coalition of 43 professional nursing and other health care organizations that are working collaboratively to attract people into the nursing profession. Among the organizations involved are the American Nurses Association and the AONE, the two organizations that provide certification for the practice of nursing at the executive level. The role of the NE is described as a leader who exemplifies the mission and vision of their organization as a role model, values diversity,

facilitates cultural competence in the care of patients and interaction with staff, and encourages creativity and innovation among the staff. The NE also educates and provides opportunities for staff to grow, uses systems thinking to promote quality improvement, is effective as a team member and leader, is fiscally accountable, and maintains current knowledge of the field of executive nursing practice (Nurses for a Healthier Tomorrow, 2006). The NE reports directly to the CEO of the health care organization.

The American Nurses Association took an active role with the Joint Commission in establishing standards requiring integration of the NE into the leadership of hospitals that seek Joint Commission accreditation. Specifically, it is required that, "An identified nurse leader, at the executive level, assumes an active leadership role with the organization's governing body, management, organized medical staff, and clinical leaders in the organization's decision-making structures and processes" (American Nurses Association, 2007, para. 3).

The Joint Commission (2013) on hospital accreditation names five standards for the NE:

1. NR. 01.01.01: "The NE directs the delivery of nursing care, treatment, and services" (p. NR-4).

2. NR.01.02.01: "The NE is a licensed professional nurse qualified by advanced education and management experience" (p. NR-4).

3. NR.02.01.01: "The NE directs the hospital's nursing services" (p. NR-4).

4. NR.02.02.01: "The NE establishes guidelines for the delivery of nursing care, treatment, and services" (p. NR-5).

5. NR.02.03.01: "The NE directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s)" (p. NR-6).

The AONE (2011) uses a model for leadership competency that includes the following domains:

- communication and relationship-building;

- a knowledge of the health care environment;

- leadership;

- professionalism;

- business skills (p. 3).

This model was developed by the Healthcare Leadership Alliance in 2004. The alliance continues to work to establish a common set of leadership competencies for health care executives. The AONE has articulated competencies that are important for nursing leaders in each of these domains. The competencies list examples of what the NE does as a leader to "shape the future of health care through innovative and expert nursing leadership," (The American Organization of Nurse Executives, 2011, p. 3). Several of the examples are:

- "Make oral presentations to diverse audiences on nursing, health care, and organizational issues" (p. 4).

- "Deliver 'bad news' in such a way as to maintain credibility" (p. 4).

- "Create an environment that recognizes and values differences in staff, physicians, patients and communities" (p. 4).

- "Support the development and implementation of an organization-wide patient safety program" (p. 7).

- "Involve physicians in on-going utilization management practices" (p. 7).

- "Recognize one's own method of decision-making and the role of beliefs, values and inferences" (p. 8).

- "Create an environment in which others are setting expectations and holding each other accountable" (p. 9).

- "Role model the perspective that patient care is the core of the organization's work" (p. 9).

- "Articulate business models for health care organizations and fundamental concepts of economics" (p. 10).

Magnet Recognition as a Model for Excellence

As noted in Chapter 1, the Magnet Recognition Program was developed to recognize health care organizations that have achieved high quality care and excellence in nursing practice. The original research was designed to reveal why nurses are attracted to and stay in specific hospitals, providing evidence that other hospitals could implement to also attract and retain nurses (McClure, Poulin, Sovie, & Wandelt, 1983). Later research revealed that these same hospitals had positive outcomes for patients (Aiken, 2002; American Nurses Credentialing Center, 2005).

In the late 1970s the traditional approach to dealing with nursing shortages by attempting to address the supply of nurses had met with mixed results, and nursing shortages continued to occur cyclically. In the 21st century, the nursing shortage will be global. It will be more severe than in the past due to the aging population in the United Sates and the concomitant needs for increased nursing care for this population (American Nurses Credentialing Center, 2005).

The ANCC Magnet Recognition Program contains evidence-based recommendations for what is required to create and maintain an environment that both attracts and retains nurses and allows them to deliver high-quality care so that their patients have improved outcomes. The 14 forces of magnetism are essential to the Magnet model and are examined in detail to determine

whether a facility has reached the standards to achieve Magnet recognition. As defined by the American Nurses Association (American Nurses Credentialing Center, 2005) the 14 forces include:

1. Quality of Nursing Leadership − Nursing leaders are perceived as knowledgeable, strong risk-takers who follow an articulated philosophy in the day-to-day operations of the nursing department. Nursing leaders also convey a strong sense of advocacy and support on behalf of the staff. (p. 36)

2. Organizational Structure – Organizations are perceived as flat, rather than tall, structures in which unit-based decision-making prevails. Nursing departments are decentralized, with strong nursing representation evident in the organizational committee structure. The nursing leader serves at the executive level of the organization, and the chief nursing officer (NE) reports to the executive level. (p. 38)

3. Management Style – Organization and nursing administrators use a participative management style, incorporating feedback from staff at all levels of the organization. Feedback is characterized as encouraged and valued. Nurses serving in leadership positions are visible, accessible, and committed to communicating effectively with staff. (p. 40)

4. Personnel Policies and Programs – Salaries and benefits are characterized as competitive. Rotating shifts are minimized, and creative and flexible staffing models are used. Personnel policies are created with staff involvement, and significant administrative and clinical promotional opportunities exist. (p. 42)

5. Professional Models of Care – Models of care are used that give nurses the responsibility and authority for the provision of patient care. Nurses are accountable for their own practice and are the coordinators of care. (p. 45)

6. Quality of Care – Nurses perceive that they are providing high-quality care to their patients. Providing quality care is seen as an organizational priority as well, and nurses serving in leadership positions are viewed as responsible for developing the environment in which high-quality care can be provided. (p. 47)

7. Quality Improvement – Quality improvement activities are viewed as educational. Staff nurses participate in the quality improvement process and perceive the process as one that improves the quality of care delivered within the organization. (p. 50)

8. Consultation and Resources – Adequate consultation and other human resources are available. Knowledgeable experts, particularly advanced practice nurses, are available and used. In addition, peer support is given within and outside the nursing division. (p. 52)

9. Autonomy – Nurses are permitted and expected to practice autonomously, consistent with professional standards. Nurses are expected to exercise independent judgment within the context of a multidisciplinary approach to patient care. (p. 54)

10. Community and the Health Care Organization – Organizations that are best able to recruit and retain nurses also maintain a strong community presence. A community presence is seen in a variety of ongoing, long-term outreach programs. These outreach programs result in the organization being perceived as a strong, positive, and productive corporate citizen. (p. 56)

11. Nurses as Teachers – Nurses are permitted and expected to incorporate teaching in all aspects of their practice. Teaching is one activity that reportedly gives nurses a great deal of professional satisfaction. (p. 58)

12. Image of Nursing – Nurses are viewed as integral to the organization's ability to provide patient care services. The services provided by nurses are characterized as essential by other members of the health care team. (p. 60)

13. Interdisciplinary Relationships – Interdisciplinary relationships are characterized as positive. A sense of mutual respect is exhibited among all disciplines. (p. 61)

14. Professional Development – Significant emphasis is placed on orientation, in-service education, continuing education, formal education, and career development. Personal and professional growth and development are valued. In addition, opportunities for competency-based clinical advancement exist, along with the resources to maintain competency. (p. 63)

The Magnet model was developed in 2008 to organize and bring conceptual cohesion to the 14 forces. As previously noted, the first model component is *transformational leadership (*TL). The ANCC (2008) defined TL as "Leadership that identifies and communicates vision and values and asks for the involvement of the work group to achieve the vision" (p. 45). This model component includes forces (1) Quality of Nursing Leadership and (3) Management Style (see list above). Magnet organizations must have a strong and visionary NE who guides and supports excellence in nursing practice in a professional environment. These leaders and the professional practice they develop elevate the standards of the nursing profession (American Nurses Credentialing Center, 2011).

Structural empowerment is the second of the five model components. Included in this component is force (2) Organizational Structure, force (4) Personnel Policies and Programs, force (10) Community and Healthcare Organization, force (12) Image of Nursing, and force (14) Professional development (see list above). The organization incorporates structures, policies and programs, and relationships with the community to support the image of nursing and development of the staff. The mission, vision, and values as well as the strategic plan of the organization are operationalized through this engagement and empowerment of the staff. Again, visionary leadership is part of creating and maintaining the empowerment structure.

Exemplary professional practice is the third model component. This component is the core concept of Magnet organizations and it is both the path to and the goal of attaining magnet recognition. The forces included are force (5) Professional Models of Care, force (8) Consultation and Resources, force (9) Autonomy, force (11) Nurses as Teachers, and force (13) Interdisciplinary Relationships (see list above). In this component the role of nursing is developed and expressed in patient care delivery and in improving the health of communities through interdisciplinary relationships and the use of evidence-based practice.

The fourth model component is *new knowledge*, Innovations and Improvements. This component includes force (7) Quality Improvement (see list above). In this component, the importance of building new knowledge and new nursing roles is described. The health care system must be improved, and this component focuses on improving the quality of care delivered through innovation in care delivery systems.

Empirical outcomes is the fifth model component. The focus of improved systems and processes is for improved clinical, workforce and organizational outcomes. The force of

magnetism is (6) Quality of Care (see list above), and the overarching goal of this component is to make a difference.

Nurses who work in Magnet hospitals are knowledgeable about healthy work environments (Kramer, Schmalenberg, & Maquire, 2010). Kramer and Schmalenberg (2002) found that bedside nurses in Magnet hospitals identified processes and relationships that are necessary to establish and maintain safety and high-quality outcomes for patients in what is now recognized as *essentials of magnetism*. Three of these essentials are (1) working with nurses who are clinically competent, (2) good nurse-physician relationships, and (3) concern for the patient is paramount (Kramer & Schmalenberg, 2002). Maxfield et al. (2011) discussed related concepts of incompetency, disrespect, and shortcuts, noting that Magnet organizations incorporate sources of behavioral influence that have been shown to increase the ability of nurses to speak up to prevent harm to patients. Current research has not addressed whether NEs in the VHA Magnet organizations have implemented sources of behavioral influence and facilitated transformation in these organizations so the environment is more favorable for nurses to speak up about their concerns.

The Role of the NE in Achieving Magnet Recognition

The ANCC lists the first primary domain of the NE as leading (American Nurses Credentialing Center, 2005). This detailed focus on the NE as a person, a professional, and a leader in the Magnet recognition process is by design. The purpose of the Magnet Recognition Program is to provide a framework to recognize excellence in:

- the management philosophy and practices of nursing services;

- adherence to standards for improving the quality of patient care;

- leadership of the nurse administrator in supporting professional practice and continued competence of nursing personnel;

- attention to the cultural and ethnic diversity of patients and their significant others, as well as the care providers in the system (American Nurses Credentialing Center, 2002, p. 13).

The purpose of the program lists the responsibilities of the NE role in everyday practice. When the role is implemented to its fullest, the NE in Magnet organizations is the one who establishes the vision and leads with ideas, and the nurse managers move forward with these ideas, working with the staff to implement them (McClure & Hinshaw, 2002).

As described above, the role of the NE in the Magnet Recognition Program is key to the success of the magnet journey of the facility. TL is a major component of the Magnet model and it is also a major component of the role of the NE. The discussion will now focus more specifically on the literature that discusses the concept of transformational leadership.

Transformational Leadership

This section will trace the literature on TL from its early conceptual foundations to its current definition. Studies of transformational leaders and transformational leadership behaviors are also included.

Bandura's (1977) understanding of social learning laid a foundation for the concept of TL. In Bandura's research, he described how a follower learns to work for intrinsic reward and he explained this as a primary reinforcer for the follower working within a social context created by a transformational leader. Bandura also noted that a person's level of mental and physical development constrains her or his potential and the outcomes the person can create.

Bass (1985) described TL as composed of charisma, individualized consideration, and intellectual stimulation (p. xiii). Bass, Avolio, and Goodheim (1987) described charismatic leadership as, "the leader instills pride, faith, and respect and has a special gift of seeing what is really important, and has a sense of mission" (p. 10). Bass et al. also described individualized consideration as "the leader delegates assignments to provide learning opportunities, gives personal attention to neglected members and treats each subordinate individually" (p. 10). Additionally, Bass et al. described intellectual stimulation as the "leader provides ideas which result in a rethinking of issues that have never been questioned before and which enable subordinates to think about old problems in new ways" (p. 10).

Bass (1985) described transactional leadership as contingent reward and management by exception. Contingent reward is exchanging rewards and promises of reward for effort from subordinates. Bass et al. (1987) described management by exception as, "the leader intervenes only if standards are not being met" (p. 11). Bass (1985) noted that the motivation of contingent reward produces a predictable outcome in that the behavior that is rewarded will be repeated.

However, contingent rewards do not include the phenomena of symbolism, mysticism, imagining, and fantasy that can produce transformation in individuals and workplaces (Bass, 1985). Transformed individuals produce outcomes that exceed what would have been predicted through transactional leadership alone. Bass (1985) explained that societal, organizational, and personal elements promote or thwart TL. He suggested that promoting TL is an advantage to the organization because transformational leaders can move people from focusing primarily on lower level needs, such as physiological and safety, or even mid-level needs such as affiliation and self esteem, to self-actualization. The followers engage in self-leadership and self-discipline,

which can lead to self-actualization. This self-actualizing behavior is self-reinforcing (Bass, 1985).

The awareness of needs that have not been perceived or have lain dormant becomes intensified and the desire to meet those needs becomes compelling. As individuals become more aware, their awareness of the need for change in the organization increases as well and can result in extraordinary effort, creativity, and innovation by those following the transformational leader.

This heightening of awareness requires a leader with vision, self-confidence, and inner strength to argue successfully for what he sees is right or good, not for what is popular or is acceptable according to the established wisdom of the time (Bass, 1985, p. 17).

The vision of the transformational leader can facilitate resolution of internal conflicts experienced by their followers (Bass, 1985). This concept is central to the work of transformational leaders as described by Torbert and Cook-Greuter (2004). They described certain advanced action-logics through which leaders can use paradox to create solutions that resolve conflicts within and between others that appeared unresolvable prior to their transformative intervention. In agreement with Bass, Torbert and Cook-Greuter found the transformational leader helps followers raise their attitudes, beliefs and motives to a higher level of awareness, engagement and maturity.

Herold, Fedor, Caldwell, and Liu (2008) studied TL and change leadership. They surveyed 343 respondents on either change leadership behaviors (Kotter, 1996) or transformational leadership behaviors (Podsakoff, Mackenzie, & Bommer, 1996) displayed by their managers. They found that TL had the greatest impact on followers' engagement in the change. TL was positively associated with change commitment when change leadership practices were low, regardless of the impact on the job. Only when change leadership behaviors were high

and job impact was low was TL not related to change commitment. Their research indicates that it is the person of the transformational leader, more than specific change behaviors, that gets support for high-impact change initiatives.

Similarly Ling, Simsek, Lubatkin, and Veiga (2008) studied 158 CEOs and 431 of their top management team members. The Multifactor Leadership Questionnaire (MLQ Form 5X-Short) was given to the top management team members to assess TL behaviors in their CEOs. Sales growth was the measure used for performance. They found that transformational leaders were effective in enhancing both perceived and objective performance in small and medium-sized enterprises. These findings align with those of Rooke and Torbert (2005) and Torbert and Cook-Greuter (2004). Ling et al. (2008) recommend training for all leaders in these organizations to support and enhance the development of transformational leaders.

Nielsen, Yarker, Brenner, Randall, and Borg (2008) also recommend training in TL behaviors to enhance job satisfaction in employees. They found that employees who have transformational leaders have positive perceptions of their working conditions through involvement in meaningful work. The authors believed that the working conditions may affect job satisfaction rather than the transformational leader, but that the transformational leader is strongly associated with multiple good working conditions. They thought it may be more efficient and cost-effective to train leaders in transformational behaviors than to implement costly initiatives to improve employee satisfaction. This study does not focus on the leaders themselves, but the behaviors observed in them.

This research contrasts with Torbert and Cook-Greuter (2004), who stated that transformational leadership behaviors cannot be fully demonstrated by someone who has not

actually developed to a postconventional level. They emphasize it is the ability of the person to consistently think at an advanced action-logic that enables them to act in transformational ways.

In summary, TL has its roots in social learning (Bandura, 1977) and is applied to elevate the individual's, teams' and organizations' abilities to engage and produce improved performance (Bass, 1985; Rooke & Torbert, 2005; Torbert & Cook-Greuter, 2004). Studies have revealed that individuals who reach increased awareness and maturity at postconventional action-logic levels are able to transform themselves and their organizations (Cook-Greuter, 2004; Rooke & Torbert, 2005; Torbert & Cook-Greuter, 2004). Some research exists that focuses only on the behaviors of transformational leaders and encourages teaching those behaviors to leaders (Nielsen et al., 2008). The majority of the research supports that it is the leaders who produce the behaviors (Herold et al., 2008), and the behaviors cannot be consistently exhibited by a leader who does has not developed a postconventional action-logic (Cook-Greuter, 2004; Torbert & Cook-Greuter, 2004). Support for developing leaders to become transformational leaders is evident (Cook-Greuter, 2004; Ling et al., 2008; Rooke & Torbert, 2005; Torbert & Cook-Greuter, 2004).

The importance of TL in business has been established, and a case has been made for supporting leaders to become transformational. Earlier, the role of the NE was described. A review of literature on TL as it applies to NEs follows.

Transformational Leadership in Nurse Executives

This section presents a review of studies of TL in nursing leaders and its effect on nurses and patients. The literature on NEs alone is sparse, so other levels of nurse leaders are included in this review when TL was studied in those leaders. Also reviewed are studies that include

specific transactional leadership behaviors and their impact on nurses. Research on programs to improve TL in nursing leaders is also reviewed.

Numerous studies show positive effects of TL on nursing staff. Vandenberghe, Stordeur, and D'hoore (2002) applied the five elements of Bass et al.'s (1987) transactional-transformational leadership paradigm to nursing. They studied the relationships of transactional and transformational leadership to quitting intentions, perceived unit effectiveness, and altruism. They sent a questionnaire to nurses working in 17 Belgian hospitals, asking them to describe the typical behavior of their immediate nursing superior using the MLQ. They received 1059 usable questionnaires. They found that the three elements associated with TL (charisma, individualized consideration, and intellectual stimulation) and one element associated with transactional leadership, that of contingent reward, when used in combination were positively related to job satisfaction and commitment in nursing staff. Vandenberghe et al. (2002) also found that TL was associated with willingness of the staff to give extra effort, increased satisfaction with the leader, and decreased intent to leave the organization. However, they found that TL plus contingent reward, which together they called *active leadership*, was more strongly related with affective commitment than TL alone.

Additionally, TL behaviors (charisma, individualized consideration, and intellectual stimulation) contribute to less emotional exhaustion (Stordeur, D'hoore, & Vandenberghe, 2001) among direct reports. Stordeur et al. (2001) studied survey responses from 625 nurses using the Nursing Stress Scale to rate their own levels of stress, a scale from the Maslach Burnout Inventory to measure their emotional exhaustion, and the MLQ 5X-rater to rate their manager's behavior. They found that nurses who rated their managers higher in transformational leadership dimensions and contingent reward reported less emotional exhaustion. Conversely, nurses who

reported to managers who displayed active and passive management by exception reported higher emotional exhaustion.

TL in nurse managers is also positively associated with leadership satisfaction and effectiveness (Casida & Parker, 2011). The study sample was 278 staff nurses and 37 nurse managers in acute care hospitals in the Northeastern United States. They used the MLQ Form 5x-Short and studied how transformational and transactional leadership affected (a) the ability to influence followers to achieve above the benchmark, (b) the nurses' satisfaction with their work, and (c) the creation and maintenance of a positive work environment that successfully meets organizational needs and outcomes. They found positive relationships with TL in combination with contingent reward. The transactional leadership behaviors of management by exception, both active and passive, were found to be unfavorable to the staff nurses and negatively correlated with the desired outcomes. They recommended that TL be a basic competency for nurse managers.

Leach (2005) studied NE transformational leadership and transactional leadership behaviors and their correlation to commitment to the organization by nursing staff. Leach did not describe transactional behaviors as other than "a relationship with the follower that is based on exchanging one thing for another" (p. 229). In practice, this could be a nurse receiving a bonus for completing a project in addition to normal duties that benefits the unit. This definition approximates the contingent reward definition used in other studies in which the combination of contingent reward and transformational leadership demonstrated positive outcomes (Chen, Beck, & Amos, 2005; Vandenberghe et al., 2002). Leach used the TL Profile (by Shaskin) and the Organizational Commitment Scale (developed by Penley and Gould) to survey 102 NEs, 148 nurse managers, and 651 staff RNs. Leach found that NE transformational leadership has a direct

effect on the commitment of staff nurses. Considering the infrequent interaction between these two roles, this is an important finding. Additionally she found that contingent reward positively impacts the commitment of nurses and that the simultaneous existence of TL with the use of contingent reward had the most positive effect on commitment of nurses.

Chen et al. (2005) sent the MLQ to nursing instructors at 18 schools of nursing in Taiwan, asking them to assess their deans and directors of nursing. They had 286 respondents. They reported that a combination of TL and contingent reward resulted in improved job satisfaction for leaders engaging in the combination of those behaviors.

In a study of nurse burnout, Kanste, Kyngäs, and Nikkil (2007) studied the relationship between leadership and burnout among nursing staff. They used the MLQ and the Maslach Burnout Inventory-Human Services Survey. They developed a Finnish version of the MLQ and tested the construct validity of the subscales, which was supported. They found that passive laissez-faire leadership was a statistically significant predictor of emotional exhaustion, a component of burnout. They also found that active management-by-exception (MBEA) by nurse managers increased the sense of personal accomplishment in staff nurses. MBEA is displayed when leaders do not just wait for something to go wrong, but they anticipate that mistakes will occur, they are diligent in searching for mistakes, and implement actions to correct and prevent future errors when mistakes do happen (Kanste et al., 2009). Both MBEA and transformational leadership behaviors protected staff nurses from depersonalization, another component of burnout.

Kanste et al. (2009) studied transformational leadership behaviors and their effect on the staffs' willingness to exert extra effort, their perceptions of leadership effectiveness, and their satisfaction with the leader. They found that transformational leadership behaviors in nurse

leaders promote the staffs' willingness to exert extra effort, their perceptions of leader effectiveness, and their satisfaction with the leader (Kanste et al., 2009). In contrast, laissez-faire leadership and active management-by-exception (MBEA) showed decreases in these elements. The positive outcomes from TL persisted when re-tested a year later (Kanste et al., 2009). It is noted that this study found a detrimental aspect to MBEA in contrast with the 2007 study, although the variables studied also differ.

Munir and Nielsen (2009) studied the relationships between TL, self-efficacy, and sleep quality using a cross-sectional and longitudinal design. Subjects consisted of staff caring for the elderly in government facilities in Denmark. The Global Transformational Leadership Scale (developed by Carless) was used to measure leadership, a self-efficacy scale by Schwarzer was used to measure self-efficacy, and sleep quality was measured using a 4-item scale developed by the authors. The sleep-quality scale demonstrated internal consistency reliability of 0.90 and 0.91. They found that employees who experienced having a transformational leader demonstrated a positive relationship to sleep quality over time. This relationship was not mediated by self-efficacy. The authors noted that potential for TL to support this important aspect of health is important.

Munir, Nielsen, Garde, Albertsen, and Carneiro (2012) explored whether work-life conflict mediated between TL, job satisfaction, and psychological wellbeing. They had 188 participants who cared for the elderly in a Danish government-run health care system that participated in a longitudinal study. They used the Global Transformational Leadership Scale, two items from the Copenhagen psychosocial questionnaire (with a Cronbach alpha of 0.90), a five-item job satisfaction scale (with a Cronbach alpha of 0.82), and a five-item psychological wellbeing scale (with a Cronbach alpha of 0.85). They found that TL in front-line leaders is

directly associated with lower work-life conflict and with greater job satisfaction and psychological wellbeing. They also found that TL and psychological wellbeing were mediated through work-life conflict. Their hypothesis that transformational leadership behaviors were associated with lower perceptions of work-life conflict was supported. They found that perceptions of work-life balance and perceptions of job satisfaction and psychological wellbeing are associated. They concluded that transformational leadership behaviors promote wellbeing among employees.

TL was associated with increased satisfaction of staff nurses with their managers even when the nurse manager had an above average number of direct reports and 24/7accountability for supervision (Meyer et al., 2011). Their study in Ontario, Canada, included 31 nurse managers and 558 staff nurses in acute care hospitals. The LPI was used to rate the managers' leadership behaviors, and the nurses' satisfaction with their managers was assessed using Scarpello and Vandenberg's My Supervisor Scale. These researchers found that the nurses were more satisfied when their managers were more transformational. As the number of direct reports per manager increased, the level of satisfaction decreased. However extending managers' working hours over longer operational periods improved satisfaction, and this enhanced effect was more pronounced with a greater number of direct reports.

In contrast to the literature supporting the positive effects of TL in nursing, the validity of the research on TL in nursing as well as the appropriateness of the model has been questioned by Hutchinson and Jackson (2013). They examined the transformational leadership model and its application in nursing research by reviewing existing nursing research on TL in nursing. These researchers noted that TL uses a dichromatic interpretation of leadership as either transformational or transactional, the focus is typically on heroic and distant leaders, minimal

attention is given to leader integrity, and there is little or no attention given to *dark* or avoidant leader behaviors that can damage individuals or the organization. They also stated that the MLQ and LPI were the primary instruments used in the nursing leadership research. They questioned the validity of these instruments and the way they have been used to assess TL in nursing, noting numerous weaknesses. As a result, they think that the claims regarding the impact and extent of TL in nursing are overstated. They recommend that future research assess the actual leadership behaviors and not perceptions of leadership. They also encourage the use of other tools and theories to examine nursing leadership.

The exploration of leadership theory for nursing has created interest in leadership competency in nurses. In 1997 the Robert Wood Johnson Foundation established the RWJ Executive Nurse Fellows Program. Subsequently, that program established five core leadership competencies that are considered essential to move NEs into critical leadership positions in health care. These competencies are "self-knowledge, strategic visions, risk taking and creativity, interpersonal and communication effectiveness, and inspiring and leading change" (O'Neil & Chow, 2011, p. 36).

The Ministry of Health in China created a 5-year plan to improve nursing care quality in China. A part of the plan was to increase knowledge and skill of the nurse leaders. Spicer et al. (2011) studied the perceived importance of role competencies for directors of nursing (DONs) based on the Forces of Magnetism. DONs and chief operative officers (COOs) were surveyed. The research team developed the Director of Nursing Survey: Importance of Role Competencies instrument and surveyed a panel of expert nurse leaders from China to ensure content validity. The survey sample was 208 DONs and 192 COOs. The scores on the items from the DONs and COOs were very similar, but there was a statistically significant difference between the

perceived importance of TL, which was higher for the DONs than for the COOs. Overall, the competencies associated with the forces of magnetism were found to be important for DONs in China (Spicer et al., 2011).

In New Zealand, health care reforms had been impacting nursing for a decade. A NE in New Zealand applied TL with action research processes and shared governance, a core magnet concept, to achieve effectiveness in the new health care culture. The NE achieved a more committed and capable nursing workforce that showed professional respect for one another and engaged in continuous learning (Bamford-Wade & Moss, 2010).

Although opinions among researchers differ, because there are numerous positive outcomes for staff and patients, TL has been increasingly recommended as important for effective leadership in nursing (Chambers, 2002; Sofarelli & Brown, 1998). Vandenberghe et al. (2002) also associated TL with change management and stated that this approach is appropriate for nursing leaders. Murphy (2005) stressed that intellectual stimulation is especially important because it helps develop analysis and exploration of practice and enhances the knowledge base nurses. Murphy encouraged development of TL as a key competency that will create a new environment to benefit nurses and their patients. However, some critical care nurse leaders still demonstrate a lack of intellectual stimulation, innovative motivation, or individual consideration for their followers (Botma, Botha, & Nel, 2012). Positive relationships have been noted between transformational leadership behaviors in mental health nurse leaders and organizational effectiveness and patient outcomes (Elisabeth & Severinsson, 2011).

Duygulu and Kublay (2011) studied TL in unit charge nurses and strongly advocated for continuing leadership training for nurses in management positions. The study used the Leadership Practices Inventory (LPI), a tool developed by Kousez and Posner, to examine

transformational leadership behaviors. The LPI was administered four times, the first being prior to the training program for the participants and a group of observers. The LPI was repeated at three months and nine months into the program as well as at the conclusion of the program. The training program consisted of 14 hours of theory and 14 hours of individual study over the topics of (a) management, leadership and transformational leadership; (b) process of influencing power; (c) motivation; (d) exemplary leadership practice; and (e) becoming an effective leader. The scores for transformational leadership behavior rose from the beginning to the end of the program in both the self-report of the charge nurses and in the reports of the observers. Although the population in this research is front-line nurse leaders, not NEs, the type of intervention used for their development may also be relevant for NE performance and development.

De Casterlé, Willemse, Verschueren, and Milisen (2008) studied another leadership development program for nurse managers. They found that the nurse manager's transformational leadership development requires more than attending a program. Their research described an iterative process of ongoing interaction between the nurse manager who is motivated and trained to become more self-aware and the staff they supervise. As the leader's self-awareness increased, so did her or his vision, empathy, self-confidence, and communication skills. The team also experienced improved communication, took more responsibility, and felt more empowered and clear in their work. The team improvements resulted in better patient-centered communication and continuity of care (De Casterlé et al., 2008). Graham and Jack (2008) reported a NE's professional development program for mid-level nurse leaders, the next level higher than the nurse manager. They noted that nurses must be strategic in establishing positive purpose, direction, and goals to be able to lead effectively in the turbulent health care environment.

Similarly, Cummings et al. (2008) performed a systematic review of the literature to determine what factors contribute to nursing leadership and effective educational preparation to develop improved nursing leadership behaviors. They found:

Leadership can be developed through specific educational activities, and by modelling and practicing leadership competencies. However, the relatively weak study designs provide limited evidence for specific factors that could increase the effectiveness of current nursing leadership or guide the identification of future nurse leaders. Robust theory and research on interventions to develop and promote viable nursing leadership for the future are needed to achieve the goal of developing healthy work environments for health care providers and optimizing care for patients. (p. 240)

Another literature review by Cummings et al. (2010) also shows the importance of transformational leadership, as well as other relationship-focused leadership styles. In this review, Cummings et al. found higher job satisfaction associated with the relationship-based styles when compared to task-focused styles. They encourage organizations and nurse leaders to develop transformational and relational leadership to improve nurse satisfaction, recruitment and retention and to support healthy work environments.

Efforts to explore leadership practices and what makes a successful NE similarly encourage further study and development as well as understanding of the role of the NE. Lummus (2010) used the Leadership Practices Inventory (LPI) to study transformational leadership characteristics for nurse leaders. She surveyed 100 nurses from different settings, including hospitals, outpatient clinics, schools of nursing and academia. She researched the perceptions of these nurses regarding leadership characteristics, as defined by the LPI, and what the ideal nurse leader would possess. She also examined whether there was a relationship

between the responses and the years of experience, level of education, and the work setting of the nurse. The highest rated leadership characteristic was "Sets a personal example of what I expect of others." The second highest was "Treats others with dignity and respect." The third was "Develops cooperative relationships among the people I work with" (Lummus, 2010, p. 55). She noted that her results supported the validity of TL as an important theory for nurse leaders. She also found support for all of the 30 leadership practices listed in the tool among the nurses surveyed. She recommended further research using existing leadership theory and measurement tools to better understand leadership practices. In particular, she advocated the study of TL in nursing leaders and its application as an important theory to advance leadership in nursing.

This section has reviewed studies that show TL in nursing leaders is positively associated with improved patient and nurse satisfaction, improved commitment among nurses, and numerous other improved outcomes for nursing staff. TL is recommended as essential for successful nurse leaders. Programs to improve TL in nursing leaders have been developed and have shown some success, as has measurement of transformational leadership behaviors. However, additional research is needed to understand, develop and measure transformational leadership in NEs, with a goal of improved outcomes for patients and the staff that care for them.

In this study, existing leadership theory and tools are being applied in a new way to NE's. This is the first study to apply action-logics to NEs in the VHA, as well as to examine the supports for nurses to speak up, including sources of behavioral influence the NEs have implemented to transform their environments to be more favorable for speaking up. In her book entitled *Transformational Leadership in Nursing; From Expert Clinician to Influential Leader*, Marshall (2011) did not reference Torbert when she discussed theories of TL. She noted that Kegan (1982) listed developmental stages of what she called, "leadership traits toward

transformational leadership" (Marshall, 2011, p. 3). This dissertation advanced work in TL in nursing through its use of action-logics as developmental stages for NEs, and increased the relevance of developmental psychology to the field of nursing.

The next section explores existing developmental theory and the associated measurement tools and their application to leaders.

Developmental Theory

Piaget is noted for studying the development of children from infancy through adolescence. He noted there are predictable stages that build progressively, one upon the other, as a child develops physically and intellectually (Piaget, 1972). Subsequently, other psychologists have studied development in children, adolescents, and adults in additional domains including multiple types of intelligence, moral development, and stages of consciousness. The distinguishing characteristic of developmental theory is that development occurs through an invariant sequence, with the accomplishments in lower stages serving as prerequisites for development to higher stages (Loevinger, 1993). Developmental theorists (Gilligan, 1993; Jensen & Wygant, 1990; Loevinger, 1976; Torbert & Cook-Greuter, 2004; Wilber, 2000a) have described human maturation as development through stages that can be defined and occur through a predictable sequence. Maturing through these stages can be achieved by anyone capable of abstract thought. Developmental theories encompass more than theories of personality type, such as is measured by the Myers-Briggs Type Indicator (MBTI), of emotional intelligence (Goleman, 1998), of Model I and Model II types of thinking (Argyris, 1999), and of systems theory (Senge, 1990). Developmental theories include all of these elements and more in an analysis of how human beings develop and how further development can be promoted (Cook-Greuter, 2004).

This section discusses literature pertaining to developmental theory. Piaget's foundational work will be introduced. Early researchers in developmental theory will be discussed and the concept of ego development, as proposed by Loevinger will be reviewed. Additionally, the lack of agreement about when hierarchical development ceases will be explored, as the work of multiple researchers who hold differences of opinion on this topic will be reviewed. Finally, the action-logic framework of Torbert will be reviewed, as will the measurement of action-logics.

Early developmental psychologists. Piaget influenced a generation of psychological thinkers with his view that human cognitive development occurs through childhood and reaches its end point in adolescence progressing through stages from birth (Mussen, 1970; Piaget, 1972). Piaget (1972) described stages as being unified wholes (the stage uses a consistent set of cognitive operations and uses a set of rules that are in concert with a particular world view). Piaget also noted that stages are hierarchical with successive stages incorporating the previous ones, with each stage becoming more complex. The order of the stages does not vary and each earlier stage serves as a necessary foundation for the next. The highest stage, according to Piaget, is formal operations and can be reached during the teen years, or it may never be reached at all. This stage involves abstract thought, developing propositions to expand the ability to consider possibilities beyond concrete manifestations. Problem solving is reoriented to start with what is possible rather than only considering what already exists. Once the capacity to think in this way developed, Piaget stated that development stopped. Increased competence was gained in application more and more comprehensively as more knowledge was gained. Alexander and Langer (1990) describe Piaget's concept of cognitive development as experimentation guided by the logic accessible at each stage. Development also entails organization and adaptation toward equilibration. Equilibration occurs spontaneously and is the primary mechanism of stage

development. Equilibrium is "the active state of balance between the cognitive system and the demands of the environment" (Alexander & Langer, 1990, p. 6).

Harvey, Hunt, and Schroder (1961) studied conceptual systems. They noted that, "The matrix of concepts embraced within the self serve as kinds of channels through which the environing world is evaluated" (p. 68). Development progresses as the matrix of concepts advances through stages, occurring "in a series of bursts or leaps" (p. 85). The progression of development is facilitated when an initial concept is clear and the new concept is discrepant or opposing. Successful integration of the two concepts results in a new conceptual map. Development is toward increasingly abstract thinking. Harvey et al. emphasized that training conditions were very important to support progression from concrete to abstract thought and listed conditions that would both arrest and support development. Arresting conditions included closedness to the opposing concept, as well as failure to evaluate both the initial concept and the opposing one. Supportive conditions included openness to the evaluation of the opposing concepts and favoring the integration of the two extremes.

Isaacs (1956) proposed the construct of relatability stating, "There is a maximum potential capacity for each individual" (p. 9), and this capacity varies with each successive stage of development. The capacity depends primarily on the perceiver and not on external conditions. An individual's capacity can be higher than their functioning. The relatability scale is "a sequence of levels of increasing differentiation of the self from others, and the increasing affective appreciation of the delineation of others" (p. 12). The most advanced level, *alpha*, can empathize with others without losing self in others. Attributes vary in activity at different levels, with attributes that may have undergone intense activity at lower levels increasing in meaning but being of less conscious concern as problematic at higher levels.

Kohlberg (1964) studied the development of moral character in boys. He defined morality as "conscience, a set of cultural rules of social action which have been internalized by the individual" (p. 384). He saw moral development as the process that increases the internalization of these values. Behavior, emotions, and judgment are aspects of internalization. He found that moral conduct is related to decision-making capacity and is not a fixed behavior trait. He also found that moral judgment develops in stages that are distinct and sequential.

Sullivan, Grant, and Grant (1957) described seven levels of development of interpersonal maturity. The person at the integration level recognizes that there are a variety of ways to perceive and integrate experience, and hence no longer seeks absolute realities. This person sees the behavior of others as a result of the other person's maturation process.

Peck and Havinghurst (1960) defined five character types that they considered as successive stages in psychosocial development. They defined individual character as " a persisting pattern of attitudes and motives which produce a rather predictable kind and quality of moral behavior" (p. 164). They noted that only their most advanced type, *the rational altruistic*, remained open to psychological growth. They also noted that, "the Id grows up, too" (p. 175). The impulse life matures so that its desires are ethical.

These early theorists explored how development occurs toward abstract thought, how conceptual systems emerge, how personal capacity for development increases, and that perception can be more influential than the environment in actualizing one's growth. Authors found stages of development for morality, interpersonal maturity, and psychosocial development. All of these concepts were important to Loevinger, whether she affirmed or departed from them, as she constructed her theory of ego development. An explanation of her concepts follows.

Loevinger's ego development theory. Loevinger (2002) told the story of how she

became interested in ego development theory. She was associated with the psychology

community at Berkeley before World War II as both a student and a teacher. Her doctoral thesis

was in the development of psychometrics and was completed during the war. After the war she

went to St. Louis to the Washington University community, initially without a job. She became

interested in studying the challenges in women's lives, and she did so, incorporating her skill in

psychometrics with a grant from the National Institute of Mental Health. She worked with other

psychologists and hundreds of subjects and developed and refined a test for measuring women's

attitudes, the Family Problems Scale (FPS; Loevinger, 2002).

Colleagues stated that she was actually studying ego development. Loevinger assimilated

concepts from psychology contemporaries and predecessors and proposed the construct of ego

development (Loevinger, 1966). With her psychometric background, using the term ego

development required that she learned how to measure ego development, as well as describe it.

Loevinger and colleagues constructed the WUSCT for that purpose. This test was initially

constructed for women, but it was expanded for use in adolescents of both genders as well as for

men. Next, some of the origins of the construct will be explained, followed by a description of

the construct itself.

Loevinger adopted the concepts of stages as unified wholes that are hierarchical from

Piaget. However, Loevinger (1966) departed from Piaget through her assertion that ego

development can occur throughout the lifespan. Her conceptual systems emerged in part from

Harvey et al. (1961). She attributed elements of the concept that a person's focus on issues

changes in successive stages to Issacs (1956). Moral development theory as presented by

Kohlberg (1964) informed aspects of Loevinger's theory regarding behavior, emotions, and

judgment as aspects of ego development. Loevinger (1966) stated that Sullivan et al.'s (1957)

contribution explaining interpersonal integration, their highest level, was significant to her work.

Character development by Peck and Havinghurst (1960) also shaped Loevinger's construct

(Loevinger, 1966). She found the commonalities in these sources, stating, "all of them have been

concerned with the abstract junction of a developmental sequence and a character typology"

(Loevinger, 1966, p. 198).

Loevinger's (1966) ego development theory greatly expanded on Freud's use of the term

ego, which referred to being able to distinguish self from non-self. Loevinger's description of ego

includes the transformations in a person's life to which the self is subjected or voluntarily submits

itself. She added the postulation that ego development occurs in an unvarying sequence.

Each element in the sequence occurs in a predictable order. She articulated the major elements as

milestones and polar aspects and described their manifestations. Milestones are observed as one

demonstrates a particular behavior. Polar aspects are inferred from patterns of observed behavior

and decrease as ego stages increase. For example, stereotyping behavior decreases as one moves

hierarchically through stages in this construct.

Loevinger (1966) described seven stages of development. The first stage is called *presocial*

and symbiotic. Initially, the child must learn to distinguish animate from inanimate objects, then

to distinguish itself from its mother.

The second stage is called *impulsive*. The child corroborates its separate existence from its

mother by using its own will. Impulse control is minimal and unpredictable.

The third stage is called *opportunistic*. The person in this stage recognizes rules and

follows them if they provide an immediate advantage. Relationships are manipulative and

exploitive and the focus is on control, taking advantage, deception, winning, and domination.

The only choice is to win or lose, and the morality at play is one of expedience.

The fourth stage is called *conformist*. This is the most widely recognized and explained stage. Rules are followed because they are rules and shame is experienced if rules are transgressed. The affinity group of whom the person is a member is important and mutually trusting relationships can be built with members of the group. However, the definition of the affinity group is often narrow and stereotyping of those not in the group is common. The focus is on material things and appearance.

The fifth stage is called *conscientious*. The person's own morality becomes more important than the morality of the group, and if the person violates her or his own morality, the person feels guilty. Relationships are more intense and meaningful then in earlier stages and the focus is on obligations and ideals. Behavior and achievements are measured by one's own standards, and those in this stage tend to be self-critical.

The sixth stage is called *autonomous*. Dealing with inner conflict is the focus, and the person becomes more tolerant of those who make choices different from their own. Interpersonal relationships are intense and one recognizes the importance of autonomy and mutual interdependence. Self-fulfillment is a conscious preoccupation, as are individuality and role differentiation.

The seventh stage is called *integrated*. The focus changes from coping with conflict to reconciling it, as well as renouncing unattainable goals. Tolerance of difference transforms to cherishing differences, and integrating one's identity is now preferred over role differentiation. This stage is rarely attained or observed (Loevinger, 1966).

Loevinger (1966) noted that the science of measurement in psychology at the time she described her stages was focused on factor analysis. She stated her construct cannot be measured

through factor analysis, which is a solely quantitative approach. The instrument she developed, the WUSCT, combines a qualitative approach to assess the presence of milestones and a quantitative approach to assess the degree to which a polar aspect can be inferred. She developed and refined the tool through decades of research. The WUSCT is now one of the most widely used tools in personality assessment. Its validation and use in thousands of studies worldwide underscore the broad acceptance of the tool and concepts (Cook-Greuter, 2004).

Loevinger (1966) noted that her construct of ego development is to be differentiated from the psychoanalytic use of the term, which focuses on one limited aspect of development in children. She also stressed the importance of the use and study of this construct, stating, "Ego development has been presented not as one interesting personality trait among many, but as the master trait. It is second only to intelligence in accounting for human variability" (Loevinger, 1966, p. 205). Further, Loevinger emphasized that "the structure of our science should reflect the structure of life. On this basis ego development must become a focal construct in psychological theory and research" (p. 206). In so doing, she refused to define her construct because she wanted it to be continually defined by research and the evidence brought through new research.

Torbert's theory of action-logics is consistent with ego development theory proposed by Loevinger (1966). Additionally, the method for measurement of action-logics is derived from Cook-Greuter's modifications of Loevinger's WUSCT (Torbert & Cook-Greuter, 2004).

Research supporting Loevinger's theory. Other researchers have supported Loevinger's assertion that her construct of ego development was distinct from the construct of intelligence. Cohn and Westenberg (2004) conducted a meta-analysis of 42 studies to determine whether Loevinger's WUSCT measures intelligence. The WUSCT has been widely tested and is considered a psychometrically sound tool for measuring ego development (Cohn & Westenberg,

2004). In their study, Cohn and Westenberg found that the WUSCT does not measure intelligence. The developmental variable of ego development is not the same as the construct of intelligence. The measurement of ego development contributes to the understanding of developmental phenomena distinctly from the measurement of intelligence.

Additionally, Loevinger (1966) stated that ego development is independent of psychopathology. This assertion was supported by Waugh and McCaulley (1981), who studied the patient records 88 adult patients of a university teaching hospital psychology clinic. These patients were not organically impaired and they displayed psychopathology on the Minnesota Multiphasic Personality Inventory (MMPI). The researchers compared the distribution of 88 patients on ego development to the distribution of four non-clinical groups, totaling 2439 people, who had also taken the MMPI and were measured on ego development. They found similar ego development distributions for persons with psychopathology to persons not displaying psychopathology on the MMPI.

Other aspects of Loevinger's construct of ego development have also been supported. Martin and Redmore (1978) used the WUSCT, a vocational choice questionnaire, and the Career Maturity Inventory (CMI) with 55 high school seniors, who were differentiated by socioeconomic status. They supported Loevinger's assertion that ego development is hierarchical and that the stages follow a particular order that does not vary. They also found that ego development was related to vocational maturity and to socioeconomic status. Rozsnafszky (1981) found that certain milestone behaviors correspond to certain ego development levels, as measured by the Sentence Completion Test of Ego Development (SCT; Rozsnafszky used this term for what is more commonly known as the WUSCT). The researchers developed and used the Minnesota Q-Set in this study to describe milestone traits in 91 hospitalized male Veterans.

The authors found that their Q-set observations of milestone traits for seven ego levels support Loevinger's milestone traits as measured by the WUSCT.

Manners, Durkin, and Nesdale (2004) demonstrated that ego development can be promoted in adulthood, noting that moving into subsequent stages occurred when they conducted an intervention study with community-living adults who were experiencing life challenges that were "structurally disequilibrating, personally salient, emotionally engaging and interpersonal" (p. 20). The participants in the two intervention groups (21 and 22 participants, respectively) met for 10 weeks, 90 minutes each week, and studied the topics of communication, self-awareness, goal setting, conflict management, and stress management. The control group (15 participants) did not receive these interventions. The researchers found a significant increase in ego stage level in the two intervention groups as measured by two alternate forms of the WUSCT, before and after the intervention. The alternate forms have demonstrated high correlation (.95) with the full WUSCT and reduce error that could be introduced by using the full WUSCT before and after the intervention (or twice without intervention, as was the case with the control group). They found no increase in ego stage level in the control group.

Carlozzi, Gaa, and Liberman (1983) examined the relationship between ego development and empathy. They gave 51 undergraduate dormitory advisors both the Loevinger's WUSCT and the Affective Sensitivity Scale, a scale designed to measure empathy. They found that, as Loevinger (1976) suggested, persons at higher levels of ego development scored significantly higher in empathy than those a lower levels. McAdams, Ruetzel, and Foley (1986) interviewed 50 mid-life adults regarding their overall plan for their future and gave them Loevinger's SCT as well as the Thematic Apperception Test (TAT). Persons with higher ego development showed a higher degree of complexity through their greater variety of goal commitments for the future

than did adults with low ego development. They also found, contrary to what they anticipated, that higher levels of ego development were not associated with an emphasis on doing new things and having marked transition in the future. Browning (1983, 1987) conducted two studies exploring the relationship between ego development and authoritarianism. Browning's 1983 study involved 966 late adolescents and young adults who were tested using Loevinger's WUSCT and the Youth Study Questionnaire. Browning sought to determine whether authoritarianism would be more evident at the self-protective (lower) or conformist (middle) stage. She found that the subjects who had reached the conscientious (higher) stage demonstrated less authoritarian attitudes. She also found that the lower and middle stage subjects varied in authoritarian expression based on the topic of the discussion. Browning (1987) studied 455 men and 475 women aged 16 to 25 years using a 200 item survey as well as Holt's 12-item version of the WUSCT for ego development. Browning (1987) found that, as Loevinger predicted, authoritarianism would have a curvilinear relationship with ego development, with persons at higher stages demonstrating less authoritarianism. Additionally, she found a significant association between ego development and education.

Authors not supporting hierarchical development in the adult. Essential to the concept of adult development is whether development continues in the adult. Piaget supported hierarchical development through adolescence, but not in the adult. Loevinger departs from his thinking in supporting hierarchical development in the adult. Other researchers also do not support continued hierarchical stage development in the adult. Their work is described below.

Levinson (1990) described seasons in adulthood in which the focus changes for the adult but does not equate them with an evolutionary process. His theory was based on research that focused on 40 male subjects between 35 and 45 years old (Levinson, 1978). They were hourly

workers in industry, business executives, university biologists and novelists. Researchers elicited life stories, conducted biographies, and developed generalizations about their observations. The goal was to determine what developmental process occurred during that decade. What they constructed was a developmental theory as they prepared the biographies. Their theory included more than the middle decade (the years 35 to 45); instead, it spanned from infancy to 80 years and older. They describe five eras in which the overall character of living, including biological, psychological and social aspects display certain similarities for the men studied. Although at every stage opposite extremes are reconciled and integrated to some degree, Levinson (1978) does not consider his seasons to be the same as hierarchical stages.

Gardner, Phelps, and Wolf (1990) described aspects of intelligence in addition to the mechanical, including visual-spatial, kinesthetic, musical, and narrative thought. They observed that these involve symbols and the capacity to express these aspects of intelligence emerges in an invariant sequence. They described the development of creativity as an epigenic process, not a hierarchical one. Gardner's 20 years of clinical experience in neurobiology, working with both normal children and those suffering from pathology, in concert with the observations of his co-researchers, as well as reading literature in brain study, genetics, anthropology, and psychology yielded a taxonomy of intellectual capacities (Gardner, 2011). The taxonomy was developed through study and clinical practice, and was not an apriori notion.

Langer et al. (1990) emphasized plasticity as a human capacity and that hierarchy may not be a necessary feature for human development. They described two mental states: mindfulness and mindlessness. Mindfulness is a process of active construction of new categories relevant to one's self and the world. Mindlessness involves passive existence within previously established categories. They tested 70 to 75 year old volunteers before and after a five-day retreat

for changes in mindfulness. During the retreat the experimental group lived as though they were 20 years younger. They did not refer to current events or speak in the present, but acted as they had 20 years earlier. In contrast, the control group reminisced about the past of 20 years before for the duration of the five-day retreat. They found that both groups improved, but the experimental group improved more on psychological functioning, demonstrating increased attention, concentration and memory as evidence by the Wechsler Adult intelligence Scale. Additionally, the experimental group improved in posture, manual dexterity, joint flexibility, and near vision. They proposed that mindfulness can result in leaps in development, skipping what others describe as necessary intermediate states, reversal to a previous state (as noted in the experiment above), or movement from a known state to a previously unknown state of development. For these authors, mindfulness results in unlimited potential for transformation. When one mindfully breaks their current patterns, disrupting their equilibrium, growth can occur. Although increasing awareness is critical to advancing through stages according to Loevinger (1976), the approach by Langer et al. (1990) did not consider stages at all, but described states that may occur in no particular order.

Lawrence Kohlberg's initial interest was to expand Piaget's work on the moral development of children to adolescents. Kohlberg (1984) reasserted the stage approach to moral development that Piaget had begun. Kohlberg (1984) described three levels of development with two stages to each level. Like Loevinger, Kohlberg posited that stages exist in an invariant sequence, they have internal consistency, and that each higher stage integrates or displaces the lower stage. He found, "culturally universal moral values developing through an invariant sequence of stages" (Kohlberg, 1984, p. 3). Snarey, Reimer, and Kohlberg (1985) validated Kohlberg's model and measure of moral reasoning in a study of 92 adolescents in a kibbutz in

Israel. In contrast to Loevinger, Kohlberg assigned a higher value to the higher stages. Kohlberg

and Elfenbein (1975) used data from a 20-year longitudinal study of American males and

evaluated attitudes toward capital punishment. They determined that a theory of punishment

using the highest stage of moral reasoning is the most valid. Loevinger (1993) did not state that

higher stages in her theory of ego development are philosophically superior; each stage has its

challenges, which bring both opportunities for development and for maladjustment.

Kohlberg and Ryncarz (1990) posited a seventh stage of moral development. In this

stage, one transcends preoccupation with self. Elements of existence that were previously

experienced as background become the center of attention. This shift of attention is toward a

cosmic sense of unity with all things. They described the thinking as beyond justice reasoning,

and as a "more comprehensive cognitive level of morality" (Kohlberg & Ryncarz, 1990, p. 206).

This state is reached through transcendental meditation or a mystical experience. Because this

state is achieved through a reflective thinking process, influenced by particular life experiences,

they do not consider it a hard structural stage. In the strict sense in which Piaget interpreted

hierarchical growth, as accepted by Kohlberg, this growth process is not associated with

establishing a hard physical structure, so it is not hierarchical. Kohlberg and Ryncarz considered

the previous hard stages essential to this process and added that the reflective thinking process in

adulthood is also essential to it. Of interest are the similar accomplishments in Loevinger's

integrated stage, her seventh stage as well. In the integrated stage one reconciles conflict, values

differences and transcends the need for role differentiation for an integrated identity (Loevinger,

1966).

Adult development theory. Development in the adult is an important feature in the

theories by Loevinger (1966, 1976, 1993) and Torbert and Cook-Greuter (2004). Torbert and

Cook-Greuter stated that their action-logics, "correspond closely to the developmental stages identified by developmental psychologists Skip Alexander (Alexander & Langer, 1990), Bob Kegan (Kegan, 1982, 1994), Larry Kohlberg (1984), Jane Loevinger (Loevinger & Wessler, 1970), and Ken Wilbur (Wilber, 2000b)" (Torbert & Cook-Greuter, 2004, p. 210). These and other authors whose work supports the idea of hierarchical development in the adult are discussed below. Their contributions shape the field and reveal the possibilities for development in the adult and the dimensions in which adult development can occur.

Fischer, Kenny, and Pipp (1990) supported hierarchical development in children and adults who moves through stages. They focused on cognitive competence, stressing that cognitive competency is only achieved through practice and does not exist without the skills required for implementation. They tested the conditions for optimal performance in the development of arithmetic skills in children and adolescents from third grade through college. The subjects were first shown a task and asked for an immediate answer. Later in the same session they were shown the same task and given a correct answer and the time to study it. This sequence of events was repeated two weeks later. These tasks were designed to assess four levels of abstraction. They concluded that competence is built and expressed only in specific areas and within a favorable environment and familiar domain. In their construct, a stage shift occurs when two skills are integrated so that there is a qualitative shift in performance that exceeds simple addition of two skills. A qualitative shift in performance is also significant from one stage to the next for Loevinger (1966) and Torbert and Cook-Greuter (2004).

Gilligan, Murphy, and Tappan (1990) observed that two distinct moral orientations may become evident in adolescence or adulthood and can be increasingly developed in a hierarchical stage beyond formal operations. They performed a longitudinal study for the purpose of

elucidating the developmental transition from adolescence to adulthood through observing how subjects thought about reality and how that thinking can affect further development. They interviewed college students age 22 about moral conflicts they had experienced, asking them to describe their thoughts about these events. Five years later, the subjects were interviewed again for their current thinking about the previously discussed moral conflict. The researchers determined that in the most advanced form of human thought reason and feeling exist as two voices that find expression together. Reason, the ethic through which justice is sought, is not sufficient to deal with the complexities of life and relationships in adulthood. Neither is the ethic of care, through which feelings are expressed, complete enough to arrive at mature and comprehensive decisions. Conflict arises and choices must be made that require the ethic of care to operate as well as that of reason to address the challenges of self in relationship. Loevinger (1966) and Torbert and Cook-Greuter (2004) also spoke of the ability to deal with conflict productively in their higher stages, taking what had formerly been opposing views and reconciling them.

Souvaine, Lahey, and Kegan (1990) also supported post-formal hierarchical stages of self-development. Their theories of consciousness and self-development used representational processes that were described as underlying all cognitive, moral, and affective development. They focused on the subject-object relationship. The subject is identified with the organizing principle or person doing the organizing. The object is that which is organized. Growth occurs as one is able to differentiate oneself from that which one identifies. When something is no longer part of one's identity, one can deal more effectively with it and organize it: it has changed from subject to object. This new ability to organize occurs through a higher, more complex structure that contains its own more complex subject forms (Alexander & Langer, 1990).

Souvaine, Lahey, and Kegan (1990) described two stages of development that occur post-formal operations, as well as the stage of formal operations that they called *the institutional stage*. Through their interview research they explored work and intimate relationships that supported each participant's values and purposes. They used this intervention as a lens to try to understand how the individual makes meaning. They discussed the importance of reflection by the individual on the limits of their own constructions. Once the reflection occurs, they may construct a new way of making meaning. They described a transitional stage, in which one gains the perspective that the polar views taken in the institutional stage may be incomplete, and a strong desire for transformation occurs. Some distancing occurs from previously held positions with the focus being on the ability to transform. The final stage they described they call *interindividual*. In this stage, one more readily accepts the experience of strong emotions and one sees oneself reflected in others. Polarities are accepted and acknowledged as a part of every decision and situation. The task is not to find the truth but to live in an increasing state of awareness. Loevinger (1966) and Torbert and Cook Greuter (2004) similarly underscored the importance of increasing awareness in the process of advancing development.

Manners et al. (2004) studied whether they could promote advanced ego development through implementing factors that appeared to be involved in ego stage transition in adults. They used Loevinger's theory, moral development theory, personality change theory, and intervention programs designed to create stage development in adults. They constructed an experiment, using two experimental groups and one control group. There were 58 participants age 22 to 53 years, a mixed sample of students from a school of management and members of a suburban church. The control and intervention groups were matched on age, gender, education and ego stage. The mean ego stage was self-aware (E5). Two alternate short forms of the WUSCT were

administered before and after the intervention to prevent error that could be introduced by repeating the full test. The intervention consisted of 10 weekly 90 minutes sessions, including didactic instruction, group discussion, and experiential exercises. The experiential exercises were performed both within and between sessions. Content focused on emotional discrimination, identity definition, understanding of relationships, and effective communication based on aspects noted by Loevinger (1976) to be relevant for ego development. They found that both intervention groups attained a significant increase in mean ego stage, and there was no increase in the control group. Their experiment supported the premise that exposure to life experiences that are disequilibrating (that disturb the sense of equilibrium), that are emotionally engaging, personally salient, and interpersonal can promote advancing stage development (Manners et al., 2004).

Alexander et al. (1990) described post-representational stages of consciousness that integrate each process hierarchically, based on the Vedic theory of consciousness. Alexander et al. stated that development occurs through changing the focus of conscious awareness. This change occurs progressively into what they described as deeper levels of mind that exist native to human beings. Increasingly more abstract processes allow greater comprehensive understanding of that which is to be learned and experienced. This growth is natural to human beings and occurs in response to sufficient stimulation and support in the environment for their mastery. Transcendental Meditation (TM) is one method to attain and sustain this level of consciousness. They support their developmental model through a series of cross-sectional and longitudinal studies on subjects including pre-and early school-age children, adult prisoners, adolescents, young adults and the institutionalized elderly. They used TM practices with experimental groups, and matched them with control groups. They list numerous psychophysiological benefits of TM, including lower respiratory and heart rates and plasma lactate levels as well as enhanced

autonomic stability during mental tasks. They find that endocrine function is more efficient and stable and that EEG hemispheric lateralization is more efficient with mental effort that requires this type of activity. Advanced meditators produced increased serotonin metabolites that are associated with lower anxiety and elevated mood states.

Cook-Greuter, a colleague of both Alexander and Torbert, compared Alexander's work with her own, also noting that acquisition and stabilization of the highest levels of consciousness almost certainly requires instruction in meditative practice (Cook-Greuter, 2008). Neither Loevinger (1976) nor Torbert and Cook-Greuter (2004) focused on the highest levels or their acquisition as much as does Alexander and Cook-Greuter in her later work.

Kegan (1994) wrote about the "curriculum of modern life in relation to the capacities of the adult mind" (p. 5). He developed this theory using the methodology of the subject-object interview in numerous studies. He noted that the different specialists in leadership, intimacy, parenting, and management are all trained in different professions and do not read each other's literature. The adult who is expected to excel in all of these different areas of life has many expectations placed upon them. These silos of literature come together in expectations upon the adult that constitute a hidden curriculum of modern life. Kegan described the vast majority of adults as being in over their heads in this curriculum.

Kegan (1994) also described the psychology of admiration, of *wondering at* as an aesthetic experience and *wondering about* as an analytic one. He combined these experiences of wondering into an exploration of the relationship between the evolution of consciousness and the hidden curriculum in a culture. This hidden curriculum is the mental demands a culture makes on its people. He described two lines of thought: constructivism and developmentalism. Constructivism is "the idea that people or systems constitute or construct reality" (Kegan, 1994,

p. 198). Developmentalism is, "the idea that people or organic systems evolve through qualitatively different eras of increasing complexity according to regular principles of stability and change" (Kegan, 1994, p. 199). Loevinger (1996) used the developmental approach.

Kegan (1994) described subject-object theories, of which his is one, as constructive-developmental. This approach "looks at the growth or transformation of how we construct meaning" (Kegan, 1994, p. 199). He stated that our culture demanded a fourth order of consciousness to cope with the modern era, yet most of the inhabitants of our culture have only reached the third order. He also stated that the post-modern era demands a fifth order of consciousness, which is beyond most people. He agreed that the acquisition of these higher states will take time, and it is not realistic to expect that a significant number of people will reach fifth order consciousness in the near future. Examples of increasing orders of consciousness include:

- Children use data and begin to understand durable categories, rather than each experience being unique, as a second order of consciousness.

- Adolescents learn to make inferences and establish mental cross-categorical structures to reach a third order of consciousness.

- Adults in a higher educational setting learn to evaluate and relate inferences, understanding complex system interaction and use formulation as the fourth order of consciousness. (The fourth order of consciousness is seldom seen before the age of forty.)

- Adults in higher education learn to reflect upon theories, are able to perceive outside ideology and reflect upon the formulation process and understand trans-system structures as the fifth order of consciousness.

Kegan (1994) noted that Torbert's research corroborated his claims, used subject-object theory, and that Torbert's evaluations of stage acquisition were similar to Kegan's. Kegan (1994) noted that:

> when conflicting parties can recognize each other's needs, views, and fears, and consider solutions which reassure the other that their most precious interests will be respected, a new dynamic for unsticking their conflictual relationship can replace the traditional dynamics of threat, deterrence, and force. These traditional dynamics arise from unilateral strategic analyses of advantage and vulnerability and essentially assume that the only changes that will occur in protracted conflicts are changes in behavior, not changes in attitude. (p. 318)

A postmodern approach to resolution of ongoing disputes involves considering that you and the other person likely have identified with the poles of the conflict, that you are each considering yourself and your world view as complete rather than incomplete. Kegan (1994) advised taking advantage of the opportunity to live into your own multiplicity and focus on how the conflict can transform the parties. Find the opposite within yourself. We need a "postmodern grounding of community on more flexible and less homogeneous assumptions" (Kegan, 1994, p. 329). We need to collaboratively fashion a richer context for our common mission.

Wilber (2011) studied the development of human consciousness and synthesized conclusions from multiple schools of Eastern and Western thought. He described increasing levels of consciousness as concentric spheres that successively incorporate the whole previous sphere as consciousness grows in an individual. He stated that the more advanced levels are largely potentials. The lower levels already exist in the physical world. These levels are matter, body, and mind. He called the higher structures psychic, subtle, and causal, and notes they are

not experienced within the consciousness of most people, so they are not commonly acknowledged to exist. He named the *Great Nest* and calls it "a great morphogenic field or developmental space - stretching from matter to mind to spirit" (p. 12). He claimed that states of consciousness and structures as "stable patterns of events" (p. 13) are equally important. Spiritual and transpersonal states are accessible at most stages of development. The interpretation of the experience while in the state is largely dependent on the stage the person is in most of the time. For development to occur, the temporary state must become permanent, taking the form of the next higher stage.

Wilber (2011) noted that in the process of transitioning to higher stages, meditative states become more and more important to stabilizing experience of advanced states and stages. Wilber named 10 functional structures. He also noted the corresponding stages by Loevinger, Cook-Greuter, Beck, and others. In an integral psychology, the greatest human drive is to actualize one's spirituality so that it is apparent in the world by expressing the ascendant spirit's insights through the body (Wilber, 2011).

The development of the field itself, starting in large part with Piaget, reflects the desire to understand how growth occurs. For most, the concept that significant growth is possible after adolescence brings attention to how that growth occurs and how it is fostered. The research and theory mentioned above, supporting the contention that ego development progresses through predictable stages, has observable milestones and can be promoted is important to leadership development. Torbert's theory of action-logics is an approach to defining and supporting those processes.

Action-logic as a developmental theory and predictor of success for leaders. Torbert

and Cook-Greuter (2004) described action-logic as "an overall strategy that so thoroughly

informs our experience that we cannot see it" (p. 66). According to Torbert and Cook-Greuter

(2004), the ability to create and implement strategy requires a highly developed world view or

action-logic. Rooke and Torbert (2005) described seven action-logics that they have observed in

leaders. Additional action-logics have been observed but are not the focus of their study on

leadership. Of the action-logics they observed and studied in leaders, they further sub-divide the

action-logics into pre-conventional, conventional, and postconventional categories. Action-logics

are developmental, and are attained in a predictable sequence, starting with the Opportunist, the

lowest action-logic observed in leaders. Rooke and Torbert (2005) and Torbert and Cook-

Greuter (2004) discussed action-logics observed in leaders as follows.

First, and lowest in their hierarchy of leadership action-logics, is the Opportunist stage.

The Opportunist action-logic is a pre-conventional action-logic and was found in 5% of leaders

they studied (Rooke & Torbert, 2005). It is the lowest in the hierarchy of action-logics found in

leaders and is one of the least effective for both the leader and the organization they lead. This

leader is competitive and focuses on winning, is self-oriented, and will manipulate others. Their

strengths are as a decision-maker in emergencies and they do well in sales. Torbert and Cook-

Greuter (2004) also noted that Opportunists interact as though the external physical world is their

primary reality and they focus on controlling things in that sphere. According to their

understanding, the only effective type of power is unilateral; they operate on a short time horizon,

and they focus on winning. This is a developmental stage that people usually transcend by

the age of 12. Leaders who remains in this action-logic are skillful manipulators who engage in

transactions for personal gain with little thought for relationships or the damage they may be

doing to those relationships or their reputation, unless and until that damage keeps them from winning. The Opportunist is decisive in emergencies and can open new avenues for sales and adventure. Over time, the Opportunist's manipulations result in others not trusting them. The Opportunist avoids accepting responsibility, externalizes blame, and cannot accept constructive feedback to improve performance. As might be anticipated, this action-logic is self-limiting among leaders.

The second action-logic, as described by Rooke and Torbert (2005), is that of the Diplomat. This is the lowest of the three conventional action-logics, with 12% of the leaders in their studies profiling at this level. The Diplomat avoids conflict and disruptive behavior and obeys the norms of the group. Their strengths are bringing people together and they are frequently found in junior leadership positions. Additionally, Torbert and Cook-Greuter (2004) explained that persons inside this action-logic treat their own experience as the primary reality and focus on controlling themselves to be effective. They observe the behavior of people of elevated status and act in concert with those behavior patterns. They are compelled to ensure that their social performance meets the expectations of the important groups in their lives. This action-logic is common in the early teenage years. Torbert and Cook-Greuter (2004) subdivided their categories of leaders at this action-logic, finding that, among managers, 24% of first line, 9% of junior, and 5% of senior managers profile at this action-logic. Although they can be reliable and loyal with an excellent sense of style and tact, they can also create conflict because they try so hard to avoid it. They do not seek negative feedback about themselves, trying to avoid that as well. This manager also cannot criticize others. They work within a time horizon of a week to three months and are focused on being on time for meetings and task accomplishment. Organizations they lead will not be able to adjust to changes in the environment that require

critical review of their current performance. Staff reporting to this leader may falsify information in order to save face for themselves and their leader.

The third action-logic is the Expert, which included 38% of the leaders studied (Rooke & Torbert, 2005). This is a conventional action-logic. Experts use expertise and logic as the foundation for their rational and efficient decision-making. Their strength is as an individual contributor. Torbert and Cook-Greuter (2004) added that the primary reality for Experts is experience, and they focus on mastering a particular specialty. Logic is very important to the Experts and they work on a six-month to one-year time horizon to accomplish projects, yet they value efficiency. The time they allow themselves, according to their viewpoint, reflects the complexity of their work. This action-logic can be seen emerging during the college years or within 10 years after entering the work force. Persons in this action-logic demonstrate extreme technical proficiency and identify with what makes them unique. They no longer rely on the opinion of their peers for validation, as they rely on their own expertise, which is considerable. They are organized, future-oriented, and work hard to perform up to their own excellent standards. They usually consider constructive criticism frustrating because they know they are experts in their area of specialty. They will accept feedback from individuals they perceive to have greater expertise than their own, but frequently discount the opinions and needs of others who do not hold their admiration. Subordinates can be inspired to work for the Expert's recognition and be frustrated by the lack of individual consideration the Expert gives them. The Expert is frequently not a good team player and can discount organizational concerns that are not within their specialty and ideas not in agreement with their own. They are excellent individual performers and have an important place on any team that is to be successful. Approximately 45%

of managers demonstrate this action-logic. Experts can fall prey to over-work, which can be one of the incentives for some to advance their lives and their action-logic to a new level.

The fourth action-logic and highest conventional action-logic is that of the Achiever. The Achiever is a good fit in the management role, with this level comprising 30% of the leaders studied (Rooke & Torbert, 2005). This person successfully implements strategy and meets goals through effectively functioning teams. Their strength is managing. Torbert and Cook-Greuter (2004) noted that the Achiever has a one to three-year time horizon within which they work. This time frame leaves time to work creatively, to plan and perform efficiently, and assess outcomes of the incremental changes they implement. They know the importance of an immediate win at times within the longer-term plan. They realize that a certain market or constituency will determine whether they are successful. Persons who are highly educated and professional are the most likely to enter into this action-logic. The Achiever is very goal-oriented and focuses on the larger perspective of the organization as a whole. The Achiever retains the ability to hone in on a particular specialty or element of a project, but can also see how each team in the organization contributes to the effectiveness of the whole. The Achiever can implement organizational strategy. The Achiever values relationships and seeks mutual interaction and benefit. They even may accept constructive feedback to improve relationships and increase success. However, the feedback must fit within their existing world-view or it will be discounted and deemed irrelevant. The Achiever is not able to transform their approach while implementing an existing plan. They are limited by a set view of the organization and its goals and they are unaware that their view inhibits strategic shifts that may be important to the organization.

The fifth action-logic is that of the Individualist, the lowest postconventional action-logic. Only 10% of leaders studied achieved this level of development (Rooke & Torbert, 2005).

This leader recognizes that conflicts exist between the values they and or their company espouse and the values expressed in the actions they take as an individual or the company takes. This conflict results in a creative tension and further development for the leader and the company. The Individualist's strength is in consulting roles. Torbert and Cook-Greuter (2004) further explained that Individualists break from the convention of valuing similarity and stability and place greater worth in diversity and continuing transformation of their own and others' action-logics. They are increasingly capable of choosing which action-logic to use in a given situation and may be very creative in the moment. The Individualist may also struggle with the sense that something needs resolution and yet they are paralyzed, unable to construct a response. The introspective journey of the Individualists involves reexamination of all of their previous action-logics and experiences. This process brings excitement and new ways of being in relationship along with a new sense of doubt with the emotional turbulence of living through both extremes. The Individualist bridges the conventional world and the postconventional world, coming from an existence perceived as stable to one that is emergent, fluid and filled with increasing power to engage and lead others into transformational change.

The sixth stage of growth is the Strategist. Rooke and Torbert (2005) found that only 4 % of their leadership sample profiled at this action-logic. This leader creates organizational and personal transformation using a powerful combination of mutual inquiry, vigilance, and vulnerability. Torbert and Cook-Greuter (2004) explained that the ability of a leader to create strategy emerges for the first time at the Strategist level. The ability to create increasing mutuality is what supports the creation of transformative strategy. This leader has the skills to invite and challenge others to become part of this process, recognizing that creating mutuality is key to the successful bringing together of people with different backgrounds and action-logics.

The Strategists are very self aware and they are simultaneously aware of their own and others' action-logics. They are aware that every situation either promotes or inhibits advancing the action-logic of individuals, groups, organizations or nations. The Strategists are aware that they are working with people at different action-logics, and they rise to the challenge of offering growth opportunities that can be appreciated by persons at each action-logic. The Strategists' enhanced awareness of developmental processes results in their recognizing the need for individuals, teams, and organizations to grow autonomously into increased integrity, mutuality, and sustainability (Torbert & Cook-Greuter, 2004).

The Strategists accept disconfirming feedback and may change their opinion and may help other people change theirs as well. They seek ways to reframe and include multiple, even conflicting, viewpoints. They have the ability to appreciate paradox and resolve previously irreconcilable differences. They focus on incongruities between operations, strategy and mission to create effective and ethical processes that support the mission. They have a global awareness and support resolving inequity based on race, class, and gender. They work diligently to offer opportunity to promote personal and institutional development to address these inequities (Torbert & Cook-Greuter, 2004).

The skill the Strategists possess makes them capable of creating transformational change. Torbert and Cook-Greuter (2004) recommended that any organization seriously initiating change that they want to be transformational and successful will benefit from having a CEO at the Strategist action-logic or higher. They also point out that a Strategist at any level of the organization will be an agent for transformation. The benefit of the CEO at the Strategist action-logic helps the change occur more readily.

Beyond the Strategist is the Alchemist, comprising 1% of the leadership sample, and the highest level for which Rooke and Torbert (2005) had leadership data and experience. The Alchemist creates society-wide transformation by integrating the material and spiritual concerns of the members of the society, especially in unique and important moments in the history of the society. Although the leader with the Strategist action-logic can further develop into the Alchemist action-logic this achievement is very rare. The Alchemist action-logic is so uncommonly reached that in multiple studies of leaders in different industries, Torbert and Cook-Greuter (2004) failed to find any corporate leader who profiled at this action-logic. A few have been found, and they submitted to various forms of observation and self-reporting to allow some understanding of and experience with persons with this capability. They demonstrate the ability to simultaneously be aware of a situation, their presence within and effect on the situation, their strategic approach, and their feelings about the situation as well as the response of others. They seek feedback about their behaviors, and strategy, and take an inclusive approach to decision-making. The Alchemist is devoted to increasing their own alertness and learning, and that of others. They also focus on increasing mutuality and contributing to transformation at local, regional, and even international levels. They demonstrate the ability to use analogy and they enjoy unpredictability and creativity. They also use their charisma to challenge others to engage in advanced collaboration, inquiry, and problem-solving (Torbert & Cook-Greuter, 2004).

These seven developmental action-logics have all been observed in leaders. Leaders displaying each action-logic have different levels of effectiveness, depending on the situation. Postconventional action-logics are required to create and sustain transformation. TL is required of the nurse executive who brings their organization to Magnet status or re-designation. Of

interest in this study is whether action-logics in these transformational nursing leaders are similar to the action-logics observed in transformational business leaders.

As previously noted, health care quality in the United States ranks approximately 42nd among industrialized nations when using life expectancy as a quality measure (Central Intelligence Agency, 2014). A critical factor impacting health care quality is communication (The Joint Commission, 2011b). Nurses frequently witness dangerous shortcuts or incompetence, as well as experiencing disrespect in the workplace environment, and these three elements contribute to poor communication (Maxfield et al., 2011). A transformational change in health care is needed to support nurses in speaking up about critical information of which they become aware in the course of their work.

The literature on quality in health care and its relationship to communication is presented in the next section.

Quality and Communication: Speaking Up

Gawande (2009), an experienced surgeon, wrote that the technology we use and the ways in which we are able to use it have become so complex that we need more structure than simply the knowledge of what needs to be done. He has become an authority on and advocate for the use of checklists to routinize complex behaviors so they are performed consistently and safely. However, checklists alone are not enough. The implementation of evidence-based practice in health care is greatly enhanced by the use of checklists and protocols, but good communication among members of the health care team is also required. As reported by The Joint Commission (2011b), good communication is less easily achieved. The Joint Commission (2011b) also noted that communication failures within the health care team are one of the primary causes of sentinel events.

Maxfield et al. (2005) conducted surveys, focus groups, and interviews and observed health care staff in the workplace to study difficult conversations in the health care environment. Their study included 13 hospitals that were a mix of urban, suburban, and rural as well as teaching, general, and pediatric. Their subjects totaled 1700 staff (including 1,143 nurses, as well as physicians, clinical care staff and administration), a majority of whom observe incompetence, willful disregard for rules, or human error on a frequent basis and do not say anything to the offender (Maxfield et al., 2005).

They identified seven difficult conversations that are closely tied to the quality of care. They noted an inverse relationship between the quality of the conversations and the number of medical errors and staff turnover. This study revealed that between 5% and 15% of health care workers do speak up and produce good results for their patients and their hospitals. They noted a positive correlation between the quality of the conversations and patient safety, staff commitment, employee satisfaction, and discretionary effort. They found that the difficult conversations were about broken rules, mistakes, insufficient support, incompetence, poor teamwork, disrespect, and micromanagement.

In a subsequent study, Maxfield et al. (2011) again studied communication in health care. They used a convenience sample of a total of 6,618 registered nurses (RNs) from two professional organizations, the American Association of Critical-Care Nurses (AACN) and the Association of periOperative Registered Nurses (AORN). There are two types of communication breakdowns: honest mistakes and undiscussables. The honest mistakes happen spontaneously and are true human error. The undiscussables are deliberately not discussed (Argyris, 1999) because people feel unsafe or unmotivated to do so. Maxfield et al. (2011) explored the concept of undiscussables (Argyris, 1999) as applied to health care teams. Undiscussables are risky and

threatening issues, particularly issues that question underlying organizational assumptions and policies that people and/or organizations do not have the ability to discuss (Argyris, 1980, p. 205).

Maxfield et al. (2011) used a tool they called the Story Collector and a traditional survey. The safety tools examined with The Story Collector did not necessarily prompt the same concerns that were addressed in the survey. The Story Collector instructed respondents to write their story about actual times they had trouble speaking up or being heard. The survey focused on the undiscussables of dangerous shortcuts, incompetence, and disrespect. It asked, using a Likert scale, how often the RNs face these undiscussables, how they respond, and the impact these incidents have on patients.

They found that 84% of the nurses observed dangerous shortcuts, 82% observed incompetence, and 85% experienced disrespect in the workplace. They also found that the existence of these undiscussables becomes evident as a team works together over a period of time. Although safety tools address some dangerous shortcuts (Gawande, 2009; Maxfield et al., 2011), these tools do not address incompetence and disrespect (Maxfield et al., 2005). Maxfield et al. (2011) claimed the silence that results from undiscussables keeps safety tools from working. Safety tools are checklists, protocols, and warning systems that are used to standardize work into evidence-based practices that research has demonstrated will result in optimal outcomes. Maxfield et al. (2011) found that over 17% of nurses experienced dangerous situations as frequently as a few times a month, which the safety tools warned them were occurring, but they were unable to speak up about the danger at hand and get anyone to listen. According to Maxfield et al. (2011) they were unable to speak up or be heard because they lacked the personal

motivation or ability, they lacked social motivation or ability, or the structural motivation or ability was not established in their work environment to support speaking up.

Maxfield et al. (2011) found that certain elements were present in the environment when nurses spoke up, including physicians supporting nurses speaking up, a history of patients being protected when nurses spoke up, and the nurse having a strong trusting relationship with the team members. Additionally, the nurses that spoke up all held three things in common: none of them used threats, none showed their frustration or anger, and they all kept their own feelings in check (Maxfield et al., 2011).

In order to support both these environmental and individual attributes that facilitate speaking up, Maxfield et al. (2011) recommended that organizations use six sources of influence. The sources of influence are (1) Personal Motivation, (2) Personal Ability, (3) Social Motivation, (4) Social Ability, (5) Structural Motivation, and (6) Structural Ability. They stated that individuals need to feel morally obligated (have Personal Motivation) and have the knowledge and skill to speak up (have Personal Ability). They further stated that their work group must support speaking up through modeling the behavior (provide Social Motivation) as well as encouraging, supporting, coaching and advising each other regarding speaking up effectively (provide Social Ability). Finally, they stated that the organization must reward people for speaking up, include speaking up in performance reviews (provide Structural Motivation), and hold managers accountable to positively influence speaking up behavior (provide Structural Ability). They suggested that the organization must create structures for speaking up and asking questions, including time outs, handoffs, and verbal order read-back. If they followed these recommendations, they would establish the six sources of influence that support speaking up.

Maxfield et al. (2011) noted that the nurses experienced fewer dangerous shortcuts and instances of incompetence and disrespect as the organization increased the number of sources of influence in use. Additionally, the harm the nurses saw and the nurses' intent to leave were inversely associated with the number of sources of influence the facility used. Maxfield et al. (2011) also noted that organizations that have attained Magnet recognition use multiple strategies that equate to using several of the sources of influence. They note that Magnet organizations have staffs that have fewer concerns about shortcuts and incompetency and have less intent to leave their job or profession.

In the next section the history of the tool for measuring action-logic, as well as a description of the tool, will be discussed.

Measurement of Development: The Development of the Leadership Maturity Assessment Instrument (MAP)

Rooke and Torbert (2005), as well as other leadership consultants, performed survey-based consulting at numerous American and European companies, including nonprofits and governmental agencies. They worked with thousands of executives in developing their leadership skills. Part of the process included the use of a 36-item sentence completion test: the Leadership Development Profile (LDP). The sentences in the profile begin with a phrase like, "A good leader…" (Rooke & Torbert, 2005, p. 68). The participant is instructed to complete the sentence. The responses are quite varied, are interpreted by highly skilled evaluators, and are coded by the action-logics the participant describes. The action-logic in the profile is representative of the leader's current way of thinking and responding, especially when challenged or under stress.

The LDP emerged over 20 years from the ongoing collaboration among Susanne Cook-Greuter, Dal Fisher, David Rooke, and Bill Torbert. Susanne Cook-Greuter, an experienced

WUSCT scorer adapted Loevinger's WUSCT to incorporate the action-logic theory of Torbert. The LDP has continued to be refined by Ms. Cook-Greuter and is now called the Maturity Assessment Instrument (MAP). Like the LDP and WUSCT before it, the MAP is a sentence completion test, containing sentence stems to which the subject responds. The subject's thinking and way of relating to others is revealed in the person's responses. The WUSCT and MAP have been widely used and validated (Cook-Greuter, 2012; Kohlberg & Ryncarz, 1990). The WUSCT focuses more on the preconventional, conventional, and postconventional action-logics, and the MAP also includes the most advanced, the transpersonal action-logics. The MAP changes the terminology from lower and higher stages of development to earlier and later action-logics. It also changes the label of the *conformist* stage in the WUSCT to the Diplomat. These changes facilitate the use of the MAP in business settings for executive development. The LDP was, and now the MAP, has been validated through its ability to predict actual performance, particularly in the significant difference in the ability of postconventional CEO's to achieve organizational transformation when compared with conventional CEO's inability to achieve the same (Alexander & Langer, 1990).

In summary, the literature in the field of nursing does not record the use of an instrument that directly measures action-logic in NEs. Applying Torbert's research and theories to NEs may be useful to predict success and may be applied to the selection and further development for these health care executives. Other methodologies (the Leadership Practices Inventory and the Multifactor Leadership Questionnaire) have been used to assess transformational leaders and their subordinates. The LPI and MLQ refer to observed behaviors. These tools did not actually measure the world-view of the leaders or their developmental stage. For this study also of interest is the leadership behaviors these NEs have used to facilitate establishing an environment

that supports speaking up for nurses. Finally, the sources of behavioral influence these NEs have implemented to support discussing critical information provide additional evidence of their transformational leadership.

Chapter 3: Methodology

A mixed methods design was used for this exploratory study. The study is exploratory because the study population has not been studied using the variables proposed in this research. The mixed methods approach is used to explore both the thinking and behaviors of these transformational leaders. The MAP test measures the thinking and the interviews allowed the NEs to tell stories that described their behavior. The MAP instrument data and the interview data were collected concurrently, treated independently, and compared during the interpretation of the study. The purpose of using this design was to increase understanding of the action-logic of NEs who attain or retain Magnet status for their organizations as compared to the action-logic of transformational business leaders. The design also enables understanding of NE actions to support speaking up, as well as barriers they have encountered. The transformational effects of the NE on the environment were further investigated by discovering which sources of behavioral influence these NEs have implemented that support speaking up.

The research questions:

1. What action-logics are demonstrated by the NEs who have brought their organizations to Magnet designation or re-designation in VHA, as measured by the MAP sentence completion test?

2. What actions have these NEs taken to support nurses speaking up about their concerns?

3. What barriers exist that impede these NEs' efforts to support nurses speaking up?

4. What sources of behavioral influence have these NEs implemented as part of their professional practice to support nurses to speak up?

Targeted Population

Of interest in this study were NEs that have brought their facilities to Magnet designation or re-designation in the VHA. The study explored NEs' action-logics and their practice as professional nurses who are transformational leaders with a specific focus on the NEs behaviors that support nurses to speak up. This was a convenience sample to which the researcher had access.

The first hospital to achieve Magnet designation in VHA was the James A. Haley Veterans' Hospital in Tampa, Florida. The Tampa VA was first designated in 2001 and re-designated in 2005 and 2009, all under the same NE. The second VHA hospital to achieve Magnet designation was the Michael E. DeBakey VA Medical Center in Houston, Texas. The Houston VA was first designated in 2004 and then re-designated in 2009. One NE was there for the designation and another NE for the re-designation. Both were invited to participate. The Portland VA Medical Center was initially designated as Magnet facility in 2006 and was re-designated in 2010 under the same NE. The Atlanta VA was designated in 2009, and the Madison VA was designated in 2010. Neither has been re-designated and both have the same NE as when they were designated. This makes a total of six NEs in VHA who have brought their facilities to Magnet designation or re-designation who were invited to participate. Four of the NEs accepted the invitation and were the participants in this study.

Data Gathering Procedures

A two-step process was used for data collection. Each participant took a sentence completion survey to assess her action-logic. Each participant also participated in an interview to discuss speaking up and barriers to speaking up.

Survey instrument. The Maturity Assessment Instrument (MAP) was used to assess the action-logics of the NEs. The MAP reveals the level of leadership maturity and personal integration of the NEs. The MAP is the "most rigorously developed, Harvard-tested, unbiased and reliable stage measure on the market" (Cook-Greuter, 2012, p. 1). Certified scorers used multiple reference manuals to score the MAP. The MAP is the most refined instrument for scoring the most mature self-actualizers. It uses sentence stems to reveal the "behavioral, self-identity, cognitive complexity, emotional intelligence and coping strategies" of respondents (Cook-Greuter, 2012, p. 1). Cook-Greuter noted that achieving cognitive complexity does not equate with achieving mature ego development and integration. The MAP assesses the multiple aspects of the person that then allows them to understand their present development in these areas. Coaching sessions are available to subjects in this study following the MAP assessment to assist respondents in their next areas of growth.

The MAP results were reported using a personal identifier for each participant. Only the final results and distribution statistics were reported. The individual NE scores were not reported to protect the participants.

Interview process. A semi-structured interview process was used to explore how the NEs have facilitated nurses speaking up, as well as the barriers they have encountered. These interviews were designed to illustrate the professional and transformational practice used by these NEs concerning the implementation of sources of influence for speaking up. The researcher conducted a telephone interview with each NE to explore two overarching interview questions (see Appendix A for complete protocol):

1. What actions have you taken to support nurses speaking up about their concerns?

2. What barriers exist that impede your efforts to support nurses speaking up?

The interviews were scheduled with each NE as soon as possible after obtaining consent to participate. The interviews were recorded and then transcribed using a professional medical transcription company. A confidential code was used for each recording, and respondents were referred to as a number, not a name. Once transcription was complete, the recordings were destroyed following the company's HIPPA-compliant privacy practices. The interviews took from 30 minutes to one hour. Demographics of interviewees included gender, age, years of employment, level of education and type of degree, and years as a NE. The demographic data was aggregated and reported without identifiers.

The interviews were coded to discern what sources of behavioral influence the NEs have implemented in their professional practice that support speaking up. The barriers the NEs encountered to speaking up, as well as their experience dealing with dangerous shortcuts, incompetence, and disrespect were also coded. The barriers to speaking up were coded as though they were the absence of or the opposite of a source of behavioral influence to support speaking up. The barrier themes emerged from the interviews and were not defined as such prior to the interviews and are discussed in the results section.

The researcher emailed a form containing a research version of the MAP to the participants. The instructions to the participants included how to download, complete, and return the instrument. In addition to the sentence completions, the form contained requests for demographic information that Cook-Greuter and Associates use for their database. The demographic information collected is gender, age, education, profession, and native language. The researcher emailed all of the completed forms to Cook-Greuter and Associates in a zipped file at the same time.

The sentence stems are the same as is the professional version of the MAP. The research results of the instrument included final scores and distribution statistics of the action-logics of the participants. The researcher gave each participant an ID number and kept the ID number memorized only and not written down so that information will not be known by anyone but the researcher. Because the MAP results include practical information that can be used in a personal development plan, the NE participants were told that they could request their individual results if they were interested in that information. Cook-Greuter and Associates will provide coaching to the participants upon request and by private financial arrangement.

Study Preparation and Approval

The researcher piloted the interview technique and questions with two NEs who aspire to bring their organizations to Magnet status in VHA but have not yet been able to do so. After completing the interview as described, the researcher asked for feedback to improve the semi-structured interview and process. The researcher discussed requested changes with the dissertation chair and decided not to change the piloted questions. The interview questions had been reviewed with the chair and refined prior to inclusion in the pilot interviews. The pilot interviews did assist the researcher with becoming more organized and relaxed with the process.

The researcher has been the sole and principal investigator (PI). The PI personally funded the MAP sentence completion test for the participants. Data was collected subsequent to approval by the Pepperdine University IRB on February 11, 2015. The IRB approval letter is attached as Appendix B. The researcher contacted the six eligible participants by email or telephone. The researcher invited each woman to participate in a study of action-logics of NEs that have brought their facility to Magnet designation or re-designation. The invitation to participate is attached as Appendix C. An information sheet to explain details about the study

was provided to the participants with the invitation to participate. The information sheet is attached as Appendix D. The PI included her contact information and asked that they contact the PI within one week regarding whether or not they were interested in participating in the study. A NE's reply to the researcher with a positive intent to participate constituted the informed consent. The researcher informed the participants that the study was to be conducted on personal time outside of VHA work hours. The researcher requested that the participants take the MAP outside of work hours and conducted the interviews outside of work hours as well. Those accepting the invitation to participate were included in the study.

The participants were not financially compensated in any way for their participation. The PI will send each participant a hand-written thank you note for participating. They may submit this note to their supervisor as an element of their performance evaluation for the year, demonstrating they have participated in a research project. Participating in, facilitating, or conducting research in VHA is a positive addition to the performance evaluation for the NE.

Measures to Protect Confidentiality

The interview results have been reported as a group with no identifiers. Common themes supporting an environment that helps nurses speak up were noted, as well as common barriers. In particular, the occurrence of sources of influence as described by Maxfield et al. (2011) was noted by frequency and type. Any positive deviant was explained in more detail in order to disseminate the information and potentially multiply the results. If the detail potentially made the location identifiable, that information would have only been presented with written permission of the participant. No details were presented that could have applied to only one location. Patient anonymity was protected at all times, and no patient identifiers were collected or used in any

form. No situation that supported speaking up or was a barrier to speaking up was communicated in such a way as to allude to a specific patient or facility.

The identity of the participants is well known, so only limited privacy was afforded by grouping the responses. However, because not all eligible NEs participated, and information is not being released about who did and did not participate, it becomes more difficult to attempt to associate any particular MAP score or interview response with an individual. The study participants were informed that the results of the MAP would be reported as frequency distributions and the results of the interviews would be aggregated without identifiers prior to being disseminated. The interview data is stored in a password-protected, encrypted file accessible only by the PI, and will be deleted one year after the end of the study.

Study Implementation

Survey instrument. Once the invitation to participate was accepted, the participants were emailed the MAP sentence completion test with instructions as previously described. Participants were encouraged on the invitation to participate and on the email including the MAP to complete the MAP within one week and return it to the PI's email address. The PI established an ID number for each participant and emailed all MAP assessments to Cook-Greuter and Associates in a zipped file.

Cook-Greuter and Associates determined the action-logic for each using the standardized method of analysis. The PI constructed a mental map for the unique identifier for each participant. The identifier was matched with the participant according to the mental map. The name was not written down in any form associated with the identifier. Cook-Greuter and Associates reported the results of the participants' MAP tests to the PI. These results included the action-logics of the participants reported as a frequency distribution. Each action-logic point on

the distribution was associated with the unique identifier assigned by the PI. Only the PI is able to associate a score in the distribution with an individual participant. Cook-Greuter and Associates did not have access to the names of the participants; therefore, they could not associate an action-logic score with the name of the participant. The individual participants were able to ask the researcher about their action-logics for purposes of their own development.

Interview process. The researcher collected qualitative data via a semi-structured interview with the study participants. Two umbrella questions were addressed:

1. What actions have you taken to support nurses speaking up about their concerns?

2. What barriers exist that impede your efforts to support nurses speaking up?

The researcher asked the following questions:

1. Can you tell me a story about a time you supported a nurse or nurses to speak up about a dangerous shortcut (such as not observing a time out, or not using a required bundle or protocol) they encountered? What barriers to speaking up occurred in that situation?

2. Can you tell me a story about a time you supported a nurse or nurses to speak up about some type of incompetence (failure to demonstrate competence but performing a task, or disregard for common standards of practice) that they encountered? What barriers to speaking up occurred in that situation?

3. Can you tell me a story about a time you supported a nurse or nurses to speak up about a disrespectful behavior they encountered? What barriers to speaking up occurred in that situation?

4. What do you think are the greatest impediments to nurses speaking up?

5. What do you think are the best supports to nurses for speaking up?

6. Do you have additional stories or thoughts to share about speaking up and barriers to speaking up?

Data Analysis

Descriptive statistics. Analysis of the action-logics included what percentage of the sample had postconventional action-logics. That percentage was compared with the results in the business literature. The distribution of action-logics was also reported and compared with results in the business literature.

Qualitative analysis of interview data. Analyses of speaking up behaviors, of actions that support speaking up, and of barriers to speaking up were based on the research and the recommendations described in Maxfield et al. (2011). The addition of the qualitative data to the descriptive statistics was needed to expand on the existing theories of action-logics and speaking up behavior. Creswell and Plano Clark (2011) noted that mixed methods research adds value to the research by providing more evidence for study than the use of either quantitative or qualitative methods alone. The interview questions were based on the top three undiscussables of dangerous shortcuts, incompetence and disrespect as noted by Maxfield et al. (2011). New definitions for barriers emerged from the interviews. Some new definitions for barriers were the absence of behaviors recommended by Maxfield et al. (2011) to support speaking up.

Interviews were recorded and transcribed by a professional medical transcription company. The transcribed interviews were coded using HyperResearch software. Definitions were established for each code based on definitions from Maxfield, patterns that emerged from the interviews, and a new concept for the absence of behaviors of influence as barriers. The list of codes grouped by whether they are barriers, supports for speaking up, sources of behavioral influence or undiscussables is attached in Appendix E. Tables 4 though 9 in Chapter 4 display

the frequency of occurrence of each coded action grouped according to the applicable research question.

A second reviewer with experience using HyperResearch and coding of interview data also coded the data to establish inter-rater reliability. The researcher coded the data first then transmitted the coded interviews and code book to the second reviewer. The second reviewer coded the interviews and suggested coding of several statements, otherwise agreeing with the researcher's coding. The researcher concurred with the suggested coding revisions and established the final coding of the interviews from this collaboration.

Some behaviors were coded both under "Actions Nurse Executives Took to Support Speaking Up" and "Sources of Behavioral Influence Demonstrated by the Nurse Executive." The coding of some actions both in non-technical language and as Sources of Influence is intended to relate their actions to the literature as well as increase understanding of the actions of these NEs by a broad audience.

In order to analyze responses to research question 3, a subset of 30 of the barriers mentioned in the NE interviews were double-coded, both as (a) the opposite of a source of influence as discussed above, and also, (b) in the more common language used by the NEs. The double coding was intended to both connect the NEs responses to concepts in the literature and also to communicate more directly in non-technical terms the ideas expressed by the NEs.

The data collected for each research question was analyzed independently. The quantitative data from the MAP instrument was compared to the literature. The participants' responses were also analyzed in accordance with responses that were predicted by their action-logics. The frequency of the sources of influence, barriers and other emerging themes were analyzed for consistency with and variation from existing literature. Of interest was also whether

a profile would emerge from the demographics. Finally, the MAP data and qualitative data were combined and analyzed to determine whether and how the separate data sets support each other and existing literature. The differences in the MAP scores were related to the differences that emerged from the interviews to discern the significance of the MAP score relative to how the NE supported speaking up.

Chapter Summation

This chapter has presented the methodology proposed for this study of NEs that have brought their facility to Magnet designation or re-designation in VHA. The methods included each participant taking the MAP sentence completion test to assess their action-logic, which was scored by Cook-Greuter and Associates. The results of the MAP were reported back to the researcher as a frequency distribution of scores. The distribution of the action-logics was compared to those of business leaders. Additionally, the NEs were interviewed about actions they have taken to support nurses speaking up about their concerns and barriers they have encountered to nurses speaking up. Finally, the number and type of sources of influence used by these NEs in their professional practice to transform their organizations were reported and analyzed according to existing literature on speaking up.

The purpose of the study was to explore the action-logics of the NEs and discover whether they were similar to the action-logics of successful business leaders. Additionally, of interest were experiences these successful NEs have had in which they supported nurses' speaking up, and/or encountered barriers to that process. Lastly, of interest was whether these NEs have been able to implement of sources of influence to support speaking up so that the environment supports nurses to speak up about their concerns. These experiences can be

instructive to others. The results of the study and analysis of the findings will be presented in

Chapter 4.

Chapter 4: Results and Findings

The purpose of this study was to determine what action-logics Nurse Executives (NE) who have led their organizations to Magnet designation or re-designation demonstrate. The study also was designed to determine what actions NEs took to support nurses speaking up about their concerns and the barriers that impede those efforts. The sources of influence these NEs implemented to support nurses speaking up were also explored. Four of six eligible participants completed participation requirements for the study. Participation included completing the MAP assessment and participation in an interview with the researcher. This chapter is organized to report the demographics of the participants and the results of each research question. Next, the findings drawn from the results are discussed. Finally, examples from the interviews that illustrate the findings are presented.

Results

The demographics of the four participants are presented in Table 1.

Table 1

Demographics of Participants

Education	Master of Science	1	
	Master of Science in Nursing	2	
	Master of Business Administration	1	
Gender	Female	4	
	Bottom of Range		Top of Range
Age	51		65
Years employment as RN	30		44
Years employment as NE	12		30

Research question 1. What action-logics are demonstrated by the NEs who have brought their organizations to Magnet designation or re-designation, as measured by the MAP sentence completion test? Action-logics are "strategies, schemas, ploys, game plans, typical modes of reflecting on experience" (Torbert & Cook-Greuter, 2004, p. 22), described in Table 2.

Table 2

Description of Action-logics

Action-logic	Category	Characteristics
Alchemist	Postconventional	Process (interplay of principle/action) rules principle. Cultivates interplay and reattunement among mind and matter as well as love, death and transformation. Constantly promotes and creates cultural transformation.
Strategist	Postconventional	Self-amending principle rules reflexive awareness. Self-conscious philosophy, sense of time and place, invites conversation among multiple voices and reframing of boundaries. Acts to support organizational learning.
Individualist	Postconventional	Reflexive awareness rules effectiveness. Experiments with new awareness that diverse assumptions may complement one another for learning and for achieving productivity goals.
Achiever	Conventional	System effectiveness rules craft logic. Dominant feature is triangulation among plan, implementation, and outcome. Takes corrective action unsystematically but regularly.
Expert	Conventional	Craft logic rules norms. Dominant task is intellectual mastery of systems outside the self.
Diplomat	Conventional	Norms rule needs. Dominant task is to understand others' expectations and molding own action to succeed in their terms.
Opportunist	Preconventional	Needs rule impulses. Dominant task is to gain power to have desired effects on the outside world.
Impulsive	Preconventional	Impulses rule behavior.

Note. From *Action Inquiry: The Secret of Timely and Transforming Leadership*, by Bill Torbert and Associates, 2004, Berrett-Koehler Publishers, Inc., San Francisco, CA. Copyright 2004 by Berrett-Koehler, Inc. Adapted with permission.

The participants' results from the MAP assessment of Action-logic are presented in Table 3.

Table 3

Action-logics of Magnet Nurse Executives

Action-logic	Number of Sample at Action-logic N = 4
Alchemist	0
Strategist	0
Individualist	1
Achiever	3
Expert	0
Diplomat	0
Opportunist	0

Table 3 shows that the participants' action-logics were at the Achiever stage and above. One participant profiled as Achiever plus, indicating that she may be in transition to the Individualist action-logic. This means that the participant shows some indications of meeting the Individualist criteria in her responses to the MAP assessment, but not yet enough to make the overall rating Individualist. One participant profiled as Individualist, which is a postconventional action-logic. In summary, the NEs action-logics were diverse with less representation at the postconventional than conventional level.

Research question 2. What actions have these NEs taken to support nurses speaking up about their concerns? The researcher conducted an interview with each participant, which included the following questions pertaining to NEs supporting nurses speaking up:

1. Can you tell me a story about a time you supported nurses to speak up about dangerous shortcuts?

2. Can you tell me a story about a time you supported nurses to speak up about incompetence?

3. Can you tell me a story about a time you supported nurses to speak up about disrespect?

4. Do you have another story that comes to mind about encouraging speaking up?

The specific behaviors the NEs used to describe their actions to support speaking up emerged from the interviews and are paraphrased in non-technical language. These are aggregated results from all of the interview questions and all of the participants and are not representative of an individual NE. The non-technical terminology describes actions the NEs took in a way that may or may not easily be described as a source of behavioral influence. However, the NEs' stories revealed their perspectives, and they perceived that they were supporting speaking up through the actions they described. The frequency of reporting these actions in the interviews is noted, in descending order of frequency in Table 4.

The first three most common actions are focused on the actions the NEs took to directly increase speaking up behaviors in the staff. The NEs:

- observed for patterns or additional information, repeating occurrences or themes to discern possible areas of weakness in practice or other concerns;

- made time to meet with managers and staff and listened to their concerns;

- talked to staff and/or showed staff that speaking up is important through meetings and following up when speaking up occurred.

Table 4

Actions Nurse Executives Took to Support Speaking Up

Action taken	Frequency
Looked for patterns or more information	13
Listened to concerns from managers and staff	11
Communicated that speaking up is important	11
Recommended and enforced personnel action	9
Communicated that speaking up is safe	8
Delineated a process that is respected	6
NE and Chief of Staff discussed concern with individual	4
Spoke up to Chief of Staff	4
Spoke up to entire executive leadership team	4
Total	70

The next three most common actions the NEs took were to protect the environment and the staff and establish a process for staff to follow to speak up. The NEs**:**

- changed the work assignment, disciplined and/or recommended termination of an employee from employment;

- talked to staff and/or showed staff that speaking up is important by ensuring that no retribution occurred and that staffs are held in high esteem/rewarded when they do speak up;

- ensured a process was written down as a memorandum, standard operating procedure or

  protocol, which included instructions to follow in a specific circumstance.

Although several NEs talked about formally delineated processes, the quote below clearly

shows support the NE implemented formally for the staff nurses to speak up to the NE about

staffing concerns, even when their managers might object.

> I think a good support is an actual delineated process that is honored and respected.... if
> indeed your voice hasn't been heard, there should be another channel....We did that
> specifically for staffing....if you were so concerned about staffing, you needed to put it in
> writing ....That was a bit threatening to the managers .... the layers in between don't
> always let the nurse executive know those issues.

The process she described supported front line nurses to speak up more powerfully than

processes that would have required approval by the managers that comprise the layers between

the front line staff and the NE.

In the final three actions, all of them were described by the NEs four times. The NEs

intervened with specific individuals when they personally engaged in speaking up as follows:

- The NE and chief of staff discussed their concerns with the individual engaging in

  inappropriate behavior.

- The NE or other staff spoke up directly to the chief of staff about concerns.

- The NE spoke up to the medical center director, associate director, chief of staff and the

  rest of the executive leadership (which may also include an assistant director, and/or a

  deputy chief of staff).

In summary, the stories told by the NEs in the interviews reveal that each NE was taking

numerous actions to support speaking up.

Research question 3. What barriers exist that impede these NEs' efforts to support

nurses speaking up? A list of barriers to speaking up included barriers found by Maxfield et al.

(2011) as well as additional barriers the NE described in the interviews. The barriers described by the participants were coded by the researcher based on the similar language used by multiple NEs in the interviews. Additionally, prior to the interviews, the researcher did not perceive the absence of a source of behavioral influence as described by Maxfield et al. as a barrier to speaking up. However, as the interviews proceeded, the absence of sources of influence emerged as a barrier to speaking up. For example, the Personal Ability Barrier occurred when people lacked the knowledge and skills they need to handle the toughest challenges of speaking up. Table 5 presents descriptions of the seven terms found to be barriers to speaking up which the NEs described as the absence of sources of influence identified by Maxfield et al. The frequency with which these barriers were mentioned are presented in descending order of frequency in Table 5.

Many of the structural motivation barriers to speaking up for nurses are due to the power differential between physicians and nurses. The design of the health care system in the United States is for physicians to bring in work and money. Nurses care for patients, but they cost money and usually bring in neither work nor money. Because the structure gives physicians power to help hospitals make money and nurses do not have this power, this imbalance can lead to problems in the team. One NE relayed an example of a structural motivation barrier in the story that follows:

> There was a situation with a tenured physician, and we'd heard that he'd gotten a nurse in a break room in between her and the door and started ... screaming at her for something that he didn't like....pointing his finger to the point that it actually hit her shoulder a couple of times. And there were...more situations like that. It was a time...when there was a lot of competition going on to keep staff at our medical center…And so, this guy was tenured, he was bringing in a lot of business, and so there was reticence of the nurse to say anything.

Table 5

Barriers Described as the Absence of Sources of Influence

Barrier Type	Description	Frequency
Structural Motivation Barrier	Included one or more of the following: The organization did not reward people who speak up and may punish them literally or allow social punishment by co-workers. Speaking up was not included in performance reviews. Managers were not held accountable for influencing these behaviors.	17
Personal Motivation Barrier	People did not want to speak up because they did not think it was a moral obligation.	10
Structural Ability Barrier	Included one or more of the following: The organization failed to establish or reinforce times, places, and tools that make it easy to speak up (surgical pauses, Situation Background Assessment Recommendation –SBAR- handoffs, read back policies, etc.). There were not sufficient times and places when caregivers were encouraged to speak up. The organization did not measure the frequency with which people were holding or not holding these conversations, and did not use these measures to keep management focused on speaking up for patient safety.	7
Social Ability Barrier	Included one or more of the following: failed to step in to help people when they try to speak up; did not support people after speaking up so the risk did not turn against them; did not offer coaching and advice for handling the conversation in an effective way and/or engaged in undiscussable behavior themselves.	5
Personal Ability Barrier	People lacked the knowledge and skills they need to handle the toughest challenges of speaking up.	4
Social Ability Barrier Leadership	Included one or more of the following actions taken by a member or members of the senior executive leadership team: failed to step in to help people when they tried to speak up; failed to support people after speaking up so the risk did not turn against them; failed to offer coaching and advice for handling the conversation in an effective way and/or engaged in undiscussable behavior themselves.	2
Social Motivation Barrier	Included one or more of the following: The people around them (physicians, manager, and co-workers) did not encourage them to speak up when they had concerns; The people they respect or work with did not model speaking up.	2
Total Barriers		47

When the NE mentioned competition to keep staff at the medical center, she meant that the focus was on keeping physician staff. The structural barrier in place that valued the physicians' ability to make money for the hospital made the disrespect he showed undiscussable for her. Others reported the incident and she reluctantly confirmed that it had occurred.

As the NEs spoke, they described barriers in non-technical language. They did use terms that Maxfield also used in describing why nurses do not speak up. These barriers are more commonly articulated by nurses and are more easily perceived than barriers that are created by the absence of support. The researcher chose to code both types of barriers to more clearly demonstrate the extent of these barriers in the workplace. The barriers described by the NEs using common, non-technical language are presented in descending order of frequency in Table 6.

Table 6

Common Non-Technical Language Barriers to Speaking Up

Barrier	Frequency
Fear of retribution	8
Barrier developed over time in the team	5
Pervasiveness of disrespect	5
Manager not supportive of speaking up	4
Nobody likes to tell on anybody else	2
Pervasiveness of dangerous shortcuts	2
Pervasiveness of incompetence	2
Spoke up before but was not heard	2
Total	30

The most common barrier was that people feared that they would suffer a negative consequence from speaking up. However it was also common that team members were unsure whether a problem existed because it developed somewhat insidiously, it affected a single team member, and they were unsure whether what they were seeing was actually a problem. Each NE stated that one or more behaviors that were condescending, insulting or rude, and included yelling, shouting, swearing or name-calling have occurred many times in her career. A recurrent concern was that the manager did not support staff when they spoke up, or the manager failed to look for areas of weakness in practice or other possible concerns.

There were several barriers that were reported a total of two times each in the interviews. These barriers were described in the following ways:

- People are taught that it is socially unacceptable to tell on someone who is behaving inappropriately, making it distasteful to speak up.

- NEs stated that not observing a time out or not using a required bundle or protocol has occurred many times in their careers.

- NEs stated that observing or reporting that practitioners are not as skilled as they should be, aren't up to date on a procedure, policy, protocol, medication or practice, or are lacking basic skills has occurred many times in their careers.

- NEs noted that staff spoke up, attempted to bring a problem, but saw no positive results from the action.

The most common non-technical language barrier was fear of retribution, a barrier Maxfield mentioned. The example given above of the angry physician also was coded as fear of retribution. The second most commonly occurring barrier, also described by Maxfield, was that

the barrier developed over time in the team. One of the NEs described how this had occurred

among her nurses as one of the staff had slowly become incompetent over a long period of time:

> The barrier was that it was subtle change. It wasn't a dramatic change. So they weren't sure about their perception....it took a while for them to actually realize what was happening. So I think that is a barrier of a sort. And then once they did, that meant that they—that he, the staff person, could have been very—was very insulted and upset and hurt, and it caused a great deal of consternation. The barrier there was the team, the way the team worked then was certainly off kilter.

> In summary, the NEs described numerous barriers they have encountered to speaking up.

Their descriptions prompted categorizing the barriers in common terms and as the absence of

support for speaking up.

Research question 4. What sources of behavioral influence have these NEs implemented

as part of their professional practice to support nurses to speak up? Sources of behavioral

influence the NEs used were identified from the responses to the interview questions using the

Maxfield et al. (2011) sources of behavioral influence to support speaking up. The frequency

with which the NEs demonstrated the Sources of Behavioral Influence is presented in Table 7.

It is difficult to quantify the presence of Source 1, Personal Motivation, for the NEs

because it permeated each story and interview; therefore Source 1 is counted as ubiquitous.

The use of Personal Motivation was predominantly articulated by the NEs as background to their

stories and it was also evident when they described their use of the other five sources of

influence. All of the NEs expressed that it is a moral obligation to speak up and to help others

speak up. One NE made the following comments:

> I think one of the things that was really important… was…the emphasis on patient safety from all angles and creating the culture to make sure that those issues are heard and that the expectation is that you will speak up…. that's the expectation for your professional role. And that…needs to be for everyone.

The significance of the NEs' use of Social Ability, Structural Motivation and Structural Ability is discussed further under the Findings from Research question 4. The Findings section follows the Results section in Chapter 4.

Table 7

Sources of Behavioral Influence Used by Nurse Executives to Support Speaking Up

Source of behavioral influence	Description	Frequency
1. Personal Motivation	Had the desire to speak up and did speak up because they thought it was a moral obligation.	Ubiquitous
2. Personal Ability	Demonstrated the knowledge and skills they needed to handle the toughest challenges of speaking up.	5
3. Social Motivation	Demonstrated one or more of the following: Encouraged the people around them to speak up when they had concerns. The people the person respected modeled speaking up.	4
4. Social Ability	Demonstrated one or more of the following: stepped in to help people when they try to speak up; supported people afterward so the risk did not turn against them; offered coaching and advice for handling the conversation in an effective way.	22
5. Structural Motivation	Demonstrated one or more of the following: The organization rewarded people who speak up and did not punish them. Speaking up was included in performance reviews. Managers were held accountable for influencing these behaviors.	15
6. Structural Ability	Supported the organization to establish or reinforce the established times, places, and tools that make it easy to speak up (surgical pauses, Situation Background Assessment Recommendation –SBAR- handoffs, read back policies, etc.), and/or establish times and places when caregivers were encouraged to speak up, and/or the organization measured the frequency with which people were holding or not holding these conversations, and used these measures to keep management focused on speaking up for patient safety.	11
Total		57

Additional Results from Interviews Beyond the Research Questions

  Strong emotion. One element appeared repeatedly in the stories the NE's told about speaking up. The NEs described the expression of strong emotions 20 times in association with the staff speaking up. For the purpose of this study, a strong emotional component was coded as present when the NE named an emotion repeatedly in a sentence or in related sentences, or used additional descriptors like "very" when speaking of the emotion. Strong emotional components occurred when the staff experienced fear of losing their job, fear and the pain of losing a valued relationship, and fear of losing their place on a team. Fear of being physically assaulted was also expressed. Other emotions described were, "really, really angry," "screaming," as well as ongoing "frustration" for lack of support.

  A nurse's strong emotion, like ongoing frustration for lack of support, was frequently a barrier to speaking up, but not always. Sometimes the emotional component of an experience served as an incentive to speak up, such as a nurse's fear of being assaulted. Frequently, the nurse was described as having strong emotions after speaking up, especially the fear of losing her job, or a valued relationship, or a place on a team. The most consistent finding was that speaking up is accompanied by strong emotions, whether they serve as a barrier, an incentive, or a consequence of speaking up.

  The emotionally charged nature of these experiences confirms the observation of Maxfield et al. (2011) that anger was involved when half of the nurses in their study spoke up. In this study, strong emotions almost always accompanied speaking up in some way. This is also consistent with Okuyama, Wagner, and Bijnen (2014) who noted that both nurses and doctors are concerned about how the person to whom or about whom they speak up will respond. Their concerns include fear of reprisal, appearing incompetent and creating conflicts in the team.

One story in this study included vivid descriptions of emotional expression. The NE described the physician as screaming, furious, and so volatile that the staff thought he might physically assault them. The NE and chief of staff (COS) intervened, but the physician abused the staff again. After the failed intervention by the executive leaders, a staff nurse came forward and asked to speak to the physician. She talked directly to him about how his behavior affected her and the workplace. He had a "great emotional response" as described by the NE, and he stopped abusing the staff.

The pervasiveness of undiscussables. Undiscussables are inappropriate things that occur but that people do not feel motivated or empowered to discuss (Maxfield et al., 2011). The interview questions focused on the three most common undiscussables, which are dangerous shortcuts, disrespect, and incompetence in the workplace. The NEs mentioned that these undiscussables were pervasive. Additionally, each NE responded with more than one story about disrespect. The results in this study support the research by Maxfield et al. (2011) that these undiscussables occur commonly in health care. The frequency with which the NEs spoke each of these undiscussables in a story and the descriptions for each term are listed in descending order of frequency in Table 8.

Sources of behavioral influence demonstrated by staff. Research question 4 focused on what sources of behavioral influence NEs used to support speaking up. As the NE's talked about their professional practice, they also described actions taken by other members of the staff or leadership team to implement sources of behavioral influence in the workplace.

The NEs gave a total of 73 examples of sources of behavioral influence that the staff demonstrated. Social sources of influence comprised just over half of the staff interventions

mentioned. Structural sources of influence were used the next most frequently, and personal

sources of influence were used slightly less than structural.

Table 8

Frequency of Undiscussables Mentioned in the Workplace

Term	Description	Frequency
Disrespect	Condescending, insulting or rude behavior, yelling, shouting, swearing or name-calling	8
Incompetence	Practitioners are not as skilled as they should be, aren't up to date on a procedure, policy, protocol, medication or practice, or are lacking basic skills	6
Dangerous shortcut	Not observing a time out, or not using a required bundle or protocol	5
Total		19

The definitions for the sources of behavioral influence are in Table 6. The occurrences of

the sources of behavioral influence described by, but not attributed to the NE, are listed in Table

9.

In the following story, the staff nurses spoke up. They engaged the NE and chief of

surgery to help them, but the initial, and later most talked-about activity, was by the staff nurses.

The staff nurses used Social Motivation and Social Ability, and the NE used Social Ability in the

story that follows:

> An attending surgeon wanted to leave a PGY 2 [post-graduate year 2 resident]
> unobserved during surgery. A PGY 2 can't be alone on a surgery. The nurses banded
> together between the patient and the PGY 2 surgeon. They complained to the chief of
> surgery and the NE. The NE went to the OR and stayed centered on the patient, and
> facilitated a discussion. The attending joined the PGY 2 before the surgery was
> performed. This became a well-known example in the medical center for nurses speaking
> up.

The entire team's implementation of sources of behavioral influence was important in this story and well as in other stories to ensure that speaking up interventions were successful in making undiscussables discussable.

Table 9

Sources of Behavioral Influence Demonstrated by Staff

Sources of behavioral influence	Description	Frequency reported
1. Personal Motivation	Had the desire to speak up and did speak up because they thought it was a moral obligation.	9
2. Personal Ability	Demonstrated the knowledge and skills they needed to handle the toughest challenges of speaking up.	12
3. Social Motivation	Demonstrated one or more of the following: Encouraged the people around them to speak up when they had concerns. The people the person respected modeled speaking up.	18
4. Social Ability	Demonstrated one or more of the following: stepped in to help people when they try to speak up; supported people afterward so the risk did not turn against them; offered coaching and advice for handling the conversation in an effective way.	19
5. Structural Motivation	Demonstrated one or more of the following: The organization rewarded people who speak up and did not punish them. Speaking up was included in performance reviews. Managers were held accountable for influencing these behaviors.	10
6. Structural Ability	Supported the organization to establish or reinforce the established times, places, and tools that make it easy to speak up (surgical pauses, Situation Background Assessment Recommendation –SBAR- handoffs, read back policies, etc.), and/or establish times and places when caregivers were encouraged to speak up, and/or the organization measured the frequency with which people were holding or not holding these conversations, and used these measures to keep management focused on speaking up for patient safety.	13
Total		73

The power of barriers. A pattern emerged during the interviews that was repeated in each story in which speaking up had a successful outcome. When speaking up was successful, the number of speaking up behaviors far exceeded the number of barriers presented in the situation. The pattern of speaking up behaviors reported compared to the number of barriers reported per story told by the NEs is presented in Table 10.

Table 10

Speaking Up Occurrences and Barriers per Story and Resulting Change

Story Name	Speaking Up Frequency	Barrier Frequency	Change Resulting from Speaking Up
A	3	2	No change – Disrespectful behavior continued over the objection of the NE and nurses.
B	4	1	Improved relationships between doctors and nurses. Is well known across the facility as an example for speaking up.
C	7	2	Employee terminated. Staffs retain positive relationship with employee.
D	4	1	Doctor came to see patient. Nurses state they will speak up again if needed for the patient.
E	9	1	Doctor apologized verbally and in writing. Residency program reinforces that respectful behavior is required.
F	2	1	New training and policies established for the medical center to encourage staff to "Stop the Line" to prevent dangerous shortcuts
G	4	2	Employee terminated for incompetence.
H	8	3	New professional behavior policy written and implemented for the medical center. Doctors stopped being disrespectful to nurses.
I	10	3	Time out was established and reinforced as a required process to follow.
J	11	4	Nurse terminated for incompetence.

Each story listed was about an undiscussable that presented itself in the workplace. The undiscussables focused upon in the interviews were dangerous shortcuts, disrespect, and incompetence. The occurrence of the undiscussable is not included in the table, as it is where each story begins. The frequencies of the actions that follow, including speaking up or barriers to speaking up, are listed as well as the result of the speaking up behaviors at the end of the story.As Table 10 shows, when examining NE's stories for the presence of speaking up, barriers and change, in nine of the ten stories in which speaking up resulted in positive change, the number of instances of speaking up in the story exceeded the barriers by at least two to one. In story E, nine speaking up interventions occurred to overcome one barrier to speaking up. Story A, in which speaking up did not result in any positive action or desired change of behavior, contained three speaking up behaviors to two barriers. The chief of staff and medical center director implemented the barriers, which then constrained further speaking up.

Summary of Results

The participants shared many similarities. They each had a Master's degree. They all had at least 30 years experience as a RN and 12 as a NE. They each had at least an Achiever action-logic, and each used at least four sources of influence to support staff to speak up. They each spoke of disrespect more than once, although only one interview question specifically focused upon disrespect. They each described strong emotions that accompanied speaking up, and they experienced one or more of the undiscussables as pervasive. They observed staff using sources of behavioral influence in the workplace. The NE's used Social and Structural sources of behavioral influence equally, whereas the staff used more Social sources of behavioral influence than Structural. The stories the NEs told repeatedly demonstrated the power of barriers to thwart

speaking up, and that multiple speaking up behaviors were required to overcome each barrier that occurred.

The NEs also displayed some differences. There was a difference of 14 years in age, one participant appeared to be in transition to the Individualist action-logic and another profiled as an Individualist. The Individualist stated that failing to look for patterns was a barrier to speaking up, which was a characteristically different response from the other NEs. The Individualist sought out ways to support the nurses to speak up, whereas those with the Achiever action-logic repeatedly told the nurses to speak up. The Individualist also told them to speak up, but focused on creating ways to help the staff to speak up, even when their managers might object.

The findings emerged from the results and associated literature and are presented in the next section.

Findings

The study produced findings of interest when each research questions was examined individually. Additionally, examining the action-logics of the participants in combination with the results of the interviews produced insights that were not evident when examining these elements separately. Some findings support the existing literature and others findings are unique to this study. The findings are presented as they relate to the individual research questions and as they relate to analysis of the action-logics in combination with the interview results.

Findings related to research question 1. Several findings pertain to the action-logics demonstrated by the NEs, and are presented:

(a) The researcher had previously thought that the NE would need to possess a postconventional action-logic (Table 2) to bring an organization to Magnet status, but that was

not the case. The Achiever action-logic appears to be sufficient, as all NEs in the sample had attained at least the Achiever action-logic.

Rooke and Torbert (2005) used the Leadership Development Profile to determine the action-logics of highly educated business leaders between the ages of 25 to 55 years old. These individuals were professionals and managers working in different companies. They are similar in education, managerial and professional aspects, but younger in age than the NEs in this study. Although other data sets exist reporting action-logics of other groups, the comparison of the action-logics of leaders in the business setting of health care to the broader set of business leaders is the most direct population for comparison. The comparison of the action-logics found in the two studies is presented in Table 11.

Table 11

Comparison of Action-logics Found in This Study and Rooke and Torbert's Study of

Business Leaders

Action-logic	This study found: % of sample at Action-logic $N = 4$	Rooke and Torbert (2005): % of sample at Action-logic $N = 4310$
Alchemist	0%	1%
Strategist	0%	4%
Individualist	25%	10%
Achiever	75%	30%
Expert	0%	38%
Diplomat	0%	12%
Opportunist	0%	5%

These findings show the NEs at more advanced action-logics than 55% of the leaders in Rooke and Torbert's (2005) business leaders. They were at the same action-logics as 40% of Rooke and Torbert's sample, with more participants at the Achiever action-logic than the Individualist action-logic, similar to Rooke and Torbert's sample.

b) The Achiever action-logic may be a good match for these VHA NEs given the nature of the VHA and the hospital environment. These health care organizations are large, regulated, and highly bureaucratic. Not only is the Achiever sufficient to attain Magnet status, this type corresponds with the systematic productivity required of the VHA to meet patient care goals as they are currently defined. Systematic Productivity was described by Torbert and Cook-Greuter (2004) as an organizational action-logic that would parallel the Achiever action-logic in the individual. Torbert and Cook-Greuter (2004) defined Systematic Productivity as the following: "Attention legitimately focused only on systematic procedures for accomplishing the predefined task; standards, structures, roles taken for granted as given; marketability or political viability of product or service, as measured in quantifiable terms, the overriding criterion of success" (p. 129). VHA health care facilities fit this organizational action-logic because each facility is expected to accomplish greater than 100 established measures of performance (predefined tasks) per year. The bureaucracy establishes additional standards and structures through which people in specific roles accomplish the tasks. The political viability of the VHA as measured in these terms determines whether VHA continues to be funded. Torbert and Cook-Greuter predicted this fit between the action-logic of leaders and the organization in which they work.

c) All of the NEs wanted to know the results of their MAP. This supports Cook-Greuter's (2002) description of the Achiever and Individualist action-logics. The Achiever is interested in learning about themselves through feedback. The Individualist tries "to make sense of

themselves" (p. 21). Seeking feedback about themselves through their MAP results supports both of these inclinations.

d) The Individualist and aspiring Individualist were both self-reflective and expressed interest in their own development. There was a different character to these conversations than the conversations with the Achievers. The researcher was aware of the differences in the conversations before she knew the action-logics of the participants. The Individualist NE talked about looking for patterns and being sure to look for patterns of good things occurring, not just problems. She noted that many people are doing good work and not drawing attention to themselves. She stressed that it is important to look for these behaviors, and you have some "delightful surprises" when you do. These remarks demonstrate the Individualist's interest in the unique self-expression she sees in the work people are doing. She also has the ability to influence others by listening and looking for patterns, which contributed to her success (Torbert & Cook-Greuter, 2004).

e) The characteristics the Individualists and Achievers expressed were noticeable and consistent with the descriptions in the literature. The Individualist demonstrated an increased ability to self-reflect, listen, and discuss failure. She expressed a desire to learn from these failures. This contrasts with the Achievers' tendency to focus on the positive (Cook-Greuter, 2002) and not focus on failure. In health care, learning from failures is an ethical imperative. Listening to discover how failures develop is an essential skill and is not one that is yet cultivated by the Achiever.

Additionally, the transition between the conventional action-logic of Achiever and the postconventional action-logic of the Individualist is observable, significant and meaningful, as was demonstrated in the transitional NE's expressions of self-reflection. The aspiring

Individualist spoke of "walking the walk, not just talking the talk" as she described how to support speaking up. What she describes as her "ramblings" were not just about telling other people what they have to do, but supporting them in doing it through discussion, storytelling, and feedback. In contrast, the Achievers spoke more about telling the staff how important it is to speak up.

Findings related to research question 2. Several findings were related to the actions NEs took to support speaking up. These findings are listed below:

a) All of the NEs were aware that there is a culture of silence in health care and that speaking up is a challenge. Because of the culture of silence, the NEs spend time and energy to reiterate to staff that speaking up is important, safe, and there are structures for reporting. The fact that NEs have to make an effort for staff to know it is important and safe to speak up, and also that there are processes that support speaking up, reveals that speaking up is not automatic. This may be counter-intuitive to the general public who do not realize that you need to keep talking to professionals about other professionals doing something they should not do. The extra effort that the NEs expended to listen to staff and look for patterns is also indicative of the extent of the problem of organizational silence.

b) All of the NEs had experience with all three undiscussables of concern in the interviews. One of the Achiever NEs expressed this reflection on her concerns about speaking up and her ideas for changing the culture:

> I've been thinking quite a bit about ... how we create the VA culture of speaking up, how everybody—every single employee in the VA should be speaking up, and then we have to find a way to listen to all of that....and to teach...every single person in the VA...when you speak up, you need to also have thought forward about the possible solutions to the problems.... I think that we're at an opportune time to start thinking deeply about how do we make people understand the absolute best way to solve problems and to speak up. So I think we have to create first a culture where everyone feels safe and ... then we have to have kind of a behavioral code...that is widespread.

Findings related to research question 3. Several findings were related to the barriers the NEs encountered to speaking up. These findings are listed below:

a) Most of the barriers to speaking up are a lack or absence of motivation. An analysis of the barriers to speaking up described by the NEs revealed that 62% of the barriers are associated with lack or absence of personal, social, or structural motivation. Maxfield et al. (2011) described these types of motivation. Personal Motivation is a personal attribute in which a person wants to speak up because they think it is a moral obligation. Social Motivation occurs when people in the workplace (physicians, manager, and co-workers) encourage individuals to speak up when they have concerns and the people they respect model speaking up. Structural Motivation occurs when the organization rewards people who speak up and does not punish them, includes speaking up in performance reviews, and holds managers accountable for influencing these behaviors (p. 8). The culture does not motivate staff to speak up when it fails to provide personal, social and structural motivation to speak up. In fact, the culture de-motivates staff through lack or absence of support, and especially when staff are punished for speaking up or allowed to suffer when they bring up concerns.

b) A lack or absence of structural support is also a major barrier. A majority (51%) of the barriers to speaking mentioned were structural, either a lack of structural motivation or a lack of structural ability. Maxfield et al. (2011) described Structural Ability as occurring when the organization establishes times, places, and tools that make it easy to speak up (surgical pauses, Situation Background Assessment Recommendation [SBAR] handoffs, read back policies, etc.). Structural Ability also includes the organization measuring the frequency with which people are holding or not holding these conversations, keeping management focused on speaking up for patient safety (p. 8). The NEs repeatedly described instances in which Structural Motivation and

Structural Ability were lacking or absent and that the insufficient presence of these structural

supports created barriers to speaking up.

In combination, the insufficient motivation and insufficient structural support results in a

failure of facilities to establish structures that consistently enable or motivate staff to speak up.

c) The absence of sources of behavioral influence in the organization creates barriers to

speaking up. This adds a dimension to the model presented by Maxfield et al. (2011). Because

organizational silence is the norm, people struggle to speak up unless they can experience the

sources of behavioral influence. To think of the absence of sources of behavioral influence as

barriers to speaking up focuses attention on what constitutes barriers. The ability to overcome

barriers may be improved when one perceives the absence, or lack, of support as a barrier. As an

example, if leaders perceive the absence of Source 5 Structural Motivation as a barrier to

speaking up, they may focus on implementing Source 5. They may prioritize rewarding people

who speak up. They could also include speaking up in performance reviews and hold managers

accountable to engage and support these behaviors, thereby implementing this source of

influence within the organization. An example of reinforcement for speaking up through the use

of Source 5 Structural Motivation is described below in which a housekeeper speaks up to a

physician about taking a shortcut.:

> We just celebrated a great thing where an environmental services guy cleaning, he called
> out a physician in a really nice way about not washing his hands or gelling up. And, you
> know, we made a great story out of it, that he was a wonderful person and he benefited
> the patient and saved lives just by what he did. And so I think it's important ... the
> storytelling is a good way to carry out that message of there is right and wrong behavior.

In this case, the leaders rewarded behavior they wanted to see repeated, celebrated the

housekeeper's intervention, and communicated it to other staff. This leadership response clearly

has the power to positively influence behavior. This is notable because the physician is at the top

of the power hierarchy in health care, and the housekeeping staff are generally considered near

the bottom. However, the NE described rewarding the housekeeper for speaking up to the

physician who did not follow appropriate hand hygiene in the patient care area. If the

housekeeper did not work in an organization that had structures in place to support speaking up,

the housekeeper would most likely not be able to speak up to someone with so much power.

      Findings related to research question 4. Several findings were related to the sources of

influence the NEs used to support speaking up, and these findings are listed below:

      a) The NEs each used multiple sources of influence, although none of them described

personally using all six sources of influence. The sources of influence are described in Table 7.

Including Source 1, the NEs demonstrated four or five sources of influence. The NEs support

speaking up primarily through three sources of influence: (a) Social Ability, (b) Structural

Ability, and (c) Structural Motivation. This finding makes intuitive sense in light of their position

in the organizational hierarchy. The source they reported using most frequently was Social

Ability, wherein they stepped in to help others speak up, protected and coached others so that

speaking up was safe and successful. The second most frequent intervention the NEs used was

Structural Motivation. The NEs rewarded people for speaking up. The NEs reported that they

implemented or reinforced Structural Ability for speaking up as their third most frequent

intervention, as presented in the story about the housekeeper speaking up above. These actions

demonstrate that in order to address structural barriers, the NE must put structural supports into

place.

      b) The NEs also observed multiple sources of influence used by others. Two of the NEs

reported observing all six sources of influence used by others in their stories. This is consistent

with the observation of Maxfield et al. (2011) that Magnet hospitals use a significantly greater

number of sources of influence than other hospitals.

The NEs gave a total of 73 examples of sources of behavioral influence they observed

demonstrated by others. Social sources of influence comprised just over half of the interventions

they observed. Structural sources of influence were used the next most frequently, and personal

sources of influence were used slightly less than structural. This is a significant finding because

it supports the likelihood that shared governance, a requirement in Magnet organizations,

facilitates empowerment for nurses and enhances their ability to change organizational culture

and structures. It is logical that the staff would use social influences frequently, but to use

structural influences more often than personal influence supports the concept that Magnet

organizations do put structures in place to support nurses (American Nurses Credentialing

Center, 2013). A NE told the following story, which illustrates the use of Source 6 Structural

Ability, by staff nurses and a nursing supervisor:

> We did have a unit one night that had a patient that they were concerned about.…But
> there was great difficulty reaching…the correct on-call physician…we've had some
> problems historically in the same arena. And so the nurses on the floor attempted to page
> the physician. Didn't get a response; tried a couple of different times. Got the nursing
> supervisor involved, and ultimately, they called the chief of medicine…going up the
> chain [of command]. It was in the middle of the night….it was something that did really
> demand that a physician be aware, and come and check the patient. And the chief of
> medicine responded and then miraculously, was able to get in touch, actually get through
> to, the on-call resident….And he came out of a call room…bounding onto the floor. And
> he was really, really angry, and very accusatory and telling the nurses they didn't page
> him and how dare they go above to the chief of medicine multiple layers above him and
> that sort of thing. And the nurses were acting, I'm told, appropriately, were very clear
> about what they had done, about what their expectation was. About the fact it was a
> situation of evolving concern, and that they needed somebody to come and see the
> patient, and that if they had to do—if they were faced with the same situation again, they
> would do absolutely the same thing. So, kind of put him on notice, I think, that that kind
> of behavior and that lack of response was not going to be tolerated in our setting. But
> they also wrote reports of contact about his behavior because he was pretty, pretty
> outrageous. Those came to me in morning report, when the nursing supervisor, handed
> off and gave morning report.

The nursing staff and their supervisor spoke up by continuing to call the resident who was on call, and calling his supervisor when he did not respond. They are confident they acted appropriately and would do the same thing again. They continued to speak up when they wrote reports of contact (the form used to report negative interactions) about his behavior and ensured the NE received the reports. The nurses used the tools (structures) that were available to them by calling up the chain of command and writing reports of contact, demonstrating Source 6, Structural Ability. They got the attention the patient needed and improved the quality of his care.

Findings from combining action-logic and speaking up data. Combining the findings from the action-logics and interview data produced findings unique to this study. These findings are listed below:

a) The thinking of the Achiever is clearly reflected in the story told as a finding related to research question two in which the NE is reflecting on her concerns about speaking up and her ideas for changing the culture. Her worldview is that we can fix this, and we need people to speak up and offer suggestions about how to fix it. Although she says we have to figure out how to listen, she is not focused on the listening process. She is focused on getting others to speak up and bring solutions. The Achiever intends to support speaking up, but her focus on telling staff to speak up rather than on listening to staff can be experienced as a challenge rather than a support. Although this challenge may create additional pressure on a staff member to speak up, it might not prove to be as effective as listening to the staff member.

b) The NE in transition from Achiever to Individualist action-logic engaged in a soliloquy about learning to listen and how important it is that people can speak up. She was trying to push herself somewhere. The many demands for performance at her facility may have created a learning crucible for her, helping her push her thinking into additional awareness. She

spoke of how critical it is that people are "able to" speak up. She rambled on, thinking out loud, saying it is important to "build and sustain and foster and nurture an environment" where people can speak up. Her language was supportive, and not so insistent as the Achiever's language. She spoke of creating a healthier organization and the NE embracing speaking up. Her choice of words was inviting, and her tone of voice encouraged openness.

c) One of the NEs was an Individualist, a postconventional action-logic. The Individualist takes a different approach to supporting speaking up than the Achiever, a conventional action-logic. The Individualist stated that failing to go out and look for problems was a barrier to speaking up. This NE was responsible for describing 16 of the 24 total occurrences of listening to concerns and looking for patterns. She was also the only NE who spoke of failures, while the others only mentioned successes. The entire conversation with this NE was characteristically different. It was based on this conversation that the lack or absence of the sources of influence as barriers as a significant factor became evident. Her focus was on detecting error and systems issues while supporting the staff. She provided a way for front line staff nurses to report to her when they thought they were understaffed. Typically, the NE is driving efficiency, and encouraging the staff to report that they need more staff could appear counterintuitive to being efficient. She also spoke boldly about her opinion about the reports of delays in care for Veterans that became headlines in Phoenix in March 2014. The other NEs did not talk openly about this problem in this way. She had been talking about how important is it to listen to people and observe for patterns, and she continued with these words:

> They [medical center and network directors] did [speak up]. And it never went anywhere,…they just crammed the performance measure, the unrealistic performance measure in some cases—like how fast you can get patients in—it was just crammed down your throat harder. And so everybody sort of figured out; Okay, this is the game, we're not going to say anything about this anymore, and we will do our best. And it was pushed down so hard, and people said, well, they don't care about the patients, they just care

about these numbers. And that's all they care about. They only care about the numbers, and we can't get the patients in. And…many people knew about how that whole, you know, scheduling system didn't work. They knew…people just were told it was all about the numbers. So again it is I think the failure to listen to the people who are trying to tell you something.

This NE is committed to the importance of listening to disconfirmatory feedback. She realized that people try to speak up about things that make most people uncomfortable. She restated that failing to listen to people who are trying to tell you something is a problem. The Achiever NEs focused on telling staff to speak up. If the staff didn't speak up, the failure was theirs, but this NE says the failure belongs to the leader who cannot or will not listen.

Figure 1 illustrates the actions NEs took to support speaking up. Those actions are described in non-technical language and as sources of influence. The MAP of the NE is included, with the Individualist MAP in bold and the supports she described personally using in the interviews also in bold, plus the assumed use of Source 1 that was attributed to all of the NEs.

Nurse Executive MAP	Non-Technical Language Support	Sources of Influence
• Conventional • **Postconventional**	• **Looked for patterns/ information** • **Listened to concerns** • **Communicated speaking up important/safe** • **Took personnel action** • **Delineated a process** • **Spoke up to COS/ Executive Team** • Spoke up with COS to another	• **Source 1** • Source 2 • **Source 3** • **Source 4** • **Source 5** • **Source 6**

Figure 1. Actions nurse executives took to support speaking up. Actions of the Individualist (postconventional) nurse executive are in bold print.

d) Combining results of these two research questions produced an additional finding. The power of barriers was evident even when speaking up occurred. The ratio of speaking up actions that were required to create change to the number of barriers was at least two to one in the stories the NEs told as summarized in Table 10. In one story, nine speaking up actions occurred to overcome one barrier. In that story, an organizational change that affected a hospital and a medical school did finally take place. The amount of effort required to effect change supports the assertion of Maxfield et al. (2011) that "organizations must overwhelm the problem of organizational silence" (p. 8). The following story involved nine speaking up behaviors to create an organizational change:

> I did share those [reports of contact] with the appropriate people; they got shared with the director of residency program. And, I'm told, that it resulted in some significant coaching and redirection, and possibly even sort of the equivalent of a little disciplinary counseling in terms of the residency program. So we did make sure we followed up with the staff, that the staff knew that their concerns were heard, that we had acted on it, and that we did not tolerate that kind of behavior, that sort of disrespectful behavior, from anybody. Not from physicians, not from nurses, not from anybody. I think they were very—you know they expect when something like that happens—they know we're going to follow up. They trust that we will and part of what we asked as a response was that the physician apologize. And he did that. He apologized both in writing and he went back up to the unit and, I'm not sure if he connected with everybody that was on that shift, but I do know that he verbally apologized to a number of people. But it did take a lot of perseverance for the staff to continue to call, and call, and call, and get the nursing supervisor involved. But they feel pretty comfortable, I think, speaking up. Possibly it was less intimidating, I think, to report somebody when the person you're reporting is a resident versus the example with the surgeon. The hierarchy is different; the balance of power is different.

This story again reveals the cultural change that can and does occur when multiple interdisciplinary team members speak up.

The existing culture in health care, however, contains many barriers to speaking up. In combination, these barriers have created a culture of silence. Figure 2 illustrates how common barriers overcome the ability to speak up. The absence of sources of influence also acts as a

barrier and the combined effect overwhelms the ability to speak up. These cumulative barriers to speaking up create a culture of silence.
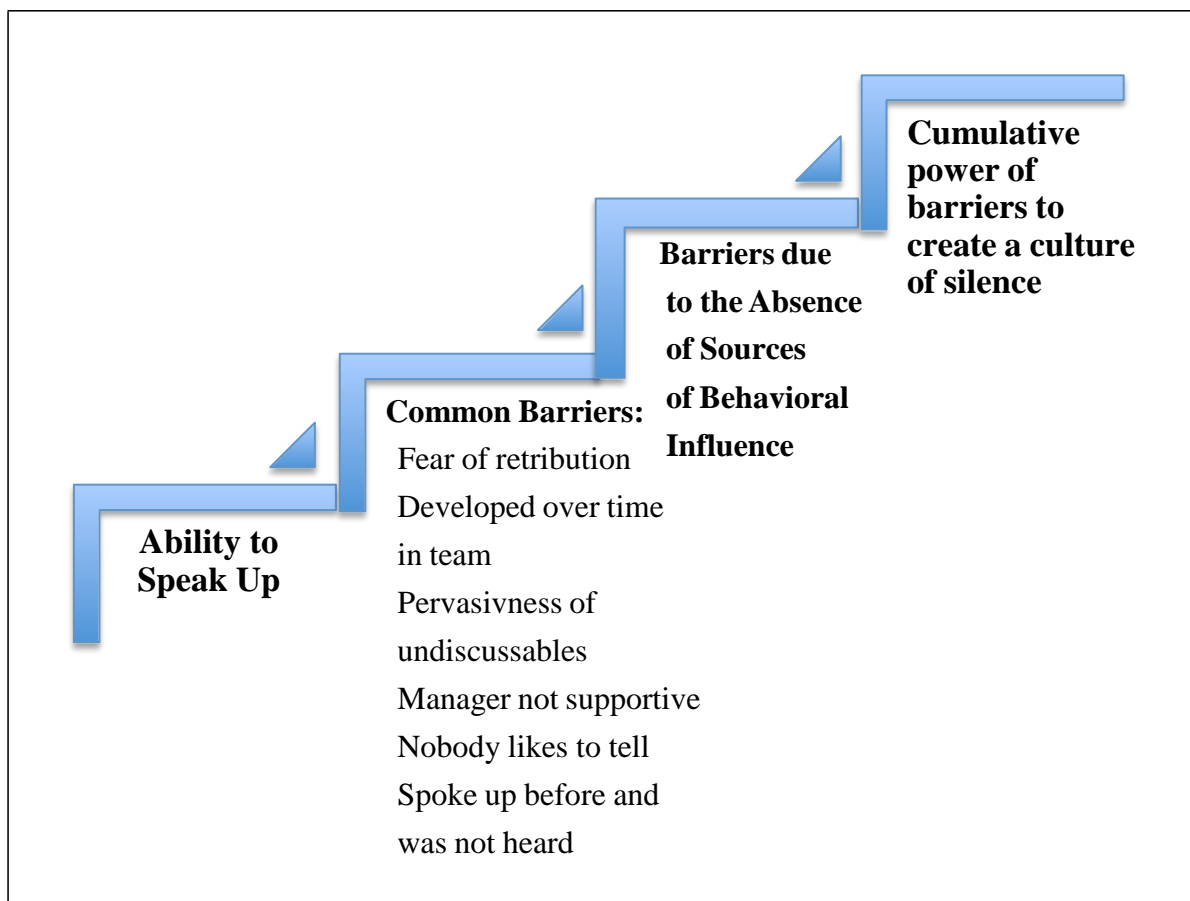
Figure 2. Cumulative power of barriers to create a culture of silence.

Chapter Summary

This chapter has presented the results of the data and findings related to the results. The relationship between action-logics and the behavior of the NE has been described, and the complex relationships between the barriers to speaking up and the sources of influence that allow speaking up have been analyzed. In Chapter 5 the results and findings will be discussed in relationship to the existing literature. The implications for NE practice and future research will also be discussed.

Chapter 5. Conclusions, Recommendations and Implications

Overview

Chapter 4 described the results and findings of the research. The purpose of this research was to determine what action-logics the NEs demonstrate who have led their organizations to Magnet designation or re-designation in the Veterans Health Administration. Of interest was whether the action-logic of these transformational NEs would be similar to the action-logic of transformational business leaders. The study also was designed to determine what actions NEs took to support nurses to speak up about their concerns and the barriers that impede those efforts. The sources of influence these NEs implemented to support nurses speaking up were also explored. Additional findings emerged from the interviews regarding the categories of barriers, the categories of speaking up behaviors, and the number of speaking up behaviors compared to the number of barriers in a given story. Finally, there was a difference in the interviewee's responses and practice of supporting speaking up when they had different action-logics.

In Chapter 2 the role of the NE, Magnet designation as a model for excellence, and transformational leadership (TL) were discussed. This chapter will begin with a review of TL as it applies to health care NEs and Magnet organizations. TL in business leaders, the fact that their action-logics were predictive of their success, and the usefulness of action-logics for NEs is discussed next. Concerns about health care quality and speaking up are then reviewed. Next, conclusions from this study are presented and discussed followed by recommendations for health care and nursing practice. Finally, this chapter will provide recommendations for future research in nursing and health care.

The Literature

      Transformational leadership in nurse executives and Magnet organizations. Bass et al. (1987) emphasized that health care professionals must understand theories of TL to support needed changes in the health care system. TL must not only be understood but implemented to change physical environments, beliefs, the practices of nurses and multiple other disciplines, and the mindsets of health care leaders and managers (Committee on the Work Environment for Nurses and Patient Safety, 2004). TL is the first of five components of the model used to describe Magnet organizations. The ANCC (2008) defined TL as "Leadership that identifies and communicates vision and values and asks for the involvement of the work group to achieve the vision" (p. 45). Magnet facilities must have a strong and visionary NE who guides and supports excellence in nursing practice in a professional environment. These leaders and the professional practice they develop elevate the standards of the nursing profession (American Nurses Credentialing Center, 2011). Therefore, NEs that lead their facilities to Magnet designation or re-designation demonstrate transformational leadership as they fulfill this required element of the model.

      Maxfield et al. (2011) noted that Magnet organizations use a multifaceted approach to improve patient care. Using this approach Magnet organizations incorporate more sources of influence to support speaking up than are typically found in health care organizations. In the current health care environment, transformational leadership is seen as necessary to create new ways of delivering care that are more efficient, safe, and accessible.

      Transformational business leaders, transformational nurse executives and their action-logics. Transformational leaders in the business community were found to have postconventional action-logics. Rooke and Torbert (2005) found that corporations who had

leaders that profiled at Opportunistic, Diplomat, and Expert action-logics demonstrated below-average performance. Leaders at the Achiever action-logic were able to implement organizational strategies. Leaders who profiled at the Individualist, Strategist, and Alchemist actions logics were able to implement transformational leadership that resulted in ongoing innovation. This model had not been used to assess NEs prior to this study, and it can be useful to predict success for NEs as well as business leaders, despite fact that the action-logics of the NEs in this study did not parallel the action-logics of the business leaders who were studied. In this study, the transformational NEs were able to achieve Magnet designation for their organizations if they had an Achiever action-logic. The uniqueness of this finding is discussed more fully under research question one below.

Health care quality and speaking up. Maxfield et al. (2011) noted that staffs frequently observe dangerous shortcuts, incompetence and disrespect, yet they are unable or unmotivated to speak up about these concerns. Maxfield et al. stated that the calculated decision to fail to speak up in these situations is so common that certain elements of the health care environment have become *undiscussables*. They noted that undiscussables are errors in communication.

James (2013) performed a review of articles reporting medical errors in hospitals in the United States and estimated that approximately 440,00 premature deaths occur per year due to preventable adverse events. James stated that a culture of silence and a failure to listen to those harmed contribute to this ongoing national problem. The Joint Commission (TJC) is another resource for data about patient harm. TJC publishes data on sentinel events, which they define as "an event in which death or serious harm occurred" (The Joint Commission, 2015a, para. 6). However, in reference to their data, TJC clearly stated:

The reporting of most sentinel events to The Joint Commission is voluntary and

represents only a small proportion of actual events. Therefore, these root cause data are

not an epidemiologic data set and no conclusions should be drawn about the actual

relative frequency of root causes or trends in root causes over time. (The Joint

Commission, 2015b, p. 4)

The culture of silence in health care is reflected in this statement, making the true magnitude of

sentinel events unknown.

The number of sentinel events with a root cause that included communication as reported

to TJC is known. Root causes are "fundamental reason(s) for the failure or inefficiency of one or

more processes" and "point(s) in the process where an intervention could reasonably be

implemented to change performance and prevent an undesirable outcome" (The Joint

Commission, 2015b, p. 3). TJC emphasized that most sentinel events have multiple root causes.

The TJC reported communication as the second or third leading root cause of sentinel events

each year from 2012 through 2014. Specifically, communication was a root cause of 1584

sentinel events of a total of 2552 sentinel events, or 62 percent the total, reported to TJC from

2012 through 2014 (The Joint Commission, 2015b, p. 8). Communication is defined as being,

"oral written, electronic, among staff, with/among physicians, with administration, with patient

or family" (The Joint Commission, 2015b, p. 5). Undiscussables are failures in communication.

The occurrence of undiscussables creates points in the process where an intervention, speaking

up, could reasonably be implemented to change performance or prevent an undesirable outcome.

The prevalence of undiscussables, the known percentage of sentinel events with

communication as a root cause, and the estimate of 440,000 premature deaths caused by

preventable adverse events when considered together reveal a very troubling scenario. It is

possible that many thousands of people suffer serious injury or premature death every year due to the culture of silence in health care. The existing data point to a statistic that is both shocking and itself undiscussable because the culture does not accurately report its harms to patients.

In this study, the researcher was interested in how transformational leaders, as exemplified by these Magnet NEs, would support speaking up and encounter barriers to speaking up. The intent was, through learning from these successful NEs, more nurses can speak up and fewer medical errors will occur. By speaking up and reducing sentinel events, thousands of incidents in which life or limb are now lost could be prevented every year.

Emotions and speaking up. Maxfield et al. (2005, 2011) described fear of retaliation and emotional risk as contributing to the culture of organizational silence. Plutchik (2001) defined emotion as "a complex chain of loosely connected events that begins with a stimulus and includes feelings, psychological changes, impulses to action and specific, goal-directed behavior" (p. 346). Plutchick further advocated that emotions are issues of survival, and that emotions are activated by things perceived as threats or by seeing a potential mate. He stated that emotions are feedback processes and that generally cognition occurs early in the chain of events that produce emotion. He also noted that people in different hierarchical positions engage in many social interactions, and emotions of defiance or submission frequently arise related to rebellion, competition, or acceptance. Plutchik suggested eight basic emotions that are opposites of one another: "joy versus sorrow, anger versus fear, acceptance versus disgust, and surprise versus expectancy" (p. 369). He said that all other emotions are combinations of these eight and include variations in intensity. Taylor and Risman (2006) noted that oppressed individuals can use anger to energize them and resist oppression.

Churchman and Doherty (2010) noted that nurses they interviewed thought they spoke up, but their study revealed that they only spoke up if no conflict or stress was involved. The nurses did not speak up if they feared the doctor or feared reprisal. Attree (2007) found that there were multiple disincentives for nurses to speak up about their concerns. They feared repercussions and retribution, as well as being labeled and blamed if they spoke up. They also thought that nothing would change if they did speak up, making speaking up high-risk with low-benefit proposition.

Power and speaking up. Garon (2012) discussed that the power relationships in health care that make nursing an oppressed profession contribute to a culture of organizational silence in health care. She also emphasized that managers' inability to accept negative feedback and lack of trust for their employees magnify the nurses' difficulties in speaking up. Garon found the nurse manager's openness was very important to support speaking up, and that all nurses needed the support of the NE to promote speaking up in the organization.

The key literature that is relevant to the results and findings in this study has been reviewed. Conclusions pertaining to results and findings from the study follow. Each conclusion is followed by a discussion and references to the literature to support its relevance and significance to Magnet organizations, VHA and the broader health care environment.

Conclusions and Discussion

The Expert action-logic was insufficient for Magnet NEs. The Expert action-logic was insufficient for these NEs to possess to enable them to attain Magnet designation. None of the participants demonstrated the Expert or lower action-logics, a finding which was predictable and supported the existing research. The Achiever action-logic was the lowest action-logic held by any of the participants. It is consistent with previous research on action-logics (Rooke & Torbert,

2005; Torbert & Cook-Greuter, 2004) that the Expert action-logic and the other lower conventional action-logics would not be sufficient to build and sustain the teamwork to accomplish this the goal of Magnet designation. Although the leaders that Rooke and Torbert (2005) assessed demonstrated Expert action-logic more frequently than the other action-logics, this action-logic was not correlated with long-term success in senior leaders. The tendency of the Expert to demand perfection and to disrespect feedback that is not consistent with their expertise typically makes them better individual performers than team players or team leaders.

The Achiever and Individualist action-logics suitable for Magnet NEs. The Achiever and Individualist action-logics were a good fit for attaining Magnet designation or re-designation for these NEs. The Achiever is a good fit in the management role (Torbert & Cook-Greuter, 2004) and the Achiever action-logic contains multiple traits that would support a NE to attain Magnet designation. The ability to focus on a long-term plan, being goal oriented, and knowing a certain constituency would judge whether they succeeded or failed to achieve Magnet designation all fit well with the Magnet journey. The Magnet literature defines the overall requirements to attain Magnet designation, so a successful strategy for a NE would be to create plans that help her organization meet the requirements. Achievers are concerned about the success of their organization, as well as their own success (Torbert & Cook-Greuter, 2004). Magnet designation is a mark of success for the entire organization (American Nurses Credentialing Center, 2011), so attaining this particular goal is a good fit for the Achiever action-logic.

The Achiever action-logic is a good fit for a NE in the VHA system. The VHA is bureaucratic and has many required measures of performance that must be achieved every year to make the facility as well as the overall VHA successful. There are performance measures that

are sometimes vilified, as noted in this study, but many of the measures are respected, and staff work hard to accomplish them. For example, some of the measures tell you how well you help your Veteran patients control their blood pressure, their blood sugar, and whether certain medications are used according to the best practices in the literature. The Achiever is well suited to take on such huge challenges and meet their goals.

The Individualist action-logic also appears to be a good fit to be able to support transformational change and achieve Magnet designation. The Individualist retains the Achiever skills and adds skills of increased desire for transformation of self and others that would support the Magnet journey. The introspective journey of the Individualists involves reexamination of all of their previous action-logics and experiences. This process brings excitement and new ways of being in relationship along with a new sense of doubt, with the emotional turbulence of living through both extremes. The Individualist bridges the conventional world and the postconventional world, coming from an existence perceived as stable to one that is emergent, fluid and filled with increasing power to engage and lead others into transformational change. The creativity and excitement the Individualist can generate would support staff engagement, which is essential to Magnet designation (American Nurses Credentialing Center, 2011).

Because the Magnet journey is well defined, it may have been less important for the NE to have a postconventional action-logic to achieve Magnet designation or re-designation than it was for the business leaders who created transformative change. A postconventional action-logic is not required to accomplish previously defined strategy. In the business world it is less common to have a proven strategy for success to follow. To the NEs credit, each facility must implement the Forces of Magnetism and fulfill the Magnet model in its own way. Additionally, the

Achiever seeks mutuality in relationships, which is an attribute that works particularly well with the shared governance components of the Magnet model.

The Achiever displays weakness in listening the Individualist has overcome. The Achiever's focus on telling people what to do and their limited capacity to listen is a critical weakness for leaders in health care, whereas the Individualist is focused on listening to concerns and has transcended this weakness. This is consistent with the literature, as noted above, and presents challenges in the health care environment that have gone unexplained until now. Listening is not well developed in the Achiever action-logic. The Achiever is not aware of her shadow side, the areas where she has less ability or is likely to make errors or to fail. In health care settings, this can be a significant problem. The Achiever is not prepared to accept disconfirmatory feedback (Torbert & Cook-Greuter, 2004). If someone is interjecting (speaking up) and the information does not fit within the Achiever's worldview, the Achiever will likely discount or ignore the information. This particular weakness among health care leaders can contribute to barriers to speaking up in health care.

If action-logic theory is applied to Garon's description of managers above, the managers who cannot accept negative feedback seem to be in a conventional action-logic and unable to accept negative feedback. The nurses described in Churchman and Doherty's (2010) study may be in the Diplomat action-logic and afraid to create conflict. They may also just be in an oppressive environment that lacks the motivation and structural support for speaking up, and their fear is an emotion designed for self-preservation (Plutchik, 2001). The impact of the action-logic of the leader on the environment can be very significant in the leader's ability to support the nurses to speak up.

The increased ability of the NE with the Individualist action-logic to listen is extremely important. The ability to listen to support nurses to speak up is not clearly discussed by Maxfield et al. (2005, 2011). The Individualist NE knows something is inhibiting the staff, and the NE is looking for it through observing for patterns and listening. This increased awareness and engagement with listening leads to early recognition of concerns and prompt implementation of sources of behavioral influence.

One NE talked about the experience of other leaders trying to speak up to leadership in Washington, D.C. She illustrated the significance of the importance of listening and the problems that can occur when the Achiever fails to accept disconfirmatory feedback. She stated that the facts about the deficiencies in the scheduling system and the inability to see the patients as prescribed by the performance measures had been brought up to one powerful leader repeatedly. The performance measures were unrealistic based on this faulty infrastructure, but this powerful leader, the leader driving the performance measure, refused to acknowledge that fact. Approaching this problem using the action-logic theory, this information may have been ignored because it did not fit into the leader's worldview. The information was important, but the leader that needed to hear it could not hear it. This and many other problems exist in health care and need to be heard. Knowing the action-logic of the leader can be important in deciding whom the best person is to listen for and to the problems.

In this study, the NE with the Individualist action-logic talked about looking for patterns and actively listening as an important part of her role as a NE. The Achiever NEs spoke repeatedly about reinforcing to staff that it is important to speak up, whereas the Individualist NE spoke repeatedly about how she listened for concerns and patterns. The Individualist NE expressed "It's a long way from a nurse executive to the staff nurse…to be able to be heard all

the way up." She also noted repeatedly that staff nurses do speak up, but leadership does not always hear them. The Individualist is interested in self-expression, both her own and that of others. The Individualist is less likely to be judgmental than those with conventional action-logics. Where the Achiever influences through advocacy, the Individualist listens and finds patterns to influence others (Torbert & Cook-Greuter, 2004).

The additional effectiveness of the post-conventional action-logic to overcome barriers to speaking up is illustrated in Figure 3. The additional support the Individualist gave to the staff nurses to report understaffed shifts helped the staff overcome the barriers to speaking up. The NE's MAP helped her listen and look for patterns. In response to her observations, she put a lineated process in place and established structural ability (Source 6) for the nurses to speak up if they experienced staffing as inadequate.
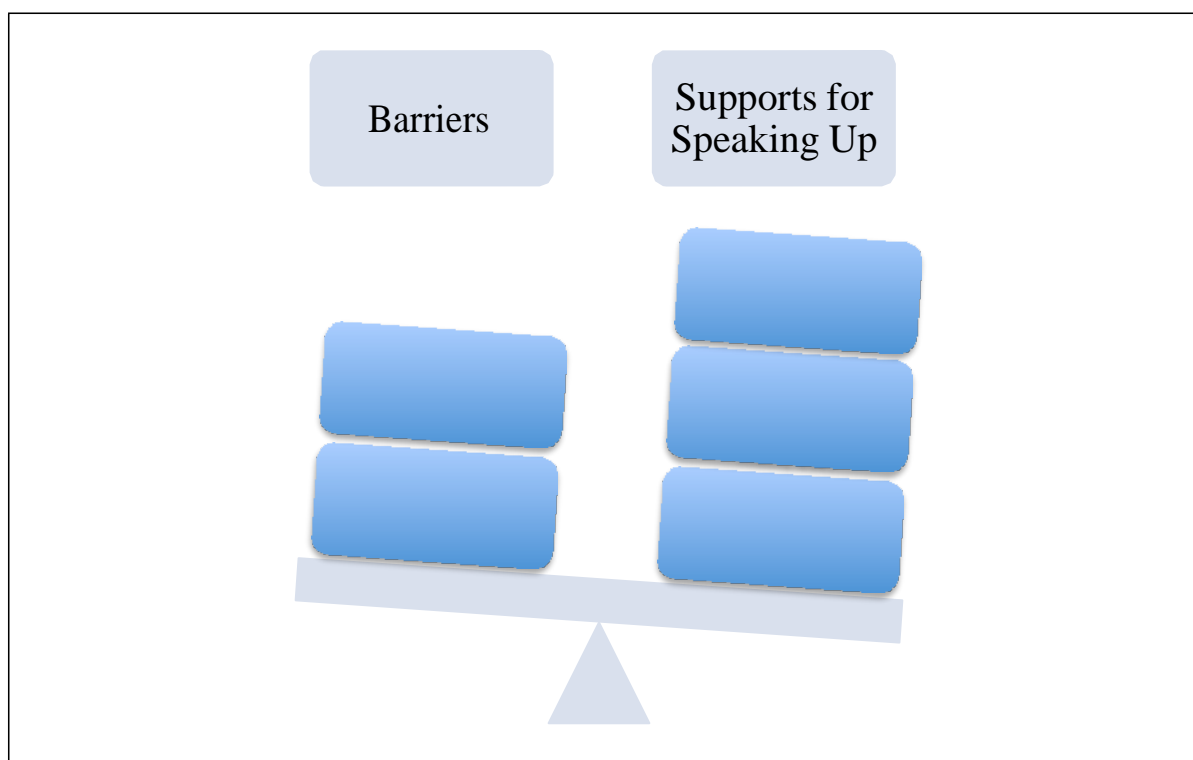
Figure 3. Barriers overcome by multiple supports for speaking up.

Organizational silence persists in health care. This study supports the findings of Maxfield et al. (2005, 2011) that there is a culture of organizational silence in health care. The NEs told stories about speaking up and barriers to speaking up, including the emotional impact of speaking up. They said that speaking up is hard, and that it requires pushing against the cultural norms that discourage speaking up.

Speaking up for patient safety was repeatedly described as requiring extra effort within the health care environment. The Individualist NE was so attuned to the culture of silence that she focused on listening for patterns and concerns and on providing safe mechanisms for speaking up. She was so aware of the culture of silence that she openly acknowledged that a failure to listen and look for patterns and concerns was a barrier to speaking up.

The absence of a source of behavioral influence in the environment is a barrier to speaking up. The Individualist NE described failing to listen and look for patterns as a barrier to speaking up. Upon reflection, the researcher viewed the absence of any or of all sources of behavioral influence as barriers to speaking up. Because the culture supports silence, the failure to support speaking up becomes a barrier to speaking up. This conclusion expands upon the model of Maxfield et al. (2011) and helps to clarify barriers that exist in the health care environment. The NEs in this study told stories revealing that an absence of motivation and an absence of structural support for speaking up are frequently experienced by nurses. The absence of motivation in combination with the absence of structural support creates an environment that will make speaking up behavior an exception rather than the rule. These findings again support the culture of silence as observed by Maxfield et al. (2011).

Organizational design important to support speaking up. Organizations designed to support speaking up will enable staff to have more confidence that they will be supported. The

Magnet NEs created structures and systems to support the nursing staff. In Magnet facilities, Structural Empowerment is one of five components of the Magnet model. Structural Empowerment includes shared governance through which nurses control their own practice by serving on committees and influencing policies and procedures in the organization (American Nurses Credentialing Center, 2013; McClure & Hinshaw, 2002). This enhanced control over practice combined with increased sources of behavioral influence provides support for speaking up. The nurses took advantage of this to build more structures, which may not be the case in all hospitals. Staff in non-Magnet facilities may not be as empowered to create structural supports.

In this study, the combination of Structural Motivation and Structural Ability comprised 45% of the NEs' interventions. These structural interventions did move the organizations toward more consistent support for speaking up. This is consistent with Maxfield et al. (2011), who predicted that multiple sources of influence would be used in Magnet facilities because achieving Magnet designation requires the use of numerous strategies that combine to support nursing practice and the concerns of nurses. An example of structural motivation is the story about the housekeeper being rewarded for reminding the doctor to do hand hygiene. The NE who described the nurses calling the resident repeatedly gave a story about structural ability. Through much effort, at first by the nurses and later by collaborating physicians, the educational affiliate changed their policy. The nurses expressed conviction about continuing to follow the policy should a similar event occur in the future.

The frequency with which Source 4 Social Ability was used by NEs and front line staff has both positive and negative implications. The most frequently described single source of behavioral influence the NEs used was Source 4 Social Ability. The staff used Social Motivation and Social Ability for half of their interventions. Although Social Motivation and Ability are

important indicators of a cultural shift toward supporting speaking up, the implementation of change through social support alone is dependent upon the people who are present at the moment an event occurs. Structural Ability and Motivation would provide more pervasive support than the social supports without the structural supports. Front-line staff and managers in VHA often will research policies before taking an action that is new or feels uncomfortable to them. If substantial support is found in policy, the staff and managers are much more likely to be able to follow through and take the action intended by the policy. If the policy, which is a component of structure of the organization, supports speaking up, a novice nurse will be more consistently supported to speak up to an experienced physician.

Barriers persist even when speaking up occurs. A pattern emerged during the interviews that was repeated in each story in which speaking up had a successful outcome. The number of speaking up behaviors far exceeded the number of barriers presented in the situation when speaking up was successful. Even in the one case when the NE described an unsuccessful speaking up endeavor, the speaking up behaviors outnumbered the barriers by 3 to 2. This supports Maxfield et al.'s (2011) assertion that we must overwhelm organizational silence, that checklists and safety tools are not enough when we have a culture of undiscussables in health care. The NEs articulated that multiple sources of influence and iterations of speaking up behavior were required to address instances of the undiscussables of dangerous shortcuts, incompetence, and disrespect so that the situation of concern was thoroughly addressed and did not come back to negatively impact the nurses. One case, which did result in structural supports being put in place in the organization, required nine speaking up behaviors to overcome one barrier. This amount of extra effort indeed qualifies as having to overwhelm the barriers to create a culture that supports speaking up.

Strong emotions are associated with speaking up. In this study, the emotions as described in the stories were all on the negative side, and frequently they were of high intensity. A NE described a situation that illustrates this. She said there appeared to be heightened fear among the staff that reported a furious physician. The physician was so angry that they said they were afraid for their physical safety and that they might lose their jobs for telling on him. She thought that in this case fear was a driver for speaking up as well as a consequence of it. The staff overcame an oppressive environment through speaking up.

Maxfield et al. (2011) described fear of retaliation and emotional risk as contributing to the culture of organizational silence. This study also revealed the presence of strong emotions associated with speaking up. Fear of retaliation was the most frequently occurring emotion. In this study, fear of reprisal and fear of retaliation were also described by the NEs as fear of retribution. The mere fact that there are three words for a similar consequence that are used almost interchangeably in this context indicates that this is a pervasive issue. The emotional undertones expressed by the NEs confirm that emotional risk is present whether or not speaking up occurs when the undisscussables of dangerous shortcuts, incompetence and disrespect are present in the working environment. This is in contrast to non-healthcare research, done through the Cornell National Social Survey in which a random sample of 1000 adults was surveyed. This survey found only about 20% of 439 respondents did not speak up due to fear of consequences (Deter, Burris, & Harrison, 2010). A sense of futility was the most common reason for not speaking up in that study.

Pervasiveness of disrespect makes speaking up difficult. The pervasiveness of disrespect makes it difficult to speak up when disrespectful behavior occurs. Thus, disrespect becomes a cultural norm. Each NE spoke of disrespect more than once, even though there was

only one question directly exploring disrespect in the interview. This reinforces Maxfield's (2011) observation that disrespect is one of the top three undiscussables in health care. Undiscussables contribute to failures in communication, which can and do result in clinical errors. Short cuts and incompetence are the other two top undiscussables, and are more technical aspects of health care. Inclusion of disrespect in the top three undiscussables underscores that relationships are important in health care teams, not just technical expertise. The fact that disrespect is pervasive and a cultural norm impacts entire teams when it is present, and undermines the technical aspects of the work.

The conclusions of the study were presented in this section, as well as a discussion to link the conclusions to the study, the literature and the health care environment. In the next section, recommendations based on the conclusions are presented with their relevance and significance to Magnet organizations, VHA and the broader health care environment.

Recommendations for Health Care and Nursing Practice

This section will first present the implications for practice from the conclusions described above. Recommendations support the use of the action-logic model for the assessment and cultivation of health care leadership as an important tool for executive development. As the action-logic model supports, advancing action-logic in health care leaders would develop health care leaders capable of creating and sustaining needed transformation in health care. As one NE stated, "health care is a team sport" and the entire team will have impact upon and is impacted by any transformation that occurs. The intent of these recommendations is to improve health care quality and safety through intentional selection and development of leaders who can support staff to speak up. Recommendations about how to support speaking up are also included.

Health system leaders should assess NE action-logic. Health system leaders in all

sectors, government and private, should assess action-logics of Nurse Executives and aspiring

Nurse Executives as part of the selection and development process. Magnet facilities provide an

environment that is magnetic to nurses, and their patients experience superior outcomes.

Possessing at least an Achiever action-logic may be necessary for a NE to lead her organization

to achieve Magnet designation.

At present, the action-logic is not directly assessed as part of selection or development of

NEs. Measuring the action-logics of NEs as part of the selection and development process is

possible using the MAP. If nurses with Achiever action-logics and higher were selected for NE

roles, more facilities may be able to establish Magnet environments.

Additionally, the literature supports that it is important to improve speaking up and

listening to improve the quality of health care in the US. The NE at the Individualist action-logic

demonstrated increased awareness and ability to listen to concerns of the nurses. Therefore,

assessing the action-logic of the NE appears to be important as part of a strategy to improve

patient outcomes and health care quality in hospitals. If more NEs were selected that have

Individualist and higher action-logics, these leaders may be more capable of listening to staff and

addressing the staff's concerns. Attaining and using this information to select NEs with Achiever

and higher action-logics may help the US health care system to improve quality outcomes.

Health system leaders should advance their action-logics. Health system leaders in all

sectors, government and private, should engage with leader development programs that target

advancement of action-logics. Because the Individualist's ability to listen is so critical, but the

available pool of Individualists is limited, the existing pool of NEs should be intentionally

developed to attain postconventional action-logics. Cook-Greuter offers coaching for further

development with the assessment of the action-logic. This coaching is a good starting point for further development of the NE. Implementing coaching of this type for all NEs as an ongoing part of their professional life could assist in their growth. Additionally, programs exist that provide intensive and ongoing development opportunities geared to advancing action-logic. A discussion of this type of program is beyond the scope of this paper, but Torbert, Cook-Greuter and others have development programs available that could accomplish this goal. Enhancing the capacity for listening is extremely important to transform the existing culture of silence into one of speaking up.

Additionally, it is important to ensure that all health care executives receive coaching for development and attend programs intended to advance action-logics. Ongoing innovation will require postconventional action-logics in the leadership team. As health care must create a new culture, this type of ongoing innovation will require leaders with postconventional action-logics because innovation is a capability that is attained at the postconventional level. Additionally, the postconventional ability to listen is critically important. Although the action-logic of the NE is important, the NE must be part of a leadership team that can listen to disconfirmatory feedback. A medical center director or chief executive officer (CEO) of a health care organization has the final decision about most actions that occur in a medical center. If the CEO is deferential to the chief of staff (COS), a medical doctor, the power of the NE is limited. If the CEO or the COS does not buy in to the empowerment of nurses and staff to speak up, the ability to change the culture is severely impaired.

Health system leaders should assess leadership team action-logics. Health System leaders in all sectors, government and private, should assess the action-logics of the entire executive leadership team. This assessment can be an important first step in building teams that

have the capability to innovate, listen and transform. The entire team should have ongoing growth challenges and opportunities that are considered a routine and essential investment any organization makes in its future success.

Knowing the action-logics of the team members can also improve the functioning of the team. When dealing with a problem, be sure that the skills of the entire team are employed appropriately to address it. The Expert will have details that must be considered. The Achiever may be able to get buy in from others. The Individualist may seek out what is still missing from the plan. The Strategist can pull together members that have disparate views and still help find solutions. Everyone does not need to be at the same action-logic. Knowing who has what types of skills, and facilitating the use of all of them by the team, can create lasting success.

Health care executives should listen and look for problems. Health care executives should listen carefully and attentively to the staff, and look for problems. Develop the postconventional skills of listening, doubting one's own perspective, assuming that problems exist and establishing processes to make it easy for staff to speak up. These processes will include implementing multiple Structural Motivation and Ability sources of behavioral influence in the organization. Do not focus only on the positive, but do not be punitive in seeking out problems. Support the staff emotionally by building a safe and healthy environment.

Health care executives should speak up as a team. Health care executives should speak up and speak up as a team to overwhelm the culture of silence. Barriers to speaking up are so well established that repeated efforts are required to overcome them. This study found that at least two speaking up behaviors were required for each barrier encountered to overcome the barrier. Extra effort is required, and multiple people in the interdisciplinary team must be involved in each effort to overcome the entrenched barriers that create the culture of silence.

Health system leaders should focus on implementing sources of behavioral influence. Health care executives should communicate with their leadership teams and staff that the absence of sources of influence for speaking up reinforces the culture of silence. Describing barriers as the inverse of the source of influence was used to clarify what the barriers are and to emphasize the types of support needed in health care to change the culture of silence to one of speaking up. This study found that the presence of barriers that undermine motivation and barriers that undermine structural support for speaking up make speaking up the exception and not the rule. Communicating this concept with the leadership team and the staff will raise awareness that using the sources of behavioral influence is important. Using sources of behavioral influence will both support speaking up and remove barriers to speaking up, and leaders as well as staff are responsible to use them.

Health system leaders should demonstrate the sources of behavioral influence. Health System leaders in all sectors, government and private, should engage executive leadership teams to use the sources of behavioral influence intentionally, consistently and repeatedly. NEs in this study supported speaking up in their organizations. The next imperative is for all health care leaders to demonstrate the Personal Motivation, Social Ability, Structural Motivation and Structural Ability sources of behavioral influence to overcome the persistent culture of silence. The entire leadership team must be engaging in supporting these sources of influence to instill motivation and build structures that can create a culture of speaking up. The knowledge that multiple attempts are required must be disseminated to each staff person so that they understand that one speaking up behavior is not enough to address their concerns. The emotional toll of speaking up must be reduced and the resilience of staff increased so that the energy to support the extra effort required for success is available.

Health care executives should engage the front line staff in speaking up. Health care executives should engage the front line staff in speaking up and supporting speaking up. Shared governance is an important tool for staff to use to promote structural empowerment. Through shared governance the staff nurses receive information from above and are heard by the leadership as well. The staff nurses also communicate with interdisciplinary teams and influence policy throughout the organization. The culture of silence is not just a nursing issue, so all staff must be included in shared governance and forms of empowerment to engage in the process of speaking up.

Health system leaders should make respect a cultural norm. Health System leaders in all sectors, government and private, should make showing respect a cultural norm in health care organizations. Maxfield et al. (2011) gave four recommendations to support speaking up and changing the culture. A team could implement a plan for making respect a cultural by following these steps:

1. Establish as design team.

2. Identify crucial moments

3. Define vital behaviors.

4. Develop a playbook. (p. 11)

Maxfield et al. recommend an interdisciplinary team lead the transformation, spotlighting crucial moments so people are aware of them, defining behaviors to use when crucial moments occur, and the use of all six sources of influence in the playbook. Please refer to Maxfield et al. (2011) for a more thorough description of their recommendations. Of importance here is that there are recommendations to assist organizations to change the culture of silence. Due to the prevalence of disrespect in the interviews in this study and the fact that disrespect may more difficult to

detect than technical elements of teamwork, creating respect as a cultural norm is a priority. Additionally, teams that demonstrate respect for their members may be more able to communicate about shortcuts and incompetence and have fewer emotional stressors at work.

Implications for Future Research

This study has begun a new exploration of the relationship between a leader's action-logic to how they support speaking up for staff. When one considers the importance of speaking up, a postconventional action-logic may be just as critical to the overall effectiveness of health care leaders as it was to business leaders, as noted by Rooke and Torbert (2005). Additional studies of action-logic in health care leaders and of speaking up are needed to continue to support changing the culture of silence to a culture of speaking up in health care.

Assess the action-logic of Nurse Executives and aspiring Nurse Executives. To determine whether the outcomes of this study would be duplicated in a larger study, a study could measure the action-logics of all Magnet NEs in a company or region. VHA and other large health care systems have a cadre of existing NEs. Assess the action-logics of these organizations NEs coupled with an assessment of nursing sensitive indicators to determine whether the action-logic of the NE is related to better nursing sensitive outcomes. Assess the action-logic of aspiring NEs and engage them in appropriate developmental activities to advance their action-logic. Follow these aspiring NEs to learn whether they advance their action-logic and careers. Do the outcomes of their facilities improve as they advance their action-logic?

Study additional Nurse Executive attributes that contribute to success. The type of support each NE had received to help her succeed was not a focus of this study. Additional study could focus on the history of Magnet NEs, both professionally and personally. To what do they attribute their success? What obstacles have they overcome? Are there commonalities, such as

resilience, that others could develop to make them more successful? What impact is doctoral education for NEs having on action-logics and speaking up? Repeat this study for doctorally prepared Magnet NEs in the community and compare the results.

Assess the action-logics of leadership teams in health care organizations. This study focused on only one member of the executive health care team, the NE. Health care systems are led by teams that include physicians, administrators and nurses. The action-logics held by the team members could have an impact on the team's success. A study could measure the action-logics of leadership teams of successful health care organizations and organizations that are struggling. Measures of success would be patient outcomes. What are the differences between the leadership teams?

Evaluate existing data focusing on elements pertaining to speaking up. In VHA, an all employee survey (AES) is done every year. This survey includes questions that address psychological safety, incompetence, and disrespect. A comparison between the action-logics of the leadership team and the AES results on these elements could be done. What differences exist between action-logics of the teams and their results on the AES? What team combination is the most effective to support speaking up? Does a positive speaking up score on the AES correlate with nurse satisfaction and patient outcomes? Does the action-logic of the NE correlate with AES scores for speaking up for nurses? Do the action-logics of the executive team correlate with the speaking up scores for the entire facility? Does reporting alignment to the NE influence speaking up? Specifically, do nurses have a different experience speaking up if their reporting relationships are through nurses in comparison to reporting to other disciplines that ultimately report to a physician or non-nurse?

The existing 152 VHA medical centers are governed through 21 networks. Each network operates like a system of hospitals. Does the action-logic of the network director correlate with speaking up among executive leadership council members? The executive leadership council is made up of the executive leadership team from each medical center. Does the action-logic of the network director correlate with the quality of care and efficiency scores for the entire network?

Limitations of the Study

A limitation is that this study had only four participants. A larger number of participants may have produced different results. The action-logics of the other members of the leadership team were not assessed. If one of the members of the executive leadership team had a postconventional action-logic, it could have enhanced the ability of the NE to lead the organization to Magnet designation. Similarly, if the organization employed a Magnet consultant to guide them through the process, the positive effect that a consultant with a postconventional action-logic has on the organization could have had a positive impact on their success.

Action-logics are a way of understanding what a person is likely to do and is capable of doing. This is not the only way to assess and understand individuals. Having a particular action-logic does not guarantee that one is ethical or free of psychological pathology. Hitler may have been a Strategist. The emphasis here is on the use of action-logics because they are tools that can and should be used more in health care, as this study has attempted to demonstrate.

An intervening variable could be the educational level of the participants. All of them were master's prepared. Action-logic and critical thinking have both been shown to increase with increased education. At this time, a doctoral degree is not required to become a NE, but it is increasingly preferred. Would the responses of a doctorally prepared NE been as different from the Master's prepared NE as the Individualist was from the Achiever? The responses a doctorally

prepared NE would have made to the interview questions remain unknown. The type of master's degree might also be in intervening variable. If a master's degree has a highly technical focus, the softer skills associated with increasing action-logics might not be developed even though graduate education was obtained.

Using NEs from the VHA as a convenience sample is also a limitation to the study. The culture of the VHA impacts these NEs even as they impact the culture. Due to the bureaucracy of the VHA, the NEs experience similar constraints that NEs in the community would not experience. The requirements for hiring, firing and resource acquisition in VHA, as well as budgetary constraints, create barriers to change that are unique to that system. However, the VHA is also a tremendous resource, filled with opportunities for collaboration and growth that are also unique to that system. Imagine being able to reach out to 152 NEs for input and assistance every day. NEs outside the VHA system have no idea how helpful that can be.

Summary

Achieving Magnet designation and re-designation is related to high quality patient outcomes and high nurse satisfaction. We now know that a NE with an Achiever action-logic can lead her hospital to this important accomplishment. We also know that most nurses do not speak up about concerns they see in the workplace. The NE with the Individualist action-logic in this study demonstrated a superior ability to listen and create a climate for hearing concerns of the nursing staff. Because the Achiever action-logic cannot accept feedback that does not fit within their existing worldview, postconventional action-logics may be required to overcome the culture of organizational silence in health care. Use of the MAP to assess the action-logic of NEs and executive leadership teams should become a risk management strategy for health care organizations. The facility needs to have leaders who have the ability to listen all the way from

the C-Suite to the front line. Supporting speaking up is more than telling people they should

speak up, as Achievers are inclined to do. Leaders with postconventional action-logics can listen

and support speaking up, which is required to improve safety and communication in health care.

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APPENDIX A

Interview Format

This study is an exploratory study of nurse executives (NE) that have successfully brought their facility to Magnet designation or re-designation in the Veterans Health Administration. Semi-structured telephone interviews will be conducted with the six NEs who have achieved the above. The topic of the interviews will be exploring the practice of the NE regarding nurses speaking up.

Qualitative data will be collected via a semi-structured interview with the study participants. To introduce the topic of speaking up, the researcher will ask the NE if she is familiar with Maxfield's studies on speaking up. The researcher will review concerns about the failure of nurses to speak up as discussed by Maxfield to a greater or lesser extent, depending on the NEs knowledge of the articles. The interviewer will then review undiscussables as a concept. Undiscussables are things that are deliberately not discussed because the nurse lacks the ability, motivation, or support to do so. The three most common undiscussables are dangerous shortcuts, incompetence and disrespect. The researcher will explain that and the Magnet organizations typically employ several of these sources, although Maxfield did not describe in depth what they might be.

To answer the umbrella question of "What actions have you taken to support nurses speaking up about their concerns?" the researcher will ask the following questions:

5. Can you tell me a story about a time you supported nurses to speak up about dangerous shortcuts?

6. Can you tell me a story about a time you supported nurses to speak up about incompetence?

7. Can you tell me a story about a time you supported nurses to speak up about disrespect?

8. Do you have another story that comes to mind about encouraging speaking up?

To answer the umbrella question of "What barriers exist that impede your efforts to support nurses speaking up?" the researcher will ask the following questions:

9. Can you tell me a story about encountering barriers to speaking up?

10. Do you have another story that comes to mind about barriers to speaking up?

The answers to these questions will be recorded, transcribed, coded and reported as a group, again to protect the privacy of the participants. The identity of the participants is well known, so only limited privacy is afforded by grouping the responses. The study participants will be informed that the quantitative results will be reported as frequency distributions and the qualitative results will be grouped together without identifiers prior to being disseminated. Participants will give informed consent prior to participation in the study.

It is anticipated that the interviews will take between 30 minutes and one hour. Additional questions will collect data on demographics for each NE including gender, age, years of employment, level of education and type of degree, and years as a NE. The demographic results will be reported as a frequency distribution with no identifiers. Common themes supporting an environment that helps nurses speak up will be noted, as well as common barriers. In particular, the occurrence of sources of influence as described by Maxfield et al. (2011) will be noted by frequency and type. Any positive deviant will be explained in more detail in order to disseminate the information and potentially multiply the results. If the detail potentially makes the location identifiable, that information will only be presented with specific written permission of the participant. This permission will be included in the informed consent. Patient anonymity

will be protected at all times, and no patient identifiers will be collected or used in any form. No

situation that supports speaking up or is a barrier to speaking up will be communicated in such a

way as to allude to a specific patient.

APPENDIX B

IRB Approval Letter

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

February 11, 2015

Protocol #: E0914D02
Project Title: Action Logics of Nurse Executives and Speaking Up

Dear

Thank you for submitting your application, *Action Logics of Nurse Executives and Speaking Up,* for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Nero, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval.** The IRB approval begins today, February 11, 2015, and terminates on February 11, 2016. In addition, your application to waive documentation of informed consent has been **approved.**

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For *any* proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **February 11, 2016,** a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

6100 Center Drive, Los Angeles, California 90045 ▪ 310-568-5600

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
        Mr. Brett Leach, Compliance Attorney
        Dr. Susan Nero, Faculty Advisor

APPENDIX C

Invitation to Participate in a Research Study

Name, Nurse Executive
Street
City, State Zip Code

Re: Invitation to Participate in a Research Study

Dear

I am writing to respectfully request your participation in a research study that I am conducting to complete the requirements to earn my doctorate in Organization Change at Pepperdine University. This is a study of the action logics of Nurse Executives who have brought their facilities to Magnet Designation or Re-designation in VHA.

Action logics are worldviews – the way people understand the world and how they respond to daily events, especially under pressure. Research in the business community has revealed that leaders with complex action logics are best able to lead their companies in environments with accelerating rates of change. This type of research has not previously been applied to Nurse Executives (NEs). You have already demonstrated success in leading your organization to Magnet Designation or Re-designation. I would like to explore whether successful NEs possess the same action logics as successful business leaders.

Action logic is measured using a sentence completion test called the MAP. The MAP has been used by over 9000 participants in numerous studies. Completion of the MAP only requires that you write the end of a sentence in response to 36 "sentence beginnings." The MAP will be sent to you by email and will take no more than 45 minutes to complete. You will be asked to complete the MAP within one week and return it back to me by email or fax.   Your name will be removed from your test to preserve your confidentiality. The results from the MAP will be aggregated and will include the final scores and distribution statistics without names attached. As a participant, you may request your result and I will make it available to you.

I am also asking you to participate in a brief interview that will consist of a few questions and demographic information and will take approximately 45 minutes. The telephone interview will be scheduled within two weeks after you agree to participate in the study. Your responses to the interview will be aggregated with those of other participants, and will not be associated with any individual or facility.

In compliance with IRB requirements, I will take care to follow rigorous security measures to insure your confidentiality. You may request your individual action logic results at any time prior to one year after publication of the dissertation. After that time, all data from this study will be destroyed.

I hope you will agree to participate in this research study. When you agree to participate, you are agreeing to take the MAP and to be interviewed on the telephone. I request that you participate outside of your working hours. Please read the attached INFORMATION SHEET FOR PARTICIPANTS. If you wish to participate, please indicate via email or fax that you agree to participate to   or by fax at   . Please

respond within one week of receiving this invitation. I may be reached by email at
and will return emails within 48 hours.

Your response confirming your intent to participate serves as your informed consent. If
you have any questions about the study, please do not hesitate to contact me by either of the
methods above.

Thank you,

Researcher

APPENDIX D

Information Sheet for Participants

Pepperdine IRB Protocol # C0914D02

PARTICIPANTS WILL BE GIVEN A COPY OF THIS INFORMATION SHEET WITH THE
INVITATION TO PARTICIPATE

Study Title: Action Logics of Nurses Executives and Speaking Up

You are invited to participate in this original research project. You should participate only if you
want to do so. If you choose not to participate, you will not be disadvantaged in any way. It is
important for you to understand why the research study is being done and why you have been
invited to participate prior to you making a decision about participating. Please read the
following and you may also discuss it with others. Please ask the researcher for clarification or
more information as needed.

Research Aims
I am interested in the action logics of Nurse Executives in VHA who have brought their
organization to Magnet designation or Re-designation. Action logics are worldviews – the way
people understand the world and how they respond to daily events, especially under pressure.
Transformational leadership is a component of the Magnet model. Nurse Executives that have
brought their facilities to Magnet status, or been able to maintain Magnet status, are presumed to
be transformational leaders. In the business world, transformational leaders have been shown to
have highly complex action logics. I would like to discover whether successful Nurse
Executives have the same action logics as successful business leaders. This research has not
been done before.

Additionally, I am interested in speaking up behavior in nurses. The healthcare environment
requires transformation to support nurses speaking up. I plan to explore how Nurse Executives
in VHA Magnet organizations have supported speaking up for nurses, and what barriers they
have encountered to speaking up.

Who Has Been Asked to Participate?
Only six people are eligible to participate in this study. They are the six Nurse Executives in
VHA who have brought their organizations to Magnet designation or Re-designation. You are
one of this elite group of Nurse Executives.

Who is Excluded from Participating?
All other Nurse Executives and persons are not allowed to participate.

When and Where Will the Study Take Place?
The study will take place in your home outside of your work environment via the telephone and
internet or U.S. mail outside of work hours.

How Long Will the Study Last?
The study will require less than two hours of your time. The study activities are planned to be completed within two weeks after you respond that you will participate.

What Will You Be Asked to Do?
You will be asked to complete the MAP sentence completion tool. It is a tool that contains phrases to start sentences. You will be asked to complete the sentences. There will be 36 sentences to complete. It is estimated that it will take no more than 45 minutes to complete all 36 sentences.

You will be asked to participate in an interview. The time for the interview will be no more than 45 minutes. The telephone interview will be recorded and transcribed. The telephone recording will be destroyed as soon as the transcription is completed.

You are requested to complete the MAP and participate in the interview on your own personal time outside of your work hours.

Will You be Compensated for Your Time?
No. Participants will not receive compensation for participation in the study.

Are There Any Risks Involved In Participating?
The only potential risk is minimal, and would be a breach of confidential information or opinion.

How Will Your Privacy and Confidentiality Be Maintained?
All data will be kept in a secure encrypted electronic file behind the VHA firewall. The data will be in a password-protected document, and the researcher is the only person who will know the password.

The MAP tools will be released to Cook-Greuter and Associates for analysis without personal identifiers. The researcher will assign a number to each participant, and will keep that number in the encrypted password-protected document mentioned above. The results of the MAP analysis will be reported by the number submitted, not by the names of the participants. Only the researcher will know the participant numbers and names.

The interviews will be coded and transcribed, and the interview data will be aggregated. The interviews themselves will be destroyed once the transcripts are completed. There will be no identifiers associated with the interviews. The date and time of the interview will be kept in the secure electronic file by the researcher to ensure all interviews are completed and transcribed.

A year after the publication of the dissertation, the secure electronic file that contains the participant numbers will be deleted.

Are There Any Benefits Involved in Participating?
Participants will be able to ask for the results of their MAP tool for up to one year after publication of the dissertation. The results of the MAP tool can be used for personal coaching and development if desired.
By participating you will contribute to the scientific knowledge base of the Nursing profession and the field of Organization Change.

APPENDIX E

Codes from Interviews
(Grouped by Type)

Barriers
      Barrier Developed over time in the team
      Fear of retribution
      Manager not supportive of speaking up
      Nobody likes to tell on anybody else
      Personal Ability Barrier
      Personal Motivation Barrier
      Social Ability Barrier
      Social Motivation Barrier
      Spoke up before but was not heard
      Structural Ability Barrier
      Structural Motivation Barrier

Non-technical language support for speaking up
      Communicate that speaking up is important
      Communicate that speaking up is safe
      Delineated process that is respected
      Listening to concerns from managers and staff
      Look for patterns or more information
      NE and COS discussing concern with individual
      Recommending and enforcing personnel action
      Speaking up to Chief of Staff
      Speaking up to the entire Executive Leadership

Sources of Influence
      NE Source 2 Personal Ability
      NE Source 3 Social Motivation
      NE Source 4 Social Ability
      NE Source 5 Structural Motivation
      NE Source 6 Structural Ability
      Source 1 Personal Motivation
      Source 2 Personal Ability
      Source 3 Social Motivation
      Source 4 Social Ability
      Source 5 Structural Motivation
      Source 6 Structural Ability
      Strong emotional component

Undiscussables
      Dangerous Shortcut
      Disrespect

Incompetence

Undiscussables, cont.
Pervasiveness of Dangerous Short Cuts
Pervasiveness of Disrespect
Pervasiveness of Incompetence

APPENDIX F

Transcription of Interview with Participant One

PARTICIPANT ONE: Hi, Bonnie.

INTERVIEWER: Can you hear me okay?

PARTICIPANT ONE: Yes. Can you hear me okay?

INTERVIEWER: I can hear you just fine. I need to remind you that I am recording the

call for transcription purposes, and then the recording will all be destroyed. I am using a

professional transcription company that does medical transcription, so they understand privacy.

PARTICIPANT ONE: Okay, very good.

INTERVIEWER: Thank you so much for participating and be willing to do your part

right away. I really, really appreciate it.

PARTICIPANT ONE: No problem at all.

INTERVIEWER: Okay. What we have is a set of questions about my area of interest,

which is speaking up. So I'll just go through, and it's really asking you about your professional

practice regarding nurses speaking up. So here we go.

PARTICIPANT ONE: Did you say speaking up?

INTERVIEWER: Yes.

PARTICIPANT ONE: Okay. Okay, speaking up. Okay, great.

INTERVIEWER: Okay. First question: Can you tell me a story about a time you

supported a nurse or nurses to speak up about a dangerous shortcut such as not observing a

timeout or not using a required bundle or protocol that they encountered?

PARTICIPANT ONE: There's many to choose from. All right. Yes, I think I will use

though the timeout in the OR. There have been particular surgeons who come over from the

university, and they claim that they didn't have to do timeouts over there and why did they have to do them at the VA. And a number of nurses came to me and to the manager and said that they were very upset by this, and they wanted it to stop. I took the information, and I asked them for specifics, specific times and which doctors this was. They were very nervous about this. They felt that there might be some retribution as a result of this, and I took it to the chief of staff, at that time that was the chief of staff, and I brought it forward to the entire Pentad actually. At first I talked to the chief of staff, and he said, well, you know, I'll check into what they're doing at the university. And I said, no, that's not really good enough; what I need from you is for you to talk to them and tell them that they have to abide by the way that we're going to handle -- that we're doing timeouts. He was a little reluctant because he felt that we may lose those surgeons as a result of this, but he did -- we brought it to the Pentad. We talked about it as a group and agreed that, yes, it was the right thing to do. And so that was communicated. But through the chief of staff, through the physicians, one of the nurses -- because then I went back and checked with the nurses a week later just to find out if everything was going okay. One of the nurses said that one of the surgeons had made a sarcastic remark to her and would not speak to her. And so I brought that back to the chief of staff, and I told him that that was not acceptable and that had to end. And he spoke to that surgeon immediately, and things just went back to normal.

INTERVIEWER: Okay. So by back to normal, meaning that there was no additional sarcasm and they followed the timeout?

PARTICIPANT ONE: That's what I -- I meant that the relationship went back to normal.

INTERVIEWER: Okay. Oh, okay, the relationship. Okay, okay. What -- I think you already told me, but I'm giving you the opportunity to articulate barriers of speaking up that occurred -- barriers to speaking up that occurred in that situation.

PARTICIPANT ONE: Well, you know, I think that -- I think it's hard for anybody, whether you're a doctor or nurse, respiratory therapist, environmental services person, I mean, there -- it doesn't really matter about power I found about speaking up. Nobody likes to tell on anybody else. I think we're taught that at an early age. And you try to work it out amongst yourselves. And I think that is actually still the best strategy, but in this case the barrier was that they were giving them an argument that they could not confirm really about what the university is doing. In fact, the nurse manager did call over to the university, and the nurse manager said, no, that's not true, we do a timeout just like everybody else does, and they do that there. So even when they brought that back to the surgeons, that message back, the surgeon was just -- didn't take it seriously. So that then prompted the nurses to come forward.

So I think right there when you can't solve it at the lowest possible level and amongst yourselves, then you do have to bring it up. And that does take courage because, you know, people do react poorly to that generally. Another barrier was just a slight hesitance on the side of the chief of staff to make waves because he was afraid then that there would be repercussions and they would say I'm not going to surgery over at the VA anymore then. And so we had to talk about that, you know, how hard -- what was the right thing to do, and we still had to maintain standards. And he and I work well together, and I think it's because of that strong relationship that he and I could say, you know, we're going to still do it. But it was a barrier. I think there could have been a potential barrier at the Pentad, too, if we had had a director that said under no circumstances are we going to upset these surgeons.

You know, earlier in my career -- I'm talking probably in the '70s and '80s, that could have been a very probable response. But in this case, I think that health care has evolved enough so that that was not a barrier in this situation.

INTERVIEWER: Okay. Another story. Can you tell me a story about a time you supported a nurse or nurses to speak up about some type of incompetence, failure to demonstrate competence but performing a task or disregard for common standards of practice? So they encountered some sort of incompetence.

PARTICIPANT ONE: Well, I personally have spoken up when I was a staff nurse about incompetence, an incompetent physician. Okay. I can think of an example. There was a RN who the staff had begun to worry about in terms of his mental competence, that they were seeing changes in his ability to remember. And that actually was a very sad story. They talked amongst themselves. They brought us then forward to the nurse manager, who for a few months observed what was going on. And it came finally to a head to me, up to me, when a very ill patient, his wife complained because he felt that the nurse was not -- had not done the right thing, had not taken vital signs, when it was really quite important for them -- him to do that. So then we -- then the nurse manager, the nurses, and I just talked about the specific times when this nurse had dropped the ball on something or was not following through. Finally, the nurse manager sat down with him and talked with him about key examples. He did not listen to what she had to say. He said he got the union involved, and for a few months then what I did was I asked her to put him on the day shift Monday through Friday so that he could -- instead of his off shift, and so that he could be observed in his practice so that he would not harm and that he had to work with somebody.

And the staff were not happy about that. He was not happy about that. But I could not see with the rules and regulations of the federal government, I could not see how we could do it any differently. And so then staff were -- did continue to report issues and problems, and finally what we were able to do, working through HR, we were able to get a fitness for duty. A fitness

for duty was based on potential dementia and Alzheimer's; and when that came back, it was

fairly clear that he could no longer do the job. And at that point, then we -- HR and myself and

others did sit down with him, and he did eventually retire. He did retire. We did have to take

him off duty for a period of time, and then he finally made the decision to retire. But that I think

was at the time a difficult situation for the staff nurses to report this. The changes were very

subtle in the beginning, and he had been a long-term staff member, a team member with them.

And I think it's pained them terribly to bring that up. But once they did, we could not ignore it.

And it was not a fast process. It took some time, so that was kind of miserable for everyone; but

you have to do it.

INTERVIEWER: Again, I think you articulated the barriers to speaking up, but if you

could go on ahead and articulate specific barriers to speaking up in that situation.

PARTICIPANT ONE: Well, I think -- I think that the staff -- the barrier was that it was

subtle change. It wasn't a dramatic change. So they weren't sure about their perception. So it

took a while for them to actually realize what was happening. So I think that is a barrier of a

sort. And then once they did, that meant that they -- that he, the staff person, could have been

very -- was very insulted and upset and hurt, and it caused a great deal of consternation. The

barrier there was the team, the way the team worked then was certainly off kilter. I think another

barrier is our -- the federal government, the rules and regulations.

We had not a great deal of support from HR just because this was going to be very tricky.

And so we just had to say we're going to continue to do the right thing. And, you know, the

barrier of getting a fitness for duty is time consuming, and you need a lot of documentation and

examples. And the union was also a barrier at -- right up until the end they were very adamant

that we were wrong. But once the fitness for duty report came back, they became very

supportive and really helped us at the end then transition in a dignified way. So I think those are the barriers that I can think of right now. It is so hard. So hard.

INTERVIEWER: Another story. Can you tell me a story about a time you supported a nurse or nurses to speak up about a disrespectful behavior they encountered?

PARTICIPANT ONE: Many times. This was back in private sector, and it was a doctor who just was abusive. He thought nothing of screaming at people, yelling at staff. He was furious, as a matter of fact. The people were afraid that he was so volatile that he may actually physically assault them at certain periods of time. And so the same scenario. Brought the concerns forward to the chief of staff. And in that case, the chief of staff and I met with the surgeon, and he made a lot of excuses. But the chief of staff and I both said that that -- this was unacceptable, and he had to stop -- that behavior had to stop immediately, and if it happened again he would not be employed. And again, it was private sector. It did happen again, and we had another encounter with him. One of the staff nurses who was involved, actually wanted to speak with him about it. And she was so powerful in her ability to tell him how his behavior affected her in the workplace that he really -- he had a great emotional response to that. And so the chief of staff and I talked again without the staff nurse and without the cardiologist, and we decided that we would give him another chance, just because he was so -- he was so -- you could see that he was affected by it and that it brought it home. And, you know, we never had another problem from him. It was a remarkable change.

INTERVIEWER: Wow.

PARTICIPANT ONE: Yeah. We gave great kudos to that staff nurse for, you know, coming in and just being so articulate and passionate. It was just -- it was a remarkable thing.

INTERVIEWER: So the barriers to speaking up in that situation were?

PARTICIPANT ONE: Oh, the people spoke up. They took a great risk, especially in the private sector. I mean, that doctor could have demanded that they be fired, and I have also seen that happen where the people who speak up take the brunt of it. And so I think the barrier was here just for their jobs, their livelihood. But I think it seemed to a point for them where they didn't want to work there anymore with that kind of environment. And I think they also -- that that fear that he could go off and physically assault them was both a barrier but an incentive to do something about it. And I think -- oh, well, I think to have the courage -- well, that's not a barrier -- for that staff nurse to really speak so passionately, I think that a barrier could have been if she hadn't come forward and done what she did to try to help him understand how his behavior affected the work environment, and the outcome would have been different. He probably would have been fired. So I think there were fewer barriers in that story, but a fear. Fear is always a strong barrier in speaking up. Huge.

INTERVIEWER: So then just a general question: What do you think are the greatest impediments to nurses speaking up?

PARTICIPANT ONE: That's a very -- I think it goes back -- I'll just speak about the Baby Boomer generation, but I think that -- I think that we were raised, Baby Boomers, especially women, were raised in a manner that caused us to not be assertive and speak out and that our voice was less than -- and I think it's still true to a certain extent. But I think that the other generations are not like that, not trained in the same manner. I think that an impediment -- and it still exists in health care, you know, that the physician is the captain of the ship and that anything that a physician does, it has to be -- that has to be right. And again though, I think there's a generational change happening. I think -- so I think the women -- that women are more assertive in breaking that impediment down. But I do think that oftentimes we -- because

nursing is a female-dominated profession and -- the physicians were predominantly male, but that's not true anymore statistically. So actually I think that solved some of the problems. Not all of the problems. Fear of retribution is an impediment. You know, health care is really a team sport. And so when one of the team members is not -- not performing the right way, I think it really goes to the heart of teamwork. And so that becomes an impediment that you'd rather try to work around and support that person. And it becomes a tricky situation. You know, and I think we have to put it right at the heart of why we exist, and that's to take care of patients, and in our case veterans. But that sort of makes it very clear what we have to do. But I think that the generational, the way we were raised, big impediment. The consequences sometimes -- and I think about the nurses in Texas, you know, who spoke up about the doctor who was stealing drugs and they ended up in jail actually for a period of time because the sheriff was in cahoots. And finally the Texas Nurses Association stepped in. And once it became national, the tables turned of course. But I think there still are stories out there. That wasn't too many -- that was maybe a couple, two, three years ago. So I think there are grave consequences sometimes to speaking up, and that's an impediment.

INTERVIEWER: Well, you alluded to this a minute ago, but my next question is: What do you think are the best supports to nurses for speaking up?

PARTICIPANT ONE: The best supports?

INTERVIEWER: Uh-huh.

PARTICIPANT ONE: I think that -- I think that good training in nursing school and then when you come into a health care setting that it's very clear the expectations that you take on as a nurse and that you talk about it frequently. You talk about it in staff meetings. You talk about it being able to speak up, and then it's an obligation. You take the ANA Code of Ethics and you

review that twice a year with your staff and you talk about ethical dilemmas, and you just make it so that there aren't many alternatives to not speaking up. You make an environment that everybody understands what is right and what is wrong. And, you know, sometimes it's great, but not -- not scenarios that we've talked about. There's -- it's pretty straightforward that to protect patients and to make safety a really high priority you just have to create the environment where you stamp out fear basically, that everybody is in power. I mean, medicine, I mean, we just celebrated a great thing where an environmental services guy cleaning, he called out a physician in a really nice way about not washing his hands or gelling up. And, you know, we made a great story out of it, that he was a wonderful person and he benefited the patient and saved lives just by what he did. And so I think it's important to -- the storytelling is a good way to carry out that message of there is right and wrong behavior. I kind of rattled on, I'm sorry.

INTERVIEWER: Oh, no apologies. Thank you. Do you have any additional stories or thoughts to share about speaking up and barriers to speaking up?

PARTICIPANT ONE: I've been thinking quite a bit about how -- particularly in the VA, how we create the VA culture of speaking up, how everybody -- every single employee in the VA should be speaking up, and then we have to find a way to listen to all of that. And I think, too, to teach everyone, every single person in the VA to -- when you speak up, you need to also have thought forward about the possible solutions to the problems. So I think we could do a lot in the VA to enhance that culture, and I think that we're at an opportune time to start thinking deeply about how do we make people understand the absolute best way to solve problems and to speak up. So I think, you know, the culture, we have to create first a culture where everyone feels safe and that -- that's hard to do, but we have to make that -- and then we have to have kind of a behavioral code I think that is widespread. So I digress a bit to talking about the VA, but it's

become very important to me in the last year or so to really think about this and to figure out how to change this and make it a really great place where there isn't fear, that we're all working on behalf of the Veteran.

INTERVIEWER: Well, thank you. That's the end of my formal questions.

PARTICIPANT ONE: Okay.

INTERVIEWER: I cannot thank you enough. And it's great to talk to you.

PARTICIPANT ONE: Well, thank you. I appreciate the opportunity.

INTERVIEWER: Okay. So this will end your need to do anything in particular for me for my study. You've done it all. Thanks again. And I hope to see or be in touch soon.

PARTICIPANT ONE: Okay, thanks a lot. Bye-bye.

INTERVIEWER: Okay. Bye,. And that ends my recording. Thank you. Bye.

[END RECORDING]

APPENDIX G

Transcription of Interview with Participant Two

INTERVIEWER: This is Bonnie Pierce, and this call is to be recorded. Thank you. I am adding the other caller now.

Can you hear me okay?

PARTICIPANT TWO: I can hear you just fine, yes, uh-huh.

INTERVIEWER: I am recording the call for transcription purposes. I'm using a professional company that does recordings and transcriptions for medical services. So they understand confidentiality and all of that.

PARTICIPANT TWO: Uh-huh, okay.

INTERVIEWER: So just wanted to let you know. All right. So let's begin.

PARTICIPANT TWO: Okay.

INTERVIEWER: The topic of the interview is about nurses speaking up.

PARTICIPANT TWO: Nurses what?

INTERVIEWER: Speaking up.

PARTICIPANT TWO: Oh, okay.

INTERVIEWER: So speaking up about things that are difficult to talk about.

PARTICIPANT TWO: Uh-huh.

INTERVIEWER: Okay. Can you tell me a story about a time you supported a nurse or nurses to speak up about a dangerous shortcut, such as not observing a timeout or not using a required bundle or protocol?

PARTICIPANT TWO: I'm not very good at remembering these things. That's my problem, I like deal with them and then I'm off.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: Let me see, because that sort of -- I understand myself well enough to know that that's how I operate. Speaking up. When's a time I spoke up?

INTERVIEWER: Yeah, encouraging a nurse to speak up about someone taking a shortcut.

PARTICIPANT TWO: About someone taking a shortcut. I guess I don't have a specific example that I can think of. I guess the major one that I can think of is bypassing BCMA.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: Yeah. And so, you know, I just -- you know, I don't remember an individual, but I remember talking about it, talking about not doing shortcuts, holding people accountable for, you know, instilling procedures so that, you know, we would not be supporting that inadvertently, you know, through policy or whatever.

INTERVIEWER: Okay, that's good.

PARTICIPANT TWO: Okay.

INTERVIEWER: If you think of something as we go, just jump right in with it, it's okay.

PARTICIPANT TWO: Okay.

INTERVIEWER: What barriers to speaking up occurred in that scenario? What would have kept the nurses from saying what they were really doing?

PARTICIPANT TWO: I think one is, you know, sort of implying that they've not been heard, you know, on other issues. You know, because it may have been actually due to, you know, staffing kinds of things, and you get people shutting down, talking about staffing. What are some of the other barriers? I think maybe a lack of understanding about how important --

how important it was. I remember, you know, hearing stories about I was so glad I used this

because it caught an error before I did it and I wouldn't have known I had done the error.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: So I think -- what other barriers? You know, time was always a

barrier. You know, people always said it was, you know, was time and time-consuming, and

there were problems with the wristbands. I mean, there was a whole list of problems in the

beginning that were actually problems. And so one has to work through all of those problems.

So, you know, just making sure that from my perspective I had people out there that were

observing, telling me, making sure that I understood what the issues were so that I could support

them.

INTERVIEWER: You know, I was a nurse manager when we implemented it in

Southern California. I volunteered for my unit to be the first unit to implement BCMA, and woo,

there was a lot of refining to do.

PARTICIPANT TWO: Yeah, right. I mean, there really was. So, you know, you just

really had to make sure that you were hearing what those barriers were. And there were many.

There were many. But, you know, later when you got some of them corrected, you know, people

would still bypass it. And so you really -- you know, because they didn't think they needed to,

they felt it slowed them down too much, and nurses sort of have a little bit of an idea that, you

know, a bad thing can't really happen to me until it does. So --

INTERVIEWER: I've seen people like that. Okay, another opportunity for a story. Can

you tell me a story about a time you supported a nurse or nurses to speak up about some type of

incompetence? And there's different -- true incompetence is somebody just doesn't know, and

then there's disregard for common standards. Either one of those types of scenarios would be fine.

PARTICIPANT TWO: Okay. Go back and repeat the question.

INTERVIEWER: Okay. I'm interested about in a time you supported a nurse or nurses to speak up about some type of incompetence.

PARTICIPANT TWO: Let me think. I just know there were many, and I can't even think of them, but I can remember some incompetent nurses.

INTERVIEWER: So how did you learn about them being incompetent?

PARTICIPANT TWO: Well, you know, I -- you know, I would hear about it or there would be a -- you know, I mean, everything from like a comment in Morning Report, like, well, it was the same person or whatever.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: You know, you just sort of listen for those things. Or, you know, a manager would come and actually say they thought they had a problem with an incompetent person.

INTERVIEWER: So would it be fair to say that you just in general encouraged people to talk about what was going on in honest terms?

PARTICIPANT TWO: Yeah. I mean, I always wanted people to be frank with me. There we go, you know. I mean, you know, sometimes when I heard that people would -- you know, sometimes I would hear that people would say, well, she's in a bad mood or something; that would always irritate me because it was always about making sure that you could talk to me at any time or bring something to me.

INTERVIEWER: Well, but you did -- you told me about Morning Report. And so every day there was an opportunity for people to talk to you about their concerns about incompetence, and you encouraged that.

PARTICIPANT TWO: Yeah, uh-huh.

INTERVIEWER: Yeah.

PARTICIPANT TWO: You know, I mean, you just had -- I mean, you just had to -- I don't know. You just had to like look for it.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: You just had to look for what people were saying and doing so that the -- one barrier to that might have been then a failure to be observant, that you hadn't been observing for potential issues.

INTERVIEWER: Uh-huh. Is that accurate?

PARTICIPANT TWO: You know what I used to do? I used to listen, you know, sort of for patterns. You know, it could be an issue even with physicians. You know, sometimes you would hear about an issue with the same physician, and it's sort of like, you know, this guy's name -- his or her name is coming up too often. There's a problem. So then you would ask a question. You know, if you heard about the same kind of thing sort happening -- so I vaguely remember there was like an issue in the ED, but I can't remember exactly what it was. But, you know, you just sort of listen to what people say. You know, now I know that, you know, the nursing doesn't even listen to morning report. And it's sort of like how can you understand what's going on. You have to take every single opportunity to listen to what's going on.

You know, I sort of would -- I could sort of identify patterns that way, you know, just by listening. But, you know, I just sort of always would be trying to put things together. But, you know, it was like I never said this is exactly what I'm doing here; I just did it.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: Well, and then -- yeah. And then, you know, the other thing -- you know, the other way that, you know, I would learn about things is, you know, one of my chiefs would come to me and talk to me about things, you know.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: I never like to be surprised, so they sort of knew that. So if they were seeing something, they would -- you know, they would let me know.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: Not all the time, but --Sometimes people get incompetent based on, you know, substance abuse. And, you know, people have to see it for a long time before they believe it. They sort of have this belief inside, you know, inside their unit. They just can't sort of believe what they see. And so they go through a period of disbelief. I've sort of seen that more than -- you know, more than once. Sometimes you don't -- you don't see incompetence until it -- well, it might not be competence. Sometimes it's the behavior change or the behavior has been there for so long that people think it's normal. And it may not be until they get into trouble, and that's more like in a personal competence, getting into trouble.

INTERVIEWER: Tell me about disrespect that you or the staff experienced and did you or the nurses speak up about being treated disrespectfully?

PARTICIPANT TWO: I have a funny story about that. There were a group of nurses. Some women who were famous for showing off their cleavage were going to come for Veterans

Day or something. And the nurses were a bit put out, and so I brought that forward. I mean, I was really -- I brought that forward to the chief of staff and the director because people were really put out about it. Well, I mean, you should have just heard the lectures. They just like couldn't believe that that was going to be an issue. And I said, you know, we're talking about taking care of women veterans in a new way. You know, I mean, we've got women veterans. I think it was maybe when we were first like doing, you know, appointing a woman veterans coordinator for the facility. You know, it was just like one of those little token things. Well, the women came. They did not listen to me. But, you know, that was just like disrespect for women in general, nurses, you know. And especially women veterans. They just thought that was very disrespectful.

So what other kind of disrespect? Years ago there was a lot of, you know, blaming nurses for patients escaping out of the mental health unit, and all of that kind of stuff. I would always challenge that kind of thing because that was disrespectful in terms of, you know, because they would always blame the nurses. They wouldn't blame, you know, other kinds of staff. You know, other things might be going on in the unit or -- I mean, there was -- that was sometime before the units were locked or sometimes the patient would just rush out. But it was always like what's the matter with the nurses? So I would challenge those things. I know I took on several issues

INTERVIEWER: What do you think are the greatest impediments to nurses speaking up?

PARTICIPANT TWO: I think not -- I think sort of the pattern of not being heard, and that's one. You know, their ideas have never gone anywhere. Their voice hasn't been very strong. And so then I think people just quit bringing up issues. I think another one is sort of the nursing unit norm and the leadership on the nursing unit. Whether or not speaking up challenges

the nurse manager or not, I think it has to do with how the manager responds to people speaking up. It's a long way from a nurse executive to the staff nurse I think sometimes, to be able to be heard all the way up. It is a long way.

INTERVIEWER: Okay, okay. What do you think are the best supports for nurses to speak up?

PARTICIPANT TWO: I think a good support is an actual delineated process that is honored and respected. I think sometimes that's useful because then people have to take it seriously. Now, I'm not meaning every single time; but, you know, if indeed your voice hasn't been heard, there should be another channel. I think there should be another channel. And it should be specific about, you know, I mean, speaking up about patient safety and unsafe staffing and that kind of thing, we did that specifically for staffing. You know, it was like if you were -- if you were so concerned about staffing, you needed to put it in writing, you know, not walk off but put it in writing so that you could actually be evaluated in writing and you would get some feedback about it. That was a bit threatening to the managers, but it was like I don't want to just push down. Because, you know, there were times when staffing was so short that we really did need to know when nurses felt like they absolutely could not manage it in any way, shape, or form. And, you know, if indeed, you know, they work that shift and something happened, then indeed, you know, they had sort of covered their butts. And, you know, so I think that is a way. I don't think that's the most ideal way, but, you know, because I think sometimes, you know, the layers in between don't always let the nurse executive know those issues.

I think one is just a culture of openness and making sure that, you know, sort of the idea of red rules where you have -- these are things that, you know, we never cross or whatever. And not so many. Not so many rules, just key important rules. And I think respect is like a two-way

street, you know. I mean, everybody wants to be respected. And so I think that's -- you know,

that is so basic that most of those horrible kinds of problems that get to EEO and all that kind of

stuff, nine times out of ten started out with some person not being respected as an individual.

INTERVIEWER: So do you have any other stories or thoughts about speaking up and

barriers to speaking up?

PARTICIPANT TWO: I think -- I think one of the things that was really important, you

know, toward the end of my career was, you know, the emphasis on patient safety from all angles

and creating the culture to make sure that those issues are heard and that the expectation is

that you will speak up and not -- you know, and stop the train. You -- I mean, that's the

expectation for your professional rule. And that should be -- you know, that needs to be for

everyone. And the other thing is, you know, I mean, I do think the no-blame culture was

important, and I do think that that was improving. I mean, I really did feel that that was

improving, at least at my facility when I was still there. But, you know, we were sort of early in,

you know, safety huddles and those kinds of things. So we were a real leader in the patient

safety -- the whole patient safety initiative-

INTERVIEWER: Yeah.

PARTICIPANT TWO: I thought nurses could make decisions on their own unit to try

new things and see if it -- and see if things worked to improve things for patients. And that was

like an interdisciplinary focus. I felt that that helped as well. But always there is the leadership

piece in an organization, that if indeed you are not heard, many times you will not keep beating

your head against the wall. And I guess that's one of the reasons I personally think the VA is in

trouble today, because of a failure to listen. It is not like people did not say things about

unrealistic performance measures early on.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: Because they did. And it never went anywhere, that, you know, they just crammed the performance measure, the unrealistic performance measure in some cases, like how fast you can get patients in, it was just crammed down your throat harder. And so everybody sort of figured out, okay, this is the game, we're not going to say anything about this anymore, and we will do our best. And it was pushed down so hard, and people said, well, they don't care about the patients, they just care about these numbers. And that's all they care about. They only care about the numbers, and we can't get the patients in. And, you know, many people knew about how that whole, you know, scheduling system didn't work. They knew. And it wasn't -- people just were told it was all about the numbers. So again it is I think the failure to listen to the people who are trying to tell you something.

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: And they did not listen. And it sounds very simplistic, but when you know, if every single director is telling you that and every single network director heard it, then I would be willing to bet at least 50 percent of the network directors said something to their boss. Not all of them, but maybe 50 percent of them at one time or another, and they were shut down and they were told you will do it. And so they worked on their merry way to try and do it.

INTERVIEWER: So yeah, if there's no ears to hear, that's a problem.

PARTICIPANT TWO: It is, it is. And, you know, I went back and read that IG report, I was just sort of interested in how this gets done. So horrible. I went back and read the IG report. And in 2010, there was a very explicit, these are the things that you will not do regarding the scheduling system. You know, and there were probably two pages of things you will not do to, you know, fudge the numbers, things you will not do, okay?

INTERVIEWER: Uh-huh.

PARTICIPANT TWO: It was very -- I don't know. You might have -- I saw it in the memo. I mean, they were very clear about don't do this.

INTERVIEWER: Right.

PARTICIPANT TWO: But somehow people were told to do it, at least some people. Somehow that memo was not followed.

INTERVIEWER: Yeah.

PARTICIPANT TWO: You know, I mean, there was clearly a huge disconnect.

INTERVIEWER: So that is it. I just wanted to ask you about speaking up and barriers and try to -- try to come up with a rich discussion about the issues. And I love what you said about observing for patterns. That's such a high-level skill, and it's so true.

PARTICIPANT TWO: Well, you know, and I always like that. You know, I -- you know, you just sort of listen to them and -- you know, I mean, you're still not going to know everything. But frequently you will know about is that accurate, but you will not know unless you really do like a Cary journey. That's a good thing people are doing. People are just sitting quietly doing everything. Those are delightful surprises, but you sort of go, hmm, you know, I really don't know a lot about your organization until you start looking for the good things.

INTERVIEWER: Yeah. So that's a barrier to speaking up about good things, is that we don't do a good job of making sure to stress those. That's important.

PARTICIPANT TWO: Yeah. Well, you know, sometimes -- yeah, but sometimes the organizations are really big. And, you know, those are important lessons made, was that there's lots of good things going on in the organization. But understanding little problems.

INTERVIEWER: Yeah, yeah.

PARTICIPANT TWO: And there's a lot of really good things going on in the organization. We just focus on the problems and unrealistic numbers.

INTERVIEWER: Well, thank you, I can't thank you enough.

PARTICIPANT TWO: You're very welcome. I hope I have been helpful to you.

INTERVIEWER: Oh, extremely. Extremely helpful. And I will of course let you know when I'm done, and I will let you know if I get a publication out of this because I think that you and others like you have a lot of wisdom to give out to the field about what supports speaking up and what stands in the way. Thank you.

PARTICIPANT TWO: You're very welcome, you're very welcome.

INTERVIEWER: Okay. Bye-bye.

[END RECORDING]

APPENDIX H

Transcription of Interview with Participant Three

INTERVIEWER: This is Bonnie Pierce, and this will be for Participant THREE.

All right. I have a few questions about nurses and speaking up.

PARTICIPANT THREE Okay.

INTERVIEWER: So, I will ask you to please tell me a story about a time you supported a nurse, or nurses, to speak up about a dangerous shortcut they encountered. And the dangerous shortcut could be something like not observing a time out, or not using a required bundle, or protocol.

PARTICIPANT THREE: An attending surgeon wanted to leave a PGY 2 unobserved during surgery. A PGY 2 can't be alone on a surgery. The nurses banded together between the patient and the PGY 2 surgeon. They complained to the Chief of Surgery and the CNE. The CNE went to the OR and stayed centered on the patient, and facilitated a discussion. The attending joined the PGY 2 before the surgery was performed. This became a well-known example in the medical center for nurses speaking up. In general, barriers occur in interdependent teams because they are forced to be interactive and they develop close relationships. They worry about the repercussions of speaking up in that close relationship. Will the relationship be harmed? Will I be able to continue to work in this team? In this case they felt they had to put the patient first and felt supported to do so. Relationships actually improved in this situation, not only because the nurses spoke up but because of the discussion that occurred as part of the situation.

INTERVIEWER: Very interesting. Okay. Another opportunity to tell a story, about a time you supported a nurse, or nurses, to speak up about some type of incompetence.

PARTICIPANT THREE: A nurse on one of the units had been unsuccessful in a previous career due to substance abuse, and also was going through a difficult time in her life. The staff on the unit decided to support this nurse during this time. The nurses liked her and cared for her and there was extra emotion because of the support for her personal challenges. After a while concerns started surfacing about the nurses judgment and they saw a tendency to make errors. When the peers confronted the nurse, she accused the peers of being against her because of her situation in her personal life. The group of nurses balanced care and concern for the nurse, supported her and still did the right thing to hold her accountable for her practice. One day the nurse was observed just as she made a med error, and nurses called a rapid response. When the team arrived they reported what happened and the CNE removed the nurse from patient care. The case did go all the way to a Disciplinary Appeals Board, where the CNE prevailed. The team in this case demonstrated that it is really all about the patient. The team knew that if they saw someone make an error that they had to speak up. They also felt safe and protected to do the right thing.

INTERVIEWER: What were the barriers to speaking up in this case?

PARTICIPANT THREE: The close relationships between the rest of the team of nurses and the incompetent nurse made this emotionally very complex for everyone. They were sensitive to her and what she had gone through. The CNE talked about the situation with the staff after the rapid response incident. They were able to talk about how hard it was. After some time had passed they told the CNE that they still see her sometimes and they have maintained the ability to show a caring approach to her.

INTERVIEWER: We are about halfway through our interview.

PARTICIPANT THREE: The type of questions, these are really tough for me for some reason. They're tough because they're hard. And it's so, it's so integrated, I think, in the type of things we do all the time, you know, all the time that to think of a specific example, and is really hard. It's very, very hard.

INTERVIEWER: What's interesting is the examples that's you're giving are similar to both my experience, and in some ways, to what other people have said, too. So there are, there are themes,

PARTICIPANT THREE: Emerging.

INTERVIEWER: I see themes here, so. You're doing a great job. Okay. So there's just one more question in this particular vein.

PARTICIPANT THREE: Okay.

INTERVIEWER: Please tell me a story about a time you supported a nurse, or nurses, to speak up about a disrespectful behavior they encountered, and what barriers to speaking up occurred in that situation.

PARTICIPANT THREE: We -- recent, recent example, again, these kinds of things do happen with I can't say great regularity, but, but we did have a unit one night who had a patient that they were concerned about. I can't remember exactly the specifics, but something. I don't know if it was a lab value or, you know, a patient's blood sugar, or what it was. But there was great difficulty reaching an on-call -- the correct on-call physician. And this has been -- we've had some problems historically in the same arena. And so the nurses on the floor, you know, attempted to page the physician. Didn't get a response. You know, tried a couple of different times. Got the nursing supervisor involved, and ultimately, they called the Chief of Medicine, you know, kind of going up the chain. It was in the middle of the night, and it wasn't a major

issue, but it was an important issue. And it was something that did really demand that a physician be aware, and come and, you know, check the patient. And the Chief of Medicine responded and then miraculously, was able to get in touch, actually get through to, the on-call resident, or whatever he was. And he came out of a call room, you know, wherever, and bounding onto the floor. And he was really, really angry, and very accusatory and, you know, telling the nurses they didn't page him and how dare they go, you know, above to the Chief of Medicine, you know, multiple layers above him and that sort of thing. And the nurses were, I'm told, appropriate were very clear about what they had done, about what their expectation was. About the fact it, was it a situation of evolving concern, and that they needed somebody to come and see the patient, and that if they had to do -- if they were faced with the same situation again, they would do absolutely the same thing. So, you know, kind of put him on notice, I think, that that kind of behavior and that lack of response was not going to be tolerated in our setting. But they also wrote reports of contact about his behavior because he was pretty, pretty outrageous. Those came to me in morning report, when the nursing supervisor, you know, handed off and gave morning report. I did, you know, share those with the appropriate people. You know, they got shared with the Director of Residency Program. And, I'm told, that, you know, it resulted in some significant coaching and redirection, and possibly even sort of the equivalent of some sort of little disciplinary counseling, you know, in terms of the residency program. So we did, you know, make sure we followed up with the staff, that the staff knew that their concerns were heard. That we had acted on it, and that we did not tolerate that kind of behavior, that sort of disrespectful behavior, from anybody. Not from physicians, not from nurses, not from anybody. I think they were very -- you know, they expect when something like that happens. They know we're going to follow up. They trust that we will and part of what we ask the, as a response was

that the physician apologize. And he did that. He apologized both in writing and he went back

up to the unit and, I'm not sure if he connected with everybody that was on that shift, but I do

know that he verbally apologized to a number of people. But it did take a lot of, you know, a lot

of perseverance, you know, for the staff to continue to call, and call, and call, and get the nursing

supervisor involved. But they feel pretty comfortable, I think, speaking up. Possibly it was, it's

less intimidating, I think, to report somebody when the person you're reporting is a resident, you

know, versus the example with the surgeon. You know, the hierarchy is different. You know,

the balance of power is different. So, I'm not sure if I adequately addressed all of the elements of

that question.

INTERVIEWER: Absolutely, you did. You did. So then, just in general, what do you

think are the greatest impediments to nurses speaking up?

PARTICIPANT THREE: The fear of, in general, so in general, I think fear of a number

of different things. Fear of, number one, am I right? You know, am I seeing this or hearing this

correctly? So people have to be very confident in their own, and very self-,assured. I think there

are times when people are afraid to speak up because they are concerned about the impact of

that. Either from, you know, the person they're, they're concerned about, expressing concerns

about, or from other, other people. You know, pressure from other people.

So I think, you know, it is, it is, and it can be in some organizations risky, very risky to

speak up. The other thing is, you know, fear of not being supported, and being kind of left out

there, you know, hanging. I think would be -- could be a very powerful reason people don't

speak up.

INTERVIEWER: Thank you. Okay. Next question. In general, what do you think are

the best support to nurses for speaking out? The best support.

PARTICIPANT THREE: Well, I think nothing in the end really speaks louder than lived experience. And if they see examples where people do speak up, and they are supported, and it does make a difference, and, you know, you sort of walk the walk, and they see evidence of that. Like tangible evidence of it in your, or real evidence in your own unit, you know, how your manager handles it, whatever, I think that is probably the most -- one of the most important reinforcers that, you know, that people are not, you know, this organization is not just saying, you know, that we -- for example, value a culture of safety and want people to report near misses and all those things. But they really, really mean it, they really, you know, walk the walk, in addition to talking the talk. And that would be, in my estimation, I think that would be the most important thing to do. To really try to build that environment where people do feel comfortable. And really maybe talk about some of those examples. You know, if those kinds of things are integrated and discussed when they have unit meetings, or you know, if the manager brings that out, and, you know, by highlighting real world examples, I think that's a very effective strategy to promote that culture.

INTERVIEWER: Just one more question. Do you have additional stories or thoughts to share --About speaking up and barriers to speaking up?

PARTICIPANT THREE: Okay, let me think about that for a minute. Speaking up and barriers to speaking up. I'm might have to think about this a little bit, Bonnie. I think that -- I don't think I, you know, have a story, per se. But I do think that it is so critical in the work that we do as nurses, that people are able to speak up. You know, stop the line, raise the flag, you know, whatever, whatever it is. It's so -- it's just -- it's imperative. You know, we work in very complex, fast paced environments, where so many things can change an outcome in an instant. That it is a very important part of the chief nursing officer's role in every level and in -- of the

organization that we intentionally try to build and sustain and foster and nurture an environment, and practice environment, where people do recognize report, speak up, you know, stop the line, whatever. Because really our patients' lives can, do depend on it. They really do, and so I think a lot of the emphasis that we've had in our campaign here has been part of the stop the line campaign. And we, you know, try to apply that, not only in a clinical setting, but even like in, like logistics and supply distribution. You know, and in any sort of process that people feel safe in raising their hands and saying, you know, something's not right, you know, let's take a step back here and see, you know, what are we -- is everything right. And I think that a sign of a healthier, more mature organization, and certainly an absolutely critical part of nursing practice. And, I think so just to emphasize the importance of it, I think it's -- if the chief nursing officer or nursing leaders don't really embrace that, it does have a direct impact on quality of care and outcome. And, that's probably about all I have to say about that.

INTERVIEWER: Thank you.

PARTICIPANT THREE: That's pretty much all I have to say about that. It's just so, it's absolutely so critical.

INTERVIEWER: The thing that I hope to do is to get more awareness of how critical it is for nurses to have a voice, to empower nurses to have a voice, and then to have, as you said in your first example, constructive dialogue after that.

PARTICIPANT THREE: Oh, you have to do that. That's a piece that a lot of times doesn't happen. And it is critical to the learning that comes out of that. And the example, then that that provides, and the, you know, we know what the outcome is because we're sitting in a different seat. And we have access to other information. But the people in the OR room don't know. I mean, they don't always know that anybody, that first of all, that it even got to me, that I

thought it was important that I, you know, acted on it, hat I supported them, and that we took it to a full closure. So it's that completion of the whole -- I mean it takes a lot of time. I mean, it's hard. It's pretty intensive, but that's the piece that I think is the most important, the closure. And I'm not sure that that's done very well, a lot of times. Sometimes, I 'm not great at it either, but it is a part of that whole process that I always try to make sure happens.

INTERVIEWER: We all have to get better at it. It's a muscle I see in health care, we're still developing, that is underdeveloped for these many years. So it caught my interest and I said, what can I do to learn more and help support this. I know with each conversation I have, I feel more enlightened and more energized around the whole topic.

PARTICIPANT THREE: Around the whole topic -- I think it's a fascinating topic, and I really do think it's a fascinating topic, and I think there has been, you know, particularly around patient, you know, creating cultures of patient safety and -- although it's a more generic, you know, issue than that. But I would be, I'm really going to be fascinated to see what you hear any other things, you know, things that emerge or other things that we as nurse leaders can do to make sure that people really do feel capable and safe, and, you know, validated and all when they speak up. And to do it, because its -- without it you just really don't have a clue what's going on.

INTERVIEWER: Yeah, yeah, out there.

PARTICIPANT THREE: You really don't. But you do know some things, like you do know some of your quality -- you know, your date, your error rates, your quality. I mean, I think it is interwoven. Recently, we were pouring over a lot of our nursing sensitive indicator data. And you know, it's really just amazing. I mean, and I sort of knew this because we collect this

data in other forms too, but to wrap it all up and look at it. I was looking, you know, in my facility. I have to brag just for a little second.

INTERVIEWER: Oh, do.

PARTICIPANT THREE: As big and as complex and as high acuity and all as we are, I had in had no central line-associated bloodstream infections. Our hospital required pressure ulcer rate, you know, exceeds the Magnet benchmark by a wide margin. We had some catheter-associated urinary tract infections, but they were all, each one was in a different quarter, and on a different unit. And I have a surgical intensive care unit that is very complex. It has not had a ventilator- associated pneumonia in years.

INTERVIEWER: That fabulous.

PARTICIPANT THREE: It's unbelievable. Those are direct reflections of nursing care and, you know, so I have to think that, you know, how does this all relate back? When it's all interconnected, and so if you, you know, even something as specific as speaking up. You know, I have to think that people do, because in the end it effects your quality, because it's all related.

INTERVIEWER: Uh-huh.

PARTICIPANT THREE: And, so, anyway, that's, I'm kind of rambling, but I do think it's -- you just have to be paying attention to everything all the time. Every quality metric, every possible signal that you could get that something's not right somewhere and delve into it. But I was really kind of, I was blown away when I looked at the summary of our nursing sensitive indicator data, and I'm like, man, my nurses really rock. People are really good.

INTERVIEWER: Well I know that you will make sure they know that, and --

PARTICIPANT THREE: Oh, absolutely. We send it out, we blasted it out. I sent it -- yeah, I mean it's really amazing. They're amazing quality outcomes, you know, especially given the sick population we serve. So, so, you know, we were very proud of that.

INTERVIEWER: Yes. And for good reason.

PARTICIPANT THREE: Well, I really do applaud your efforts on your doctorate and wish you all the best, and will there be anything else that you will email me, or that I will -- can be expecting?

INTERVIEWER: There's nothing else that you are required to do. What you can do is, if you want to request the results of your map assessment, when I --

PARTICIPANT THREE: Oh, I would love that. Yeah, absolutely. I think that sounds wonderful. And that MAP questionnaire was very interesting.

INTERVIEWER: Wasn't it though?

PARTICIPANT THREE: It really was. I felt like I learned some things about myself.

INTERVIEWER: Uh-huh.

PARTICIPANT THREE: It was like, oh, this is interesting.

INTERVIEWER: Yeah.

PARTICIPANT THREE: It was very interesting, and some of the props, I really had to kind of think about because my initial reaction was -- like I didn't just put the first thing that popped into my head. You know, I didn't deliberate over it, but I didn't, you know, because a lot of times things that popped in my head were very comical -- funny. I thought well that -- I can't remember a specific example, but anyway, it was kind of fun, actually. I enjoyed it. And I would love to see my results.

INTERVIEWER: You bet, and the other half of my dissertation is about developmental psychology, so.

PARTICIPANT THREE: Oh, cool.

INTERVIEWER: It's all about that kind of topic, which is fascinating and I'll let you know more about that as we get the chance.

PARTICIPANT THREE: I would love to hear that. I would love to hear that. And listen, thank you for your time and for bearing with my, enduring my ramblings this morning.

INTERVIEWER: Thank you so much.

PARTICIPANT THREE: It's wonderful to talk with you. I hope we get to talk or connect again soon.

INTERVIEWER: Same here. Thanks so much.

PARTICIPANT THREE: All right. Take care. Goodbye.

INTERVIEWER: Goodbye.

[End Recording]

APPENDIX I

Transcription of Interview with Participant Four

INTERVIEWER: This is Bonnie Pierce, and this will be for Participant Four.

PARTICIPANT FOUR: Okay.

INTERVIEWER: I have a few questions, and it's about nurses and speaking up.

PARTICIPANT FOUR: Okay.

INTERVIEWER: So, I will ask you to please tell me a story about a time you supported a nurse, or nurses, to speak up about a dangerous shortcut they encountered. And the dangerous shortcut could be something like not observing a time out, or not using a required bundle, or protocol.

PARTICIPANT FOUR: Uh-huh. You know, what comes in mind is not a individual, per se, but what comes to mind is we had issues with, I don't remember now if it was along like surgery. It might have been. There was an -- some -- it was an issue with something like that and it had to do with, with a time out actually. And so, I sent out an email, that was called, "Stop The Line." And it was, you know, basically indicating that every nurse was empowered with an expectation to honor their gut, you know, if they felt like something was happening that shouldn't be happening. Or if they felt like they were voicing concern and it wasn't being taken seriously. Reminded them to follow the chain of command, both, you know, nursing had a chain of command, and so did the medical side of the house. And then proceeded to talk about the fact that there was going to be an interdisciplinary team that was going to look at training and establishing policies for a medical center. That's the only thing that can come to mind. I really am not thinking about, you know, individual conversation with a nurse, but they told me they like that.

INTERVIEWER: Well, and that's fine, because it actually touches on all of the important things that you did. What barriers to speaking up do you think were happening with the situation that developed?

PARTICIPANT FOUR: So I think some of it had to do with tenure and being a nurse. We had for a long time the situation where there were -- you know, we had a very tenured staff. And then with our extreme growth, we grew over 25% in four years. And so we needed to add a lot of new RN positions, as well as just had a lot of turnover due to retirement. And so, it was surprising to me, but it was managers who said that many of the staff, you know, are less experienced in being an RN, and so less secure about speaking up and those sorts of things. And it surprised me at the time, because I know that in talking with the Dean, you know, in our area, they talked about how they stressed that so much in both clinical work and in lecture. But that's what I would say was one of those things that totally had some impact.

INTERVIEWER: Very interesting. Okay. Another opportunity to tell a story or, like you did a moment ago, if you don't remember a specific story, just addressing the issue was perfect. About the time you supported a nurse, or nurses, to speak up about some type of incompetence?

PARTICIPANT FOUR: Let's see. I think most often of things like drug diversion. We had, a manager who suspected a nurse. And it had to do with critical thinking skills, and HR giving a lot of pushback because what she was describing, in their opinion, you know, was not anything that was objective enough, that could be actionable. And so, it really was a journey of probably two years, and this was a nurse that, she finally got her letter to say that she was going to be terminated. But it's been quite a lengthy process of needing to go through many different

steps until we could finally get to that point. So I guess that's the, that's the one that comes to mind.

INTERVIEWER: And so then, what are some of the barriers to speaking up that occurred in that situation?

PARTICIPANT FOUR: I think that she kept getting shot down, and she kept raising it as an issue, but, so we've got a Product Line, and she doesn't report to me, and so she went through her own chain of command, you know, and was not getting a lot of support, and so I think that it was the frustration of continuing to raise her concerns but not feeling like she was getting heard, and then secondly, not getting supported.

INTERVIEWER: Let's see. Can you tell me a story about a time you supported a nurse, or nurses, to speak up about a disrespectful behavior they encountered?

PARTICIPANT FOUR: So this isn't a recent example, but in the past there was a situation with a tenured physician, and we'd heard that he'd gotten a nurse in a break room in between her and the door and started just, you know, screaming at her for something that he didn't like. And then, actually, you know, was pointing his finger to the point that it actually hit her shoulder a couple of times. And there were kind of more situations like that. It was a time when he was in private sector. It was a time when there was a lot of competition going on to keep staff at our medical center, because there was one not too far away that was kind of recruiting staff away. And so, this guy was tenured, he was bringing in a lot of business, and so there was reticence of the nurse to say anything. But, once again, the manager told me, and so the upshot of all of that is that I got the information from this nurse and she was not interested in any additional confrontation or anything with this physician, but worked with a person in medical affairs and got a professional behavior policy that was implemented and long story short

is that word got out to the medical staff and so this physician, in particular, and others as well, really started to change their behavior because any time there was an incident that was raised, it would be put in writing. I would take a look at it if I felt that it was legitimate. I took it the Vice President of Medical Affairs, and then he had a one-on-one with the individual. And it just happened a couple of times, with a couple of different docs, and word got out, and so behavior changed.

INTERVIEWER: Wow. That's great. What barriers were you -- you spoke about barriers to speaking up about that this physician brought in a lot of business.

PARTICIPANT FOUR: Uh-huh.

INTERVIEWER: Any other barriers you can think of to speaking up --

PARTICIPANT FOUR: Well his age, again it was, you know, probably almost 60-something physician, and a twenty-something RN. So his was that power gradient of age and experience.

INTERVIEWER: We have a lot of that.

PARTICIPANT FOUR: Yeah, we do. Still.

INTERVIEWER: And we want to recruit the young nurses.

PARTICIPANT FOUR: Uh-huh.

INTERVIEWER: That is still a consideration. Just in general, what do you think are the greatest impediments to nurses speaking up?

PARTICIPANT FOUR: I'd say, you know, believing whether or not their boss has their back, and their nursing chain of command has their back. You know, it is a culture such that is one of that support, you know, no bullying. And the expectation of collaboration isn't one that if

issues like that are raised, there's evidence that something was done about it, or not. So I think all of those factors.

INTERVIEWER: Uh-huh. What do you think of that supports nurses to speaking up?

PARTICIPANT FOUR: Well, I think that education and training when it comes to crucial conversation, dealing with conflict, I think, and you know, helping them with some tools, and giving them some language to use. I think that's been helpful. I think providing feedback, generally, about what's been done when a question or concern has been raised, you know, knowing that confidentiality comes into play, too. But there is feedback that can be given.

INTERVIEWER: Uh-huh.

PARTICIPANT FOUR: I think, you know, promoting messages about conflict resolution and anti-bullying is important, too, because then it sets the stage, I guess, that the environment is open to conversations about those things that are going on.

INTERVIEWER: Thank you. Do you have additional stores or thoughts to share about speaking up, and barriers to speaking up?

PARTICIPANT FOUR: I think we kind of covered them. It's an issue that exists, I think, you know, I have to tell you that here, people pretty much do speak up. So, and yeah, there's still are issues, but it's a pretty vocal environment, I would have to say.

INTERVIEWER: Which I think is terrific.

PARTICIPANT FOUR: Yeah, I do too.

INTERVIEWER: So, good for you. Good, good, good. Well that is it. That's all --

PARTICIPANT FOUR: Okay.

INTERVIEWER: That I have, and thank you. I thought that it looked like you completed, I haven't tried to open it yet, but it looked like you completed the map survey.

PARTICIPANT FOUR: I did, yes, I did that today. Uh-huh.

INTERVIEWER: So, thanks so much.

PARTICIPANT FOUR: You're welcome.

INTERVIEWER: I really appreciate it. And it looks like you completed the MAP.

PARTICIPANT FOUR: Yes, it was very easy.

INTERVIEWER: And interesting too.

PARTICIPANT FOUR: Uh-huh, yeah.

INTERVIEWER: So, if you would like your results--

PARTICIPANT FOUR: Yes, I sure would.

INTERVIEWER: I will let you know when I receive them. Thank you so much for

participating.

PARTICIPANT FOUR: I enjoyed it. It is good to talk to you.

INTERVIEWER: It really is. Thanks again.

PARTICIPANT FOUR: Bye, and best wishes.

INTERVIEWER: And best wishes to you. Bye now.

This ends the recording. Thank you.

[End Recording]