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Developing influential nurse leaders: Utilizing strengths and styles assessments to create individualized, intentional coaching

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Developing Influential Nurse Leaders: Utilizing Strengths and Styles Assessments to Create Individualized, Intentional Coaching

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Dedication

This project is dedicated to the special people in my life who have supported me over the entire course of this journey. To my husband, Gary, thank you for your unwaning love and support, patience, understanding, and being my pillar of strength. To my family, a huge thank you for understanding when the pursuit of this degree meant not always being present and available on vacations, holidays, and other times of celebration or just casual family time. To my children along with their spouses, I appreciate all of you cheering me on and constantly reinforcing your faith in me through your words and jokes. To family and friends, thank you for your words of encouragement and prayers as they meant the world to me. To my preceptor and "bro," thank you for collaborating with me, providing support and direction, and cheering me on in times of extreme frustration. I will always cherish our time working together as it was not only a learning experience, but also fun. To Iryna, thank you for your thoughtfulness and friendship. To Janet, your ongoing support in this effort and within multiple professional realms means more than you will ever know. To Katherine, a resolute friend and colleague who always challenged me in good way and provided daily words of encouragement, "thank you" does not seem sufficient. To Karen, your friendship, knowledge, and persistence are appreciated as are your kind words and brilliant smile. To the team at HSA, a huge thank you for taking me in as one of your own and for the ongoing support and friendship from the entire leadership and staff.

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Abstract

Background: A north-central Virginia university and a hospital in the British West Indies (BWI) entered a collaborative agreement in 2020. Growing competitive environments heightened awareness and urgency in creating expansively competent, influential nurse leaders in the BWI. Without formalized data to quantify or validate nurse manager strengths, leadership style, or competencies, an assessment of these items and an evidence-based coaching intervention were performed.

Methods: The population for this evidence-based (EB) practice project was 20 inpatient nurse leaders. The Multifactor Leadership Questionnaire (MLQ) and the Clifton Strength Finders Assessment (CSF) for Managers were deployed as pre-intervention assessment tools. MLQ results were analyzed to create individual, intentional coaching plans targeting developmental needs. CSF results were used to drive development through EB coaching. Post-intervention the MLQ was redeployed to determine the effect of the coaching. The American Organization of Nurse Leaders-Nurse Manager Learning Domain Framework provided the theoretical framework.

Interventions: Coaching plans were structured using the ADDIE Model Framework (Analyze, Design, Develop, Implement, and Evaluate) and the coaching principles of the International Coaching Federation (ICF). EB individualized, intentional coaching plans were developed, followed by EB coaching sessions conducted over two months for .50 hours per week.

Results: Eight nurse managers completed the entire process. Pre-intervention response rate for tool completion was 70% (14/20). Post-intervention MLQ response rate was 57% (8/14). Pre- and post-intervention MLQ results were compared. Cohen's d results

suggested some effects of EB individualized, intentional coaching, operational outcomes were recognized through participant behavior changes and comments.

Conclusion: Individualized review of the CFS and MLQ pre-intervention results and coaching intervention offered an opportunity for nurse leader to gain insight and targeted development integrating AONL nurse manager competencies. Although the small .population size did not lend to statistical analysis, Cohen's d effect scores indicated a possible positive migration effect based on rater results supportive of EB coaching as developmental intervention.

Keywords: Nurse Manager, Nurse Leader, Leader Development, Strength-Based Coaching, Leadership Styles, and Competencies

Introduction

One of the top challenges facing organizations is the effective development of nurse managers within a complex healthcare landscape riveted with volatility, ambiguity, and uncertainty (Figueroa et al., 2019). These leaders have 24-hour responsibility and accountability over their designated areas while serving as a direct line and vital link to strategic deployment from the bedside to the boardroom (Goktepe et al., 2018). Therefore, anything other than consistently competent performance threatens quality patient care delivery, unit nursing culture, and organizational outcomes (Day et al., 2014). While clinical expertise is a predominant qualification in nurse manager selection, leadership style, skill, and competency are often ignored. However, healthcare advancement depends on nurse managers bridging the gap between clinical practice and the business of healthcare (Lin et al., 2015). Deficits in knowledge and competency, including (but not limited to) systems thinking, change management, financial acumen, and communication, are compounded by the lack of educational investment needed to develop individuals into dynamic, influential leaders (Nunes & Gaspar, 2016). Areas such as leadership style, skill, and strengths are frequently not evaluated, yet, each has been linked to patient outcomes, employee engagement, and organizational success (Asiri et al., 2016; Lin et al., 2015; Fennimore et al., 2011; Spiva et al., 2021).

In 2020, a north-central Virginia university entered into a collaborative agreement with a hospital in the British West Indies (BWI). The focus was to offer graduate nursing students an international preceptor and project site while exploring expanded educational opportunities for the BWI nurses. The facility's strategic goals included achieving Joint Commission International (JCI) Accreditation and creating a focused initiative to

influence nurse leader development and competency. The need for strong, highly skilled clinical leaders is critical to improving patient care and reaching organizational goals. An initial evaluative survey conducted by JCI in 2019 revealed a significant opportunity to enhance leadership performance in preparation for a successful JCI accreditation survey. This project supported the BWI facility in attaining its goals and served as an initial step in developing the nurse managers responsible for guiding and leading healthcare delivery into the future. This project served as a foundation upon which a structured developmental process could be built for existing and novice leaders at the organization.

Background

Nurse executives and organizational leaders' assessments regarding the need to strengthen nurse manager leadership competencies, coupled with the JCI preliminary recommendations, served as the impetus for this evidence-based project. Through observation, interaction, and discussions with the Chief Nursing Officer (CNO), a project focused on nurse leader development became an evident priority to positively impact patient and organizational outcomes. Identified organizational processes, which impact leadership development, included lack of ongoing feedback, inconsistent evaluations, and the absence of competency assessments. Nurse leaders identified these factors as potential reasons for the turnover of nurse leader positions and burnout within the ranks. The current nursing leadership structure and multiple competing priorities limited attendance at educational opportunities and involvement in quality improvement initiatives. Without nurse leader development, the negative impact on patient and organizational outcomes continues to cycle (Asiri et al., 2016). This project was the first step in developing ongoing leadership assessment and development. An assessment of

nurse leaders' innate strengths and leadership styles was conducted to establish a baseline and to provide an understanding of the use of strength-based, individualized, intentional coaching on narrowing leadership competency opportunities.

Problem Statement

There was no formalized data to quantify or validate nurse leader strengths, leadership styles, or competencies. The result was the inability to meet organizational objectives, successfully navigate change, enhance nursing cultural environments, and create ongoing team accountability. Worldwide, effective nursing leadership is critical in implementing strategic objectives to drive quality patient outcomes, positive unit cultures, organizational success, and outperform external peers within a competitive environment (Asiri et al., 2016; Fennimore & Wolfe, 2011; Spiva et al., 2021).

Aggressive environments heightened the awareness and urgency in creating expansively competent, influential nurse leaders. Direct, shared observations by senior nurse leaders and mock survey results from the 2019 Joint Commission International (JCI) mock survey validated the need for further leadership development. The facility continues to pursue Joint Commission International (JCI) Accreditation. This ongoing preparatory process further highlighted opportunities for enhancing nursing leadership competencies. Nurse leader development is critical to achieving JCI accreditation and creating a road map for improving quality, safe care delivery, and associated outcomes.

Review of the Literature

An initial online search focused on keywords related to the established PICOT question. Three electronic databases, including PubMed, CINAHL, EBSCO, and PsycInfo were searched. The key terms "nurse manager" and "nurse leader" yielded

19,495 articles. Upon updating the period from 2011 to the present and articles solely in English, the search yielded 13,402 articles. Terms were combined to obtain a comprehensive review of the targeted subject matter. The terms “nurse manager” and “nurse leader” were used in conjunction with the terms “leader development,” “strength-based coaching,” “leadership style,” and “competency.” Abstracts were reviewed to determine the eligibility for review based on the study’s purpose, including subjects, instruments utilized, and conclusion. Studies were included in the matrix review if they met the following criteria: 1) examined factors (including educational interventions) associated with or influencing nursing leadership; 2) examined leadership styles, 3) addressed tools to measure nurse leader/manager qualities/style; and 4) strength-based leadership development. Relative to intervention studies, only those reflecting pre-and post-intervention analysis were included. Grey literature was excluded. Definitions associated with key terms and concepts were globally aligned and accepted. Inclusion and exclusion criteria for matrix review focused on relevance to the PICOT question. Studies were assessed for research design, relevance based on the purpose of the study, and related interventions. Additionally, targeted sample populations meeting search term criteria, instruments utilized including, those with high reliability and validity, quality grade and evidence level analysis, compelling statistical evidence, limitations, and conclusions were examined (Appendix A).

Historically, as remains the practice in some organizations, clinical expertise and experience serve as the predominant qualifications in nurse manager selection. Once in the role, many individuals struggle to fulfill the job's responsibilities, accompanied by little or no formal training or educational maturation relative to leadership development

and associated competencies (Fennimore & Wolf, 2011; Severinsson & Holm, 2012; Spiva & al., 2021). As a result, turnover in these roles is often high and disruptive to an organization (Fennimore & Wolf, 2011). Asiri et al. (2016**)** contend that hiring underdeveloped nurse managers with little leadership experience and minimal training leads to a devalued role, which contributes to nurses and nurse leaders leaving the organization, furthering the impact of organizational nursing shortages.

The nurse manager role is exceptionally stressful as the position continues to expand without the support of colleagues and the required structure to be successful (Loveridge, 2017). Studies by Loveridge (2017) and Warshawsky & Havens (2014) revealed over 72% of surveyed nurse managers reported plans to leave their positions due to insufficient development culminating in burnout. From a financial perspective, the impact on an organization's turnover in the nurse manager role can cost a company an estimated 75% to 125% of the individual's annual salary to replace the vacated positions (Loveridge, 2017). Nonetheless, the monetary effect is only a portion of the overall impact.

Unstable frontline nursing leadership proliferates burnout, and lack of engagement of frontline staff which is associated with a higher incidence of hospital-acquired conditions (Bormann & Abrahamson, 2014). To minimize burnout and accentuate success, nurse managers must possess the required leadership skills and competencies to survive in their roles and effectively support their frontline team members. As the nurse manager role continues to morph, it requires a new and enhanced skill set (Goktepe et al., 2018; Heinen & al., 2019), ongoing agility and adaptation to meet the growing demands of an ever-changing healthcare landscape is not a nicety, but a

requirement (Severinsson et Holm, 2012). Prioritization is critical as the span of responsibility within the role is often vast (Borden, 2018). Nurse managers own the initiation and implementation of multiple strategic initiatives aimed at numerous domains. These domains include internal and external customer satisfaction; quality care outcomes; the integration of evidence-based care into bedside practice; nursing recruitment, retention, performance excellence; and engagement of staff at the bedside, amid balancing responsibility for successful financial performance (Asiri et al., 2016; Fennimore & Wolfe, 2011; Spiva et al., 2021). According to DiGirolamo & Tkach (2019), many individuals in managerial roles struggle to be "good" managers. It is estimated that 50% or more of these individuals lack the necessary skill sets to reach success (DiGirolamo & Tkach, 2019). Issues such as short-term thinking, limited perspectives, lack of wanting to surrender control, underdeveloped competencies, limited emotional intelligence, inability to motivate others, and insufficient interpersonal skills have contributed to their inability to perform effectively (DiGirolamo & Tkach, 2019; Kotter, 2008).

Zuberbuhler et al. (2020) argue the need for learning and innovative organizational development to assist nurse managers in becoming influential leaders now and in the future is essential as healthcare resources plummet due to ineffective leadership. Many nurse leaders hired for their bedside skills are expected to fill leadership roles by leveraging personal characteristics and experience without any special training, culminating in adverse outcomes (Goktepe et al., 2018; Spiva et al., 2021). Fennimore & Wolfe (2011) challenge the development of nurse managers given the complexity of their role and the need to meet organizational goals, while attempting to maintain a healthy

workforce with insufficient staffing and limited leadership skills. These researchers assert the development of nurse managers remains loosely structured and significantly fails to develop the competency and skill of these leaders, among ongoing arguments, that sufficient training currently exists (Fennimore & Wolfe, (2011).

As needed versus actual skillsets fall short of those required, adverse outcomes can prevail, including a decline in staff competency and productivity, challenges in retaining and recruiting team members, a decrease in quality care provision, and an overall inability to embrace organizational success (Asiri et al., 2016; Day et al., 2014; Fennimore & Wolf, 2011; Goktepe et al., 2018; Lin et al., 2015; Severinsson & Holm, 2012). Given leadership strengths, styles, and competencies vary among leaders; each domain exudes its unique impact on employees and the environment (Boamah & Tremblay, 2019). Borden (2018) argues a nurse manager's ability to lead is one of the primary indicators of a nurse's intent to stay. As a result of the interactive process between the leader and their team, it is the team member's perception of the leader's behaviors, relationships, and skills which translate into overall outcomes influencing the quality of work-life, job satisfaction, and organizational commitment of staff (Asiri et al., 2016; Boamah & Tremblay, 2019; Lin et al., 2015; Nunes & Gasper, 2016). To be an effective leader, one must acquire leadership skills to motivate, inspire, foster staff engagement, and instill a sense of purpose and value within the staff (Prufeta, 2017). According to the literature (Asiri et al., 2016; Boamah & Trenblay, 2019; Lin et al., 2015; Nunes & Gasper, 2016; and Spiva et al., 2021), leadership style and competency play a critical role in boosting a nurse's desire to work within the organization and do a good job, "not because they have to, but because they want to" (Asiri et al., 2016, p. 30).

A Focus on Strengths

While nurse manager leadership styles and strengths are not frequently measured and evaluated, each has been linked to positive patient outcomes and employee engagement (Lin et al., 2015). Unfortunately, when gaps are recognized, plans to correct identified deficiencies focus on deficit areas to obtain correction. However, focusing on weaknesses is frustrating, demeaning, and demoralizing (Borden, 2018). It requires individuals to operate in uncomfortable ways, creating high levels of stress and resulting in minimal success (Kaiser, 2011). While strength-based learning redirects the focus from deficits, weaknesses, and problems to personal resources to overcome weaknesses, the approach does not ignore or pretend weaknesses do not exist (Gottlieh et al., 2012; Key-Roberts & Budreau, 2012). Multiple studies (Asiri et al., 2016; Borden, 2018; Key-Roberts & Budreau, 2012; Spiva et al., 2021) revealed enhanced performance through a strength-based learning approach resulting in improved work production. Developing strengths requires the exercise of talents, skills, knowledge, and time investment (Gallup, 2008; Key-Roberts & Budreau, 2012).

Gallup (2008) defines *competency* as a needed skill set that can drive positive performance when employed in a usual manner and repetitively. Knowledge is understanding of principles and facts acquired through experience or education (Gallup, 2008). At the same time, talents are ways of behaving, feeling, and thinking which come into play naturally and are not obtained in the same fashion as knowledge or skills (Gallup, 2008). The term strengths refer to those inherent psychological traits individuals naturally excel at, lending to peak performance of self and others in pursuit of excellence (Gallup, 2008; Key-Roberts & Budreau, 2012; Van Zyl Llewellyn et al., 2021). A

strength-based approach is valued across multiple educational contexts and cultures (McGrath, 2015), while a focus on weaknesses is considered offensive by some cultures (Gottlieb et al., 2012). According to Hone et al. (2015), a strength-based approach includes four "D" stages: discovery of one's strengths; dreaming of what could be done when identified strengths are exercised consistently; designing a plan to move toward harnessing strengths to overcome areas of opportunity; and delivery through daily practice of strengths.

Strengths are essential to defining oneself and eliciting energy when tapped and utilized consistently (Key-Roberts & Budreau, 2012; Littman-Ovadia et al., 2017). According to Spiva et al. (2021) and Van Zyl Llewellyn et al. (2021), by harnessing one's resources and by aligning identified strengths, learning not only occurs but serves as a strong driver of manager satisfaction by resulting in positive outcomes for both the leader and the organization. The research aligns the use of strengths development with positive self-esteem, pro-social behaviors, goal achievement, happiness, personal fulfillment, and subjective and psychological well-being; while reducing stress, depression, and anxiety (Littman-Ovadia et al., 2017; McGrath, 2015).

Multiple studies combine coaching with strengths-based development to successfully enhance skills and competencies across professions and organizations successfully (Borden, 2018; Key-Roberts & Budreau, 2012; Spiva et al., 2021; Zuberbuhler et al., 2020). In studies conducted by Borden (2018) and Spiva et al. (2021), the researchers employed the Clifton Strength Finders (CSF) assessment to gauge strengths, while Zuberbuhler et al. (2020) utilized the Values in Action Inventory of Strengths to evaluate individual strengths. Although the populations assessed varied

among the studies, the outcomes supported utilizing combined tactics to build upon strengths. The Spiva et al. (2021) study targeted nurse managers; Borden's (2018) study assessed students and faculty at an academic institution. Zuberbuhler et al. (2020) focused on managers within the automotive industry. According to Borden (2018) and Zuberbuhler et al. (2020), strategies focused on strength-based development through coaching to promote a culture focused on positive attributes, while fostering positive outcomes, including goal attainment and optimization of skill transference, promotion of self-awareness, fulfillment, and overall enhanced well-being. Borden (2018) contends that strength-based approaches can be utilized with confidence to improve customer engagement by 3.4%-6.9%, employee engagement by 9%-15%, profitability by 14.4%-29.4%, and safety, while decreasing turnover in low-turnover organizations by 5.8 -16.1 points and by 26.0-71.8 points in high turnover organizations (p. 164).

The focus on self-discovery evolves into a stronger appreciation for others. It creates a common language of strengths, which translates into a sense of community, generating an appreciation and understanding of diversity among leaders (Borden, 2018). Spiva et al. (2021) attributed strength-based coaching to work environment improvement, enthusiasm among nurse leaders, and recognition of improved retention and recruitment. At the same time, Zuberbuhler et al. (2020) recognized a 23.8% increase in awareness and professional insight, 14.4% increase in leadership skill development, 13.6% increase in management and team performance, 11.9% increase in personal strength and resource development, and an 8.5% positive change in the environment (p. 5).

According to the U.S. Army, an essential step in leadership doctrine is understanding what individuals do well and their areas of needed growth and

development (Key-Roberts & Budreau, 2012). This focus on strengths extends from the front lines to the highest leadership ranks to better equip and further develop existing talents to create strong leaders for today and succession planning for the future (Key-Roberts & Budreau, 2012). In a study published by the United States Army Research Institute for Behavioral and Social Sciences in 2012, the U.S. Army cited the need to have adaptable, agile, highly competent leaders with the ongoing capability to lead within an ever-changing environment. A strength-based model, which aligns with the Army Doctrine, was utilized to develop current leaders, future leaders, and other military staff. The study results demonstrated that strength-based leadership theory and development and Army Leadership Doctrine collectively encourage leveraging strengths to correct identified weaknesses (Gallup, 2008; U.S. Department of the Army, 2019). Strengths-based development occurs once individuals are aware of their strengths and understand how to integrate them intentionally into their ways of thinking and behaving (Key-Roberts & Budreau, 2012; Gallup, 2008). The more strengths are integrated into daily practice, the stronger they become (Key-Roberts & Budreau, 2012). The U.S. Army has adopted a strength-based approach in combination with counseling, coaching, and mentoring to develop all enlisted personnel. This methodology assists in preparing today's leaders and those for tomorrow, regardless of their role or rank (Key-Roberts & Budreau, 2012; Gallup, 2008; U.S. Department of the Army, 2019).

According to Key-Roberts (2014), development utilizing a strength-based approach requires: identification of areas of strengths and opportunities for growth; enhanced self-awareness and education on areas of strengths; insight into tapping identified strengths to address areas of opportunity; willingness to receive ongoing

feedback creation of a positive coaching relationship; and empowerment of leaders to leverage their strengths. Strength-based leadership aligns with transformational leadership (Gottlieb et al., 2012). As a leader, knowledge of personal and staff strengths provides insight and appreciation of the team, acknowledging their value. Such leadership encourages recognition of individual uniqueness, promotes the value of learning from mistakes to develop strengths further, and supports the freedom to align values and beliefs in meeting professional and personal goals reflecting the individual and their interest (Gottlieb et al., 2012; Key-Roberts & Budreau, 2012; Key-Roberts, 2014; McGrath, 2015).

Leadership and Management Style

Although not a part of the routine assessment of new managers, the ability to lead is one of the three most potent drivers of nurse job satisfaction as it relates to communication, staff recognition, and encourage involvement in decision-making (Asiri et al., 2016; Lin et al., 2015; Nunes & Gasper, 2016; Spiva et al., 2021). Studies by Asiri et al. (2016), Lin et al. (2020), Nunes & Gasper (2016), and Spiva et al. (2021) point to transformational leadership styles and relational approaches as significant factors influencing intent to stay. Lin et al. (2015) revealed a positive relationship between transformational leadership and the general health status of nurses in terms of job characteristics. Asiri et al. (2016) contend nurse managers are essential in facilitating care, ensuring a high level of quality care, patient safety, and enhanced work-life balance for staff while championing change to meet these ends. Correspondingly, adverse outcomes on efficiency, commitment, and performance are realized when managers need to possess transformational leadership behaviors. Asiri et al. (2016) argue that managers

should adopt transformational leadership behaviors as these individuals are more effective in creating and sharing the mission, vision, and values to achieve organizational goals while enhancing meaningful work and empowering nurses. Asiri et al. (2016), Boamah & Tremblay (2019), Lin et al. (2015), Nunes & Gasper (2016), and Spiva et al. (2021) agree leadership style plays a critical role in increasing a nurse's desire to work within an organization. For leaders who display transformational leadership characteristics, the literature reflects these individuals are more likely to be associated with highly engaged team members, experience a high level of nurse satisfaction, and correspondingly high retention rates (Huddleston & Gray, 2016). These leaders garnish extraordinary levels of work satisfaction by providing a shared vision, engaging staff in decision-making, and celebrating successes (Gottlieb et al., 2012). Conversely, for those managers who display primarily transactional, passive avoidant, or laissez-faire leadership styles, the staff exhibited higher levels of burnout, emotional exhaustion, and turnover, negatively impacting organizations, nursing, and, most importantly, patient care (Bormann & Abrahamson, 2014).

Leadership Development

Developing nurse managers begins with assessing needs and creating actions to assist in closing opportunities contribute to struggles functioning within the nurse manager role. Evidence-based practice assessments and interventions are essential to keeping nurse managers in their roles and building a solid leadership workforce.

Assessing Leadership

Understanding leadership styles and competencies are essential to leadership development. Asiri et al. (2016), Boamah & Tremblay (2019), Dimitrov & Darova

(2016), Lin et al. (2015), and Spiva et al. (2021) utilized the Multifactor Leadership Questionnaire (MLQ) to assess leadership style, while Nunes & Gasper (2016) used the Leader Membership Exchange (LMX-7) as related to their study. The MLQ, based on the work by Bass (1985), Bass and Avolio (1993), and Bass and Avolio (1994), the assessment measures the following leadership styles and competencies: transformational, transactional, and laissez-faire/passive-avoidant techniques; leadership outcomes including effort, effectiveness, and satisfaction; and attributes of transformational leadership including idealized influence and behaviors, inspirational motivation, intellectual stimulation, and individualized consideration (Asiri et al., 2016; Boamah & Tremblay, 2019; Dimitrov & Darova, 2016; Lin et al., 2015; Spiva et al., 2021) (Table 1). The five characteristics of transformational leadership, as described by Bass & Avolio (2005), include the following. Idealized Attributes (IA) ascribes to the leader's ability to build and earn the trust of their followers while aspiring followership. Idealized Behaviors (IB) are **t**he ability to be a role model while earning and giving respect and motivating others to give their best. Inspirational Motivation (IM) is the way the leader effectively conveys the mission, vision, values, and objectives of the organization to motivate followers, assisting followers in understanding their contributions, evasion the future, and their place within that future as related to the organization (Bass & Avolio, 2005). Intellectual Stimulation (IS) is the ability to create solutions through innovations and restructuring problems while developing new ways to respond, encouraging new ideas throughout the organization (Bass & Avolio, 2005). Individualized Consideration (IC) is based on the ability to assign tasks based on individual strengths and connect with followers personally. These individuals demonstrate equal concern and attention to each

follower and the ability to ensure equal participation of employees, helping them achieve their goals and dreams (Bass & Avolio (2005).

The span of leadership styles ranges from highly effective to ineffective. Those earmarked as ineffective represent avoidance of responsibility and action (laissez-faire leadership) (Bass & Avolio, 2005). While at the most effective end, behaviors such as those which reflect the highest level of effectiveness represent a leadership style that is highly ordered, developed, and reflect practical skill sets (transformational leadership). The tool's advantages include 360-degree capabilities (Avolio & Bass, 2004). The scale can assess the perceived effectiveness of a leader's leadership by having the leaders engage in a self-assessment and having team members, colleagues, and the leader's supervisor/s provide feedback by serving as raters for the designated leader (Avolio & Bass, 2004). This methodology provides a much more robust assessment. The survey items also measure a leader's impact on the developing emotional and intellectual components of self and others (Avolio & Bass, 2004). Once the areas of leadership development are targeted for the leader's self-growth, newly found behaviors and performance skills can be built upon, which can positively impact the behaviors of their teams as a byproduct of the leader's development (Avolio & Bass, 2004). The bonus effect is cascading leadership development (Avolio & Bass, 2004). As others see the leader's changes and sacrifices to achieve targeted goals, the motivation level of those observing the leader in action will elevate the subordinates' motivational level (Avolio & Bass, 2004). Self-efficacy and willingness to stretch further to accept extraordinary challenges will become more assertive among followers (Avolio & Bass, 2004).

Asiri et al. (2016), Boamah & Tremblay (2019), Lin et al. (2015), Spiva et al. (2021) utilized the MLQ relative to its successfulness in capturing the entire leadership factor constructs of transformational leadership theory with consistent reliability with each leadership factor ranging from 0.74 – 0.94 among all scales. According to Dimitrov et Darova (2016), the psychometric features of the MLQ questionnaire have been validated by a sample of over 7000 U.S. respondents, making it one of the broadest used instruments for assessing leadership style. Asiri et al. (2016), Lin et al. (2015), and Spiva et al. (2021) employed the tool for self-assessment, while Boamah & Tremblay (2019) utilized the instrument for a 360-degree leadership assessment. Dimitrov & Darova (2016) sought to confirm the factor structure and internal consistency of the MLQ to analyze and access the scales and subscales of the MLQ and evaluate the reliability of the questionnaire. The study confirmed that the efficient psychometric qualities and factor structure were proven and well-established (Dimitrov & Darova, 2016).

Nurse Manager Skill/Competency Development

The American Organization of Nurse Leaders (AONL) Nurse Manager Leadership, Collaborative Learning Domain Framework for leadership development was cited in multiple studies (Fennimore & Wolfe, 2011; Goktepe et al., 2018; Spiva et al., 2021). Fennimore & Wolfe (2011) promote the evidence-based Nurse Manager and Leadership Competencies as the most effective curriculum for development with recognized outcomes of healthy workforce environments and staff retention, citing organizational savings financially on average approximately $300,000 annually per 1% turnover and in the area of quality care translated to the team through effective leadership. Spiva et al. (2021) engaged the AONL framework, cross-walking the domains

and subcategories with the results obtained from the MLQ to address identified learning needs. All argue that the constructs of these skills and competency-based essentials are critical to nursing manager success (Fennimore & Wolfe, 2011; Goktepe et al., 2018; Spiva et al., 2021).

Coaching

Although the literature identified multiple avenues to provide nurse manager development, coaching was cited more frequently than other methods throughout the literature. Grover & Furnham (2016) cite coaching as an intervention that has continued to evolve into an established practice in many organizations as an avenue to successful development. Coaching as a professional developmental process was founded upon psychological theories aimed at helping individuals or groups to enhance and improve their effectiveness and performance (Burke, 2018; Madden et al., 2020). Coaching offers numerous avenues to assist, develop, and employ training techniques (Grover & Furnham, 2016). According to the literature, words associated with coaching include systematic one-on-one relationships, self-awareness, behavioral change, learning, and overall effectiveness (Grover & Furnham, 2016; Madden et al., 2020).

Evidence-based coaching involves using relevant and current best knowledge integrated with expertise from psychology (Grant & O'Connor, 2019). Instructional frameworks for coaching have been designed utilizing evidence-based practice and can be found reflected in the structure of such organizations as the International Coaching Federation. In a systematic review performed by Grover & Furnham (2016), multiple qualitative and qualitative studies point toward coaching effectiveness on development and performance. Based on the studies included in the meta-analysis, most results

reflected a significantly notable improvement in job and skill performance post-coaching interventions (Grover & Furnham, 2016). In reviewing the number of coaching sessions and the correlation with outcomes, sessions lasting one hour or longer did not correspond to more significant positive effects. However, the most notable impact occurred with sessions ranging from thirty minutes to forty-five minutes weekly or bi-weekly (Grover & Furnham, 2016). Suggested timeframes for coaching ranged from 2 to 6 months based on coaching frequency. The more frequent the coaching sessions, depending on the purpose of the sessions (for example, professional coaching versus coaching for mental health), the less time is required to conduct the coaching sessions (Grover & Furnham, 2016; Mackie, 2014). Coaching outcomes are impacted by the individual being coached and their readiness, motivation, and circumstance relative to the experience and the environment (Grover & Furnham, 2016; Jones et al., 2015; Mackie, 2014). The most impactful elements are the relationship between the coach and the coachee, expectations, and the techniques and framework utilized during the sessions (Grover & Furnham, 2016; Jones et al., 2015; Mackie, 2014). Studies on coaching focusing on alterations in self-efficacy, leader self-efficacy, and goal attainment resulted in full or partially supported positive impact (Grover & Furnham, 2016; Jones et al., 2015; Mackie, 2014). Other studies focusing on outcomes related to job satisfaction revealed significantly positive alignment with career, job, work, and organizational satisfaction (Grover & Furnham, 2016). Mackie (2014) examined scores for a group three-month post-coaching interventions targeted at transformational leadership development. Results revealed that the most significant change in the use of transformational leadership scores correlated with the completion of the coaching sessions (Mackie, 2014). Nevertheless, further

analysis demonstrated continued growth in transformational leadership skills well beyond the conclusion of the coaching sessions (MacKie, 2014). These results were also replicated by other similar studies (Grover & Furnham, 2016; Human Capital Institute (HCI), 2016; Jones et al., 2015). According to DiGirolamo & Tkach (2019), a study conducted by the HCI and the International Coaching Federation (ICF) (2006) investigated the use of coaching by organizations as part of development. The study revealed that over 80% of facilities utilizing coaching for development recognized overall leadership enhancement, reflecting a 56% uptick, while professional growth increased by 46% (DiGirolamo & Tkach, 2019, p. 216).

Objectives and Aims

The primary objective of this evidence-based project was to evaluate the leadership style and competency of the nurse leaders on an island in the British West Indies and investigate the impact of strength-based individualized, intentional coaching as an effective, evidence-based intervention. A secondary objective was to supply data to the organization with information for future comparison and validation of resource allocation for baseline nurse manager assessment and development tools, onboarding educational program development, expansion of these resources, and support for other leadership groups. This project aimed to:

- Assess project facility nurse manager leadership strengths through self-assessments using Clifton-Strengths Finders (CSF) Assessment pre-intervention
- Assess project facility nurse leader leadership style/competency through self- and multi-rater Multifactor Leadership Questionnaire (MLQ) assessments pre-intervention

- Develop intentional, individual, evidence-based coaching plans incorporating identified areas of strengths and style/competency opportunities to guide evidence-based coaching sessions
- Implement intervention (individualized, intentional evidence-based coaching sessions)
- Evaluate the impact of the intervention on nurse managers/leaders by redeploying the MLQ to study the results of participants and raters of the participants who completed the initial assessment

Theoretical and Implementation Framework

Nurse Manager Learning Domain Framework

The American Organization of Nurse Leaders (AONL) nurse manager competencies are based upon the Nurse Manager Learning Domain Framework and served as the theoretical framework for the project. The AONL Nurse Manager Learning Domain Framework captures the skills, knowledge, and abilities that guide the practice of nurse managers (AONL, 2015, p. 3). In 2004, the American Organization of Nurse Leaders (AONL) and the American Association of Critical-Care Nurses (AACN), and the Association of peri-Operative Registered Nurses (AORN) formed, creating the Nurse Manager Leadership Collaborative (AONL, 2015). The purpose was to identify and organize skills specifically required for the nurse manager role (AONL, 2015). "Reliability and validity for the Nurse Manager Competencies are established by periodic job analysis and role delimitation studies" (AONL, 2015, p. 3). The AONL nurse manager competencies are "based on the National Practice Analysis Study of the Nurse Manager and Leader (2014)" (AONL, 2015, p. 3). According to AONL (2015), to be a

successful nurse leader, one must gain competency in each of the three following domains: The Science-Managing the Business, which includes financial management, human resource management, performance improvement, foundational thinking skills, technology, strategic management, and appropriate clinical practice and knowledge (AONL, 2015, p. 4). The second domain focuses on The Art of Leading People, including human resource components, leadership skills, relationship management and influencing behaviors, diversity, and shared decision-making (AONL, 2015, p.6). The final domain concentrates on the Leader Within: Creating the Leader within Yourself including personal and professional accountability, career planning, personal journey disciplines, and optimizing the Leader Within (AONL, 2015, p. 7).

Each of the three domains can be dissected further into competency subsets. The following information reflects the AONL Nurse Manager Competencies (2015). The Science of Leading encompass the following competencies: monetary management focuses on budgeting, forecasting, value-based purchasing, and associated quality outcomes aligned with reimbursement and recognizing the impact of reimbursement on revenue. Human resource management focuses on staffing needs, legal aspects of human resource management, recruitment, hiring, staff selection processes, and scope of practice components. Performance improvement focuses on performance improvement activities, customer and patient engagement, and patient safety. Foundational thinking leads to system thought processes, while technology focuses on information technology components. Strategic management includes facilitating change, project management, contingency planning, presentations, shared decision-making, innovation promotion, collaboration, and serving as an influencer. Appropriate clinical practice knowledge

points to the use of evidence-based practice. The Art of Leading includes the following competencies: human resource leadership skills, performance management, staff development, and staff retention elements. Relationship management and influencing behaviors require conflict management, situation management, relationship management, influencing others, and promoting professional development. Lastly, diversity focuses on cultural competence, social justice, and generational diversity. The Leader Within reflects on personal and professional accountability for personal growth and development, ethical role modeling, involvement in professional organizations, and obtaining certification within a specific field. Career planning focuses on knowing your role, where you are going, and positioning yourself to get there. At the same time, personal journey disciplines use action learning and reflective practice. According to AONL (2015), these international competencies are foundational building blocks and critical for nurse manager success.

Lewin's Theory of Planned Change

Lewin's Theory of Planned Change (TPC) was the implementation framework to "mobilize the human capital aspect of change" (Shirey, 2013, p. 69). One of Lewin's primary constructs for approaching change is democratic participation, requiring all participatory members to be involved on an equal and open basis for change to be effective (Barnes, 2020). The theory is most effective in a top-down method to ignite, support, and drive change. The theory reflects three phases. Stage 1 requires unfreezing through recognizing the problem, identifying the need for change, and mobilizing change (Shirley, 2013). Stage 2 refers to the transitioning stage, requiring coaching and clear communication to set a new reality (Shirley, 2013). Stage 3, refreezing, involves

embedding change into the existing system through culture and process change (Shirley, 2013). Lewin's Theory of Planned Change elements aptly fit the project roll-out. Stage 1 reflects the participants' global recognition of the problem and awareness through strengths awareness and opportunities in leadership style and competency. Stage 2 involves to developing an evidence-based intentional, individual coaching plan and associated coaching. Stage 3 represents the transference of learning into action to establish a new normal.

Project and Study Design

Nurse leaders' top five strengths, leadership styles, and competency assessments results served to inform the development of evidence-based, intentional, individual coaching plans and enacted coaching sessions, which were addressed as part of the project development, implementation, and evaluation, occurring during the Summer and Fall of 2022.

Setting

The facility is located in the British West Indies. The official language is English, and banking and tourism are the significant economic supporters of the island. The chief healthcare provider system on the island is the project facility which serves as the public community hospital. The organization offers inpatient and outpatient services, public health, and community-based services. The primary facility serves as a full-service hospital with 124 beds.

In comparison, a sister facility includes a smaller community hospital with an emergency department and 18 inpatient beds. Currently, the organization holds Joint Commission International (JCI) Accreditation for the laboratory only and is pursuing

initial organizational JCI accreditation in early 2023. Organizational competitors include an India-based hospital, which holds JCI accreditation according to JCI's website. Another competitor holds ambulatory JCI accreditation and a fourth hospital is being built, whose parent organization also holds JCI accreditation.

Sample Population

The facility's inpatient area was the setting for this project. The sample population was 20 nurse leaders who met the inclusion criteria. These individuals were assigned the following titles: Shift Coordinator; Senior Nurse Leader; Nurse Manager; and Nurse Director. The sample size of 20 consists of 14 nurse managers, five shift coordinators, and three Senior Nurse Leaders. Staff nurses and management staff, who are not nurse leaders were excluded from the project.

Methods

Approval was obtained from the organization's Ethics Committee in early Spring 2022 (Appendix B). The north-central Virginia University's Institutional Review Board (IRB) approval was obtained in the Spring of 2022 (Appendix C), with an addendum made and approved in July 2022 (Appendix D). Project rollout initiated in June 2022. The CSF for Managers and the MLQ were the survey platforms utilized pre-intervention. Only the MLQ was utilized post-intervention, as the CSF is not sensitive to change.

Survey Tool Costs

Both survey tools required the purchase of licensures. The CSF for Managers assessment was administered only pre-intervention, serving as a baseline assessment of the individual's operational strengths. The CSF for Managers licensure cost was $39.99 per participant, with a minimum purchase requirement of twenty licenses. Tax on the

purchase was $32.00, culminating in a cost of ($39.99 per participant x 20 licenses) = $799.80 + $32.00 tax = $831.80 U.S. dollars. The survey tool was offered through its parent company Press Ganey.

The MLQ required a similar licensing purchase. The MLQ required a minimum of 20 participants and provided limitless raters per nurse manager participant at no extra charge. The following dollar amounts reflect U.S. dollars. The cost of the MLQ licensure was $100.00 per individual pre-intervention ($100.00 x 20 participants) = $2000.00 and again post-intervention ($100.00 x 20 participants) = $2000.00 for a cumulative cost of ($2000.00 + $2000.00) = $4000.00. MLQ group rater reports were an additional option at $150.00 per report. Two reports were required, one pre- and one post-intervention. Associated cost = $150.00 x 2 = $300.00. MLQ custom fees for informed consent one-time set-up = $50.00 and demographic information inclusion = $20.00 per question (the fees cover informed consent and demographic questionnaire with pre-and post-intervention surveys). Six demographic questions were included at $20.00 per question (6 x 20.00 =$120.00) with an additional $10.00 for text build of demographic question creation (10.00 x 6 =$60.00). The cumulative cost of the MLQ was $4530.00 ($4000.00 + $300.00 + $50.00 + $120.00 +$60.00). An additional cost included the purchase of an MLQ Third Edition Manual and Sample Test by the project lead at the cost of $50.00. The overall cost of the MLQ purchases = $4580.00 ($4530.00 + $50.00 = $4580.00). The survey tool was offered through MindGarden’s secure platform, Transform.

The CSF for Managers cost was $39.99 per participant and based on 20 individuals for a cost of $799.80 ($39.99 x 20 = $799.80). Taxes associated with the purchase was $32.00. The total cost of the CSF for Managers equated to $831.80

($799.80 + $32.00 = $831.80). The total MLQ cost was $4580.00 and CSF cost was $831.80 for a total project cost of $5411.80 ($4580.00 + $831.80 = $5411.80) (Appendix E).

The request to purchase the CSF and MLQ pre-and post-intervention assessment surveys to support this was approved by the Chief Nursing Officer (CNO) at the project site in May 2022 (Appendix F).

Project

This quantitative, evidence-based practice project evaluated the impact of strength-based individualized, intentional coaching as an effective, evidence-based intervention for nurse leader development. The project involved four phases:

- pre-intervention strength and leadership style surveys
- analysis of pre-intervention data and development of evidence-based coaching plans
- execution of coaching sessions
- post-intervention re-assessment of leadership style and competency.

Study Design

MLQ Questionnaire

The MLQ (Appendix G) (Appendix H) is a vastly researched, validated, and reliable tool measuring leadership styles (transformational, transactional, laissez-faire/passive avoidant), leadership outcomes, and transformational leadership characteristics (see Table 1) (Asiri et al., 2016; Boamah & Tremblay, 2019; Lin et al., 2015; MindGarden, n.d.). The tool demonstrates the linkages between survey results and organizational outcomes, with each form containing 45 questions and an estimated 15-30

minutes to complete (MindGarden, n.d.). The MLQ measures different spectrums of leadership. The assessment includes both self (Appendix I) and rater tools (Appendix J). Self-perceptions were measured through the self-rater form, while the "rater" form gathered data on the assigned leader as perceived by individuals at a higher level, laterally, and a lower level (Asiri et al., 2016; Boamah & Tremblay, 2019; Lin et al., 2015; MindGarden, n.d.). Nine outcome measures cumulatively identified the effectiveness and satisfaction of the leader's performance based on frequency results/scoring (MindGarden, n.d.). Responses were rated on a four-point Likert scale from 0 = not at all, 1 = once in a while, 2 = sometimes, 3 = fairly often, 4 = frequently, if not always. The survey allowed free text feedback from the leader, the leader's raters, or both. The assessment was completed by participating nurse leaders and pre-selected raters (as identified by the participants). All pre-intervention participants and raters were invited to complete the post-intervention MLQ. The effectiveness of the evidence-based intervention was determined by comparing pre- and post-intervention survey results for impact. Modifications and content were added to the MLQ, including demographic data and consent. The MLQ was initiated through *Transform*. Transform is the secure, confidential, online platform through which the MLQ is deployed electronically and was included as part of the online pricing package (MindGarden, n.d.). Each participant was assigned a "unique identity" for data collection among specific individuals and rater groups. The tool was selected based on its long-standing and trusted reputation in the field of leadership and its application across different industries and leadership titles (Asiri et al., 2016). The MLQ was included in the pre-intervention and post-intervention survey for participatory self-and rater groups.

CSF for Managers

The Clifton-Strength Finders (CSF) for Managers (Appendix K) was included in the pre-intervention survey only, as the survey is not sensitive to change. The CSF assessment has been recognized as a highly reliable tool used universally for strength identification (Clifton, 2008). The CSF is a psychometric, reliable, and validated assessment tool utilized to identify nurse leaders' top five talent themes based on intensity within the four domains of strategic thinking, executing, influencing, and relationship building **(**Gallup, 2008**).** The tool objectively measured personal talent by measuring recurrent patterns of thought, feelings, and behavior (Clifton, 2008) related to individual emotional, cognitive, and social skills and talents (Borden, 2018). The constructs measure intrapersonal and interpersonal competencies (Borden, 2018). The assessment identified individual strengths through a secure online platform using 177 paired statements (Gallup, 2008). The individual determined which descriptors best depict themselves and to what extent within 20-second time intervals, with overall completion estimated at less than 30 minutes (Gallup, 2008). The following serves as an example: "I want everyone to like me" versus "I want people to adore me" (Gallup, 2008). The tool has undergone extensive psychometric testing. Thirty-four strength themes have been identified (Borden, 2018). The survey utilized a five-point Likert scale: strongly disagree (1), disagree (2), neither agree nor disagree (3), agree (4), and strongly agree (5). The top five strengths often referred to as signature strengths (Madden et al., 2020), were incorporated into the individual's coaching plan by focusing on how each theme contributes to one's success and incorporating specific actions required to build upon each of the five themes as prescribed by CSF. Awareness of one's signature

strengths conveys a feeling of authenticity and ownership, leading to a sense of intrinsic motivation to harness these identified strengths and put them to use (Madden et al., 2020). Incorporating strengths into coaching increases the chances of meeting basic psychological needs for confidence, competence, and autonomy resulting in enhanced success at meeting established goals (Littman-Ovadia et al., 2017; Madden et al., 2020; McGrath, 2015; Van Zyl Llewellyn et al., 2021). Clifton-Strengths is a proprietary tool (Gallup, n.d.) generating a report of inputted data as part of the licensure agreement. Clifton Strength Finders for Managers reports included guidance on actions to build upon existing strengths, pitfalls relative to strengths, and how to incorporate strengths as building blocks to overcome opportunities.

Time Requirements of Participants

The time requirements of participants to complete pre- and post-assessments and attend coaching sessions was 8.5 hours per nurse leader throughout the project.

Phase I: Preintervention

Pre-intervention MLQ and CSF surveys were deployed. Demographics of participants were collected as a component of the MLQ survey. The MLQ, a licensed product of MindaGarden.com, was deployed through its secure online platform, Transform, to the nurse leaders and their designated raters during week one. Each nurse leader selected the designated raters. The nurse leader participant was requested to select raters who met the following criteria: three leaders above the nurse leader's level, three lateral to (non-nurse leaders), and three below. The following week, the CSF for managers was issued through Press Ganey's secure online platform, support@mail.gallup, the following week. Both surveys remained open for two weeks.

Basic demographic data (Appendix L) included gender, the highest degree of education, native culture, years as a registered nurse, years as a manager, and current role. Consent for participation was secured via associated customized instructions provided to participants through the MLQ Transform platform. This work occurred in June and July 2022.

Contacting Potential Participants. Two weeks and one week prior to survey deployment, an introductory, informational email with the purpose, the intent, and the inclusion of raters to provide feedback was sent to the nurse leaders (Appendix M). Reiteration of email content and other general information was shared daily by the project lead at the Nurse Manager's Daily Huddle. The Nurse Manager's Daily Huddle occurs Monday–Friday from 10 am-11 am. The meeting transpires through a virtual platform. The huddle intends to share information, problem-solve, and discuss concerns. Nurse managers, supervisors, and senior nursing leaders are required to attend. The information provided at the huddle was in the form of a detailed Question and Answer (Q&A) format. Utilizing a self-constructed Q&A guide (Appendix N), the project lead provided targeted and consistent information related to the project to further inform prospective participants. Q&A information was provided verbally at the Nursing Huddle at two weeks, one week, and the week of survey deployment. A copy of the document was sent to the nurse leader group based on an issued group request.

Rater Communication Specific to the MLQ. Two weeks and one week prior to the survey deployment, potential "raters" (nursing administration, ancillary managers, and nursing frontline staff) received informational emails sent to their organizational email account from the Chief Nursing Officer's Assistant on behalf of the project

lead (Appendix O). The email contained the following: a request for voluntary participation; the intent and purpose of the associated request; an explanation of the role as a "rater"; information relative to the MLQ, including time to complete; anonymity and confidentiality associated with the rater role; and contact information for the project lead regarding further questions or clarifications. Information contained in the rater email was reiterated through the Daily Facility Safety Huddle corresponding with the weeks of the email and survey deployment. The Facility Safety Huddle occurs Monday-Friday from 9:30 am -10:00 am. utilizing a virtual platform. The objective of the huddle is to review quality data from the past 24 hours and issues, discuss problem-solving, and provide informational updates. Participants included all managers, directors, and senior leadership. The meeting is mandatory for all leadership house wide.

For front-line nursing staff**,** the email communication was printed and placed on the informational board of each nursing unit by the project lead. The project lead cycled through the nursing units to review the flyer information with staff during their daily change of shift unit huddle to capture day and night staff for two weeks, one week, and the week of the MLQ deployment. The choice not to email the staff directly was based upon the recommendation of the project facility CNO and Senior Nursing Leader. Historically, according to both parties, email served be an ineffective mode of communication relative to critical messaging for staff.

A request for questions and clarification of information was offered verbally at the Safety Huddle and through written email communication. Written communication was drafted and sent out by the Chief Nursing Officer's assistant at the request of the project lead.

Nurse Leader Invitation for Participation in the MLQ. Organizational-issued emails of nurse leaders were entered into the associated MLQ account established by the project lead. A project-specific, customized email created by the project lead in collaboration with Mind Garden (MLQ) was sent to each nurse leader through Mind Garden's secure online platform, Transform, on the agreed-upon date with the project lead. Customization allowances by Mind Garden provided the opportunity to obtain consent for both (the MLQ and the CSF) assessments in the email invitation for participation. The consent statement reflected: "By accessing and participating in the Multifactor Leadership Questionnaire assessment and the Clifton Strength Finders survey, one is providing their consent to participate in the assessment/s." Other email information included an invitation for voluntary participation, instructions for entering rater organizational email addresses and a link to the MLQ survey. Upon entering the link for the MLQ, nurse leaders were asked to enter, at minimum, the work email addresses for three self-designated raters in each category: above, lateral to, and below the nurse manager. Once completed, the nurse leader was directed to access the assessment link. Should a nurse leader decline the use of raters, a soft stop stating, "Do you want to proceed without entering rater emails?" was provided upon attempting to enter the link to the survey. If the manager acknowledges "yes," the manager was redirected to the instructions. If the manager/leader responded "no", the nurse leader was instructed to access the survey link to complete their self-assessment. Once the survey was accessed, and before beginning the assessment, each nurse leader participant was requested to add their employee ID along with their favorite color as indicated to create a unique identifier. The unique identifiers requested were utilized during pre-and post-intervention

surveys to match survey results and demographic data for comparison. All information was explained to the respondents prior to survey engagement and was not reported in the final study. Basic demographic data, selected by the project lead, was constructed and obtained at the beginning of the MLQ survey, both pre-and post-intervention. Demographic data included gender, the highest degree of education, native culture, years as a registered nurse, years as a manager, and current role.

Nurse Leader Rater Invitation for MLQ Rater Participation. Upon entering the email addresses of self-selected raters into Transform, an invitation was immediately generated from the secure online platform to the selected raters. The email served as an invitation from the associated nurse leader, which requested the individual to provide feedback on the leader initiating the email. Rater assignments were requested but not mandatory. Information accompanying the survey provided by Transform included the purpose of the survey, consent for participation, instructions for accessing and completing the survey, information regarding confidentiality, and voluntary participation accompanying the invitation. Other informational instructions were included should the selected rater choose not to participate; no further action would be required. Should the individual choose to participate, the link in the email was available for immediate access by the rater for completion. Raters were not required to add a unique identifier as the platform's privacy setting was enabled to keep the identity of all raters confidential. The MLQ nurse leader and rater assessments were available simultaneously. The self-and rater assessments remained open for two weeks, from June 26 through July 9, 2022.

MLQ Results Received. Individual results for nurse leaders were generated once the MLQ survey was closed to targeted participants and selected raters. Upon closure of

the survey, participatory nurse leaders were provided with a report from Transform to the leader's email. Individual results, rater feedback, and aggregate data were provided to the project lead via Transform. Pre-intervention results were housed within the Transform platform until study completion.

CSF for Managers. The project lead entered the work email addresses of the study population into the Gallup system in preparation for survey deployment. The Clifton-Strengths Finder, a licensed product of Gallup, was deployed via a secure online platform initiated from support@mail.gallup to each potential participant's work email address on an agreed-upon date. The CSF was deployed one week following the initial MLQ deployment and remained open for two weeks. An invitation email was generated from support@mail.gallup to the nurse leaders' work email addresses requesting voluntary participation in the CSF assessment. The email included each participant's unique one-time user code and a link to the online assessment. Upon entering the assessment, the participant inputted the provided code. The code was utilized to pair results with participants. Once the survey was completed, each participant immediately received a copy of their results directly from Press Ganey by entering a link through its secure platform support@mail.gallup. Upon survey closure, the project lead received the individual results of all nurse leader participants via the secure online platform.

Phase II: Pre-Intervention Survey Results: Analysis Method and EB Coaching Plan Development

Pre-intervention survey results were analyzed and critically appraised, with results serving as the foundation of coaching plan development. Each parent company generated individual and aggregate data reports as part of the licensing agreements. Two areas of

opportunity were selected from the MLQ to develop the EB individualized coaching plan based on the coaching timeframe of eight weeks. MLQ characteristic opportunities were cross-walked utilizing the AONL nurse manager domain theoretical framework and associated competencies to guide the evidence-based, individualized, intentional coaching plans. The Clifton Strength Finders served to identify each nurse leader's innate top five strengths, which were then used to inform the individualized development plan. Strengths were incorporated into the plans as a means to influence development positively. This work transpired in July 2022.

Survey Analysis Methodology. The MLQ pre-intervention survey was analyzed by descriptive statistical method. Score averages were utilized and calculated as follows. In a report supplied by Transform, all ratings for each nurse leader were averaged, and then all averages per nurse leader were averaged, thus, weighing each leader equally (MindGarden, 2022). Rater data was averaged accordingly per leader so leaders with more raters would not be outweighed in the "average score" (MindGarden, 2022). Average scores per leader group, per rater group, and evaluator group were analyzed. Data was also analyzed per individual nurse leader, rater group for the leader, and per leader evaluator group.

Next, results were analyzed by comparing rater groups' mean scores per leadership style, transformational leader (TL) characteristics, and established benchmarks. Results were assessed for congruency, discrepancy, and trends among the following: the overall transformational leadership (TL) domain; each of the five "I" s, which collectively compose the characteristics of the TL domain; transactional and passive/avoidant leadership styles; and the overall outcomes of leadership style, inclusive

of scores associated with Generates Extra Effort, Is Productive and Generates Satisfaction. Outcomes of leadership measures reflect followers' perceptions of what is provided by the leader to the group, including extra effort; individual, unit, and organizational effectiveness; and satisfaction generated by the leader. Positive outcomes are associated with high scores and result from using an effective leadership style (TL) and associated characteristics.

The areas used to inform the focus for the evidence-based, individualized developmental coaching plans were based upon two criteria: the lowest mean rater scores and the largest area of opportunity when comparing rater scores to benchmark scores in the area of TL characteristics. Rater scores, which reflect a more accurate picture of the leader, were viewed with more reliability (Avolio & Bass, 2004). Self-rater scores were not discounted, yet, the role of illusory superiority was taken into consideration. Illusory superiority reflects a cognitive bias wherein persons overestimate their individual qualities and abilities, thus, rating themselves as more substantial than others perceive them to be (Deonna, 2005).

First, scores were compared to identify the predominant leadership style based on rater groups' scores and how these scores compared to benchmark, either meeting benchmark, which would indicate expected performance, or below, which would indicate an area of opportunity. Next, comparative analysis occurred utilizing mean scores of self-raters and the rater group to identify areas of opportunity across TL characteristics based on areas of lowest scoring. Thirdly, benchmark data per TL characteristic was evaluated based on scoring provided across each rater group. The lowest rater scores assigned to TL characteristics were compared to benchmark. The two TL characteristics receiving the

lowest scores across rater groups and those with the most significant benchmark variance relative to TL characteristics scoring were noted to be congruent 100% of the time. This same methodology was deployed at the individual level to analyze self-rater and individual-rater results and related benchmarks. Therefore, the two lowest-scored TL characteristics and the two scores furthest from the benchmark were used to inform the targeted areas of development for the evidence-based, individualized developmental coaching plan. These areas identified included inspirational motivation (IM) / individual consideration (IC) (which are combined under the MLQ) and intellectual stimulation (IS).

MLQ characteristic opportunities were then cross-walked utilizing the AONL nurse manager domain theoretical framework and associated competencies to guide the evidence-based, individualized, intentional coaching plans. The CSF served to identify each nurse leader's innate top five strengths, which were then used to inform the individualized developmental plans. Strengths were incorporated into the plans as a means to influence development positively.

The CFS for Managers report, reflective of the individual's results, was provided by Press Ganey for each leader immediate post-completion and to the project lead immediate upon closure of the survey. The report reflected the following information: the leader's top ten strengths, guidance on how each identified strength promotes or hampers a leader's success, and ways to apply the strength and build upon it in all areas, including those of needed development. Only the top five strengths were utilized to inform the developmental plans for simplicity.

Review of Findings with the Individual Leaders. Dates and times were established to review individual results of both assessments with each nurse leader

individually, thus, setting the platform for stage 1 of Lewin's change theory. CSF and MLQ results and comments were reviewed, discussed, and reflected upon with each participate. A second meeting was established at one-week post-discussion, allowing time for assimilation of the assessment results and prior to engaging each manager in collaboration to create an evidence-based (EB), intentional, individualized coaching plan.

Evidence-Based Coaching Plans. Survey results guided the design and implementation of the EB intervention. MQL data areas of identified concentration were aligned with the AONL nurse manager domains and competencies. These were then cross-walked with the AONL competencies. Specific competencies were then identified for development along with pre-selected EB content (see Table 2).

Table 2

MLQ and AONL Nurse Manager Competency Cross Walk and Coaching Content Focus

Transformational Leadership Competencies	AONL Nurse Manager Competencies based Nurse Manager Learning Domain Framework	Educational / Coaching Content Focus
Inspirational Motivation (IM): Interactive Leadership Individualized Consideration (IC): Generative Leadership	The Art of Leading	
Performance management	Performance management	HR/ crucial accountability/ manage to success
Develop others	Staff development	Coaching to success
Retention of talent	Staff retention	Methods/ strategies of retention
Relationship Management	Relationship management	Emotional Intelligence Principles
Influencing others	Influencing others	Be compelling /competent
Managing conflict	Managing conflict	Conflict management
Recognition of others	Recognition of others	Key means to acknowledge others
Social justice	Social justice	Equity, diversity, inclusion, ethics

Engagement of the workforce	Empowerment	Strategies/tactics to empower
Motivate and support others	Motivate others	Lead with impact
Effective communication	Communication	Practicing effective communication
Idealized Attributes: (IA) Generative Leadership	The Science: Appropriate Clinical Practice Knowledge & HR Management	Educational/ Coaching Content Focus
Set performance standards	Appropriate clinical practice knowledge	Evidence-based practice
Follow performance standards	Human Resource Management	HR Principles
Intellectual stimulation (IS) Generative leadership	The Science: Strategic Management & PI	Educational/Coaching Content Focus
Facilitate change	Facilitate change	Leading change
Shared decision making	Shared decision making	Engagement / empowerment
Engage others to accomplish goals	Collaboration	Collective thinking
Innovation	Innovation	Leading through innovation
Effective communication	Communication	Communication modes /delivery
Effective management	Effective Management	Endearing followers
Problem solving	Contingency planning	Planning for tomorrow
Challenges ways of thinking	Project management	Organizational skills
Challenges the status quo	Systems thinking	Growing one's vision
Continuous improvement	Performance improvement	Conversations, goal, expectations
Idealized Behaviors: IIB Aligned with self-leadership	The Leader Within	Educational / Coaching Content Focus
Personal Growth/Professional Accountability	Personal & professional accountability	Value of accountability
Ongoing self-development	Ongoing self-development	Career Development: the message
Ethical behavior standards	Ethical behavior standards	Building trust
Professional development	Professional org. involvement	Professional growth/knowledge

Taking on challenges for growth	Achievement of certification	Lifelong learning
Prepare for the future	Career Planning	5- and 10-year plans
Engage in reflective practices	Personal journey disciplines and reflective practices	Resilience /understanding oneself as a leader
Self-awareness and insight	Apply action learning	Emotional Intelligence Principles

Note: The educational context and subject matter were taken from McNally, K. & Cunningham, L. (2010). *The nurse executive coaching manua*l, Sigma Theta Tan. And Schinko-Fischli, S. (2019). *Applied improvisation for coaches and leaders: A practical guide to creative collaboration*. Routledge.

Evidence-based intentional, individualized coaching plans (Appendix P) were constructed, integrating each participant's leadership style/competency opportunities and innate strengths into the plan. Nurse leaders' top five strengths were incorporated into the developmental design to build upon existing strengths. Self-identified learning preferences and styles were considered as part of the tactical design. AONL focal areas of development were mapped to specific evidence-based content to enhance growth. The information provided targeted enhancing individual, team, and organizational performance, assisting leaders in successfully navigating change with their team, generating healthy work environments, and fostering succession planning. The content delivery methods included discussion, reading, reflection, role-playing, and behavioral practice.

Collaboration and Review of Coaching Plan Draft. A communication was sent to all nurse leaders' work email by the project lead before establishing individual meetings targeted at collaboration and reviewing a working draft of their individualized development plan (Appendix Q). Invitations for collaboration and draft coaching plan

review were sent electronically to each nurse leader who participated in both surveys. Meetings transpired over a week to jointly tweak and further develop the evidence-based, individualized, international coaching plan. Evidence-based educational content was included, which was obtained through two sources: McNally & Cunningham's (2010) "The Nurse Executive's Coaching Manual" and Schinko-Fischli's (2019) "Applied Improvisation for Coaches and Leaders: A Practical Guide for Creative Collaboration."

The ADDIE (Analyze, Design, Develop, Implement, and Evaluate) Framework Instructional design has been proven successful due to its excellent quality design and the establishment of clear learning objectives. The framework carefully tied content, integrated activities, and assessments to specific learning outcomes (Adri et al., 2020). The acronym reflects the following phases and associated processes utilized for this project. During analysis, opportunities were identified and clarified, utilizing instructional goals and objectives based on learning needs. New behavioral outcomes were identified, and constraints to learning were examined and addressed as part of the coaching plan and coaching sessions. The design phase focused on learning objectives, content, subject matter, and instructional methods. SMART goal establishment, including specific, measurable, action-oriented, realistic, and time-sensitive goals, was set to guide strategies and clarify in expectations. Systematic, specific, logical, and orderly developmental plan strategies were established to attain set goals. Steps included applying instructional strategies to reach intended behavioral outcomes and using visual aids, such as a written plan to guide the learning process and record ongoing progress. The development required integrating learning techniques into the plan, which would benefit the nurse manager. Implementation included an established procedure for training and facilitating

the nurse manager's development through evidence-based, individualized, intentional coaching plans and sessions. The evaluation included the ongoing cycle of plan, do, study, and act through active feedback and evaluation to assist the nurse manager in obtaining established goals and adding modifications as required. Feedback was shared verbally through the coaching documentation and self-reflection. Evidence-based developmental plans incorporated ADDIE principles.

Phase III: Intervention: Evidence-Based Individualized, Intentional, Coaching Sessions

Evidence-based, individualized, intentional coaching plans guided coaching sessions aligning with Stage 2 of Lewin's change theory as leaders worked toward transition through coaching. This work occurred August-September 2022.

Coaching sessions were guided by the evidence-based framework of the International Coaching Federation (ICF) and the Coaching Research Institute (CRI). These frameworks included joint planning, relationship building, observation, action/practice, reflection, accountability, and feedback. According to the Coaching Research Institute (CRI) (2013), coaching conversations typically range from 30 to 45 minutes, citing sessions greater than 45 minutes have been linked to decreases in attentiveness and information assimilation. In contrast, shorter sessions make one more productive and focused (CRI, 2013). Session length was guided by evidence-based guidance and established for 30-45 minutes per session.

When correlating coaching conversations with outcomes, the CRI (2013) revealed coaching which occurs every one to two weeks garnished more remarkable overall outcomes than those occurring at longer time intervals. Coaching sessions for this project

were established and occurred weekly. Timeframes for coaching interventions can vary based on multiple factors such as the readiness of the learner, acceptance of the coaching process, engagement, and other factors. According to the CRI (2013), shorter and more frequent coaching sessions aligned with an overall timeframe of coaching targeted at two to four months improve overall results. In alignment with institutional recommendations, coaching sessions were set to transpire over eight weeks for 30 minutes per session.

Before coaching transpiring, consent for coaching (Appendix R) was obtained. Once the coaching agreement was signed, coaching sessions were conducted face-to-face and or virtually to support the nurse manager's progress toward achieving the needed AONL Nurse Manager Competency development. Coaching session dates and times were negotiated and established between the coach and the coachee. Progress toward goals, reflection on success, setbacks, and needed support structures were discussed. Ongoing guidance and support were provided at weekly sessions and as required.

Feedback and observations were recorded on the coaching plan document to track progress. ADDIE methodology was utilized throughout the coaching sessions, and adaptations to the coaching plan were made based on the evaluating the current state of nursing leaders.

EB ICF and CRI frameworks supportive of effective coaching included the following actions: establishing trust, communicating effectively, using open-ended questions, creating awareness, and managing progress and accountability. Trust establishment with the coachee was translated through the expression of support and concern as an appropriate demonstration of respect regarding the coach’s perceptions, learning style, and personal well-being; while championing new behaviors and actions

inclusive of risk-taking and fear of failure (ICF, n.d.). Communicating effectively included active listening to support self-expression while distinguishing between tone, words, and body language. Mirroring back what the coachee stated was essential to ensuring clarity and understanding. Open-ended questions assisted in revealing information for the maximum benefit of the coachee (Grant & O'Connor, 2019; ICF, n.d.). To facilitate learning and enhance results, awareness of opportunities assisted the coachee in developing strengths, which increased one's ability to take actions and mobilize toward results, while challenging coachee assumptions and perspectives to generate innovative ideas to create new possibilities for action (Grant & O'Connor, 2019; ICF, n.d; Synder et al., 2015). Progress toward goals, reflection on success and setbacks, support structures were discussed, and guidance was provided during weekly sessions. Feedback and observations were recorded on the coaching plan document to track progress.

ADDIE methodology was utilized throughout the coaching sessions, and adaptations to the coaching plan were made as needed based on the evaluation of the nurse leader's progress at the time of coaching. Effective coaching plan maintenance was critical in effectively managing coaching sessions, progress, and accountability, so expectations and follow-through were easily managed while maintaining a focus on that which is essential for the coachee to be successful (Grant & O'Connor, 2019; ICF, n.d.; Mosteo et al., 2021). Each of the above actions was incorporated into the coach's actions (project lead) during coaching sessions.

Upon completion of the coaching sessions, all participants and raters who completed the pre-intervention MLQ assessment were invited to repeat this assessment post-intervention. The request was sent to each individual's work email address.

Phase IV: Post-Intervention Survey Redeployment/ Results Analysis

Post-Intervention, The MLQ survey was redeployed to nurse leader participants and previously established raters through the confidential and secure online platform, Transform. Demographic information was collected as part of the MLQ survey, mirroring that of the initial survey. Cohen's d was utilized to compare pre-and post-MLQ data to evaluate the impact of the intervention. Final data analysis occurred in October 2022.

In October 2022, the post-intervention MLQ was redeployed to all prior participants and raters who completed the pre-intervention MLQ assessment for comparative analysis in determining the impact of the individualized, intentional coaching sessions on nurse manager development. Redeployment of the MLQ occurred on the Monday following the conclusion of coaching sessions on the preceding Friday. A project-specific, customized email created by the project lead in collaboration with Mind Garden (MLQ) was sent to each nurse leader who participated in the initial MLQ assessment. Customization allowances by Mind Garden included consent for post-intervention participation in the MLQ assessment within the invitation. The email for participation was issued from Transform, Mind Garden's secure online platform. The consent statement reflected: "By accessing and participating in the Multifactor Leadership Questionnaire re-assessment, one provides their consent to participate in the assessment." Raters mapped to the initial MLQ (per email submission by the selected nurse leader) automatically received a second generated email invitation to participate in

the post-intervention assessment on the identified nurse leader's behalf. The same demographic information as established pre-intervention was included in the post-intervention assessment. A link to the assessment site was supplied in the email, and instructions for completion by MLQ (Transform) to nurse leaders and rater participants. The post-intervention assessment remained open for two weeks. Upon closing the survey, the project lead received individual and aggregate results aligned with the survey by accessing the Transform site. The nurse leader participants received a post-survey results report generated via Transform to their work email addresses. Pre-and-post-MLQ assessment results were compared utilizing Cohen's d to evaluate the impact of the coaching intervention on nurse manager leadership styles and competency.

Risk

The benefits outweigh the risk associated with the project. The risks were minimal, including potential cross-cultural misunderstandings and miscommunications; therefore, cultural sensitivity practices were incorporated throughout the study. There was the risk of embarrassment if assessments identify significant development opportunities.

Ethical Considerations

There was no payment to survey participants. Surveys were sent electronically to the participant's work email through each parent company's secure online platforms. In advance of survey deployment, participants were informed the project lead would receive copies of their independent survey results to assess areas of strengths and opportunities required to draft individual, intentional developmental coaching plans and sessions. No patients were included in this project. All data was kept strictly confidential. Unique

identifiers were utilized via MLQ and CSF to map individuals to results and were not reported in the final form of this project.

Anticipated Benefits

Anticipated benefits of this project include the ability to impact nurse manager knowledge and competency, including understanding one's innate strengths and utilizing these strengths to engage others and promote success within the leadership role and personal life. Understanding one's leadership style, gaining insight into optimal styles and associated outcomes, and nurse leader competency enhancement are all potential benefits. These elements are critical in achieving quality patient and organizational outcomes. This project provided participants with impactful, information regarding their individual leadership strengths, feedback through colleague appraisals on leadership competencies, enhanced self-awareness of individual performance, and individual coaching experiences. The results of this project are intended to serve as the foundation for an ongoing sustainable journey for leadership development and to be instrumental attaining Joint Commission International.

Disclosure

During the project timeframe, the primary investigator was on site fulfilling a contractual agreement as a consultant to facilitate preparation for JCI accreditation readiness.

Analysis

Pre-Intervention Demographics

There were 14 nurse leader survey respondents to the pre-intervention surveys. Eleven were female and three were male. Native culture was reported as follows: nine

Jamaican, two Caymanian, one British, one Latin American, and one Filipino. Ten were master's degree prepared and four were bachelor's prepared. Twelve were currently in the role of nurse manager and two in the role of nursing supervisor. Eight held 20 or more years of experience as a registered nurse, one held 15-19 years, two 10-14 years, one 0-4 years, and two with less than one year of experience. Eight held 15-19 years of experience as a nurse manager, four reported 10-14 years, one reported 5-9 years, and one reported 1-4 years.

Pre-Intervention MLQ

The pre-intervention MLQ assessment results were obtained on (July 20, 2022). The project lead confirmed fourteen data sets existed for the participatory nurse managers/leaders reflective of demographic survey results, MLQ and CSF results. Results of each survey were released to the participants and project lead by the parent companies MindGarden-Transform (MLQ) and Gallup (CSF) upon completion of the corresponding survey. On July 23, 2022, both surveys were closed to collection, and analysis of the existing data began (see Table 3).

Of the 20 possible nurse leaders, 14 participated in the MLQ (70%). Out of 126 possible raters (9 raters per leader x 14 leader participants = 126), 80 participated (63%). One participant outside of the 14 engaged in the CSF yet did not participate in the MLQ survey; therefore, the individual's data was excluded as part of the analysis. Mind Garden reports were downloaded into secured PDF files for analysis. The MLQ report prepared by Mind Garden for the project lead contained data summaries of all questions within a group report reflecting frequency average score results for: leaders and collective rater

groups; delineated rater groups including self, those above the leader, lateral to, and below the leader, individual results, and standard deviations based on group means.

Utilizing the established methodologies, analysis of Transformational Leadership Style frequency rating scores was performed. Frequency rating scores were aggregated per group reflective of self-raters (leader) and raters. In addition, results were analyzed by breaking down rater group average scores further by averaging results (using the previously described technique) into groups representative of those above, lateral to, and below the leader.

The analysis included a review of each leadership style, TL leadership behavioral characteristics, and associated benchmark data. Individual questions within the survey were numbered and corresponded to distinct areas of leadership competency. The Likert-scored results were tallied for each question providing a total, then averaged for each characteristic aligned with a particular leadership style, culminating in a final score related to the specific competency (Bass & Avolio, 2015). Survey questions ranged from two to four questions per behavioral competency. Comparative, research validated benchmarks for all categories of leadership styles, competencies, and outcomes were provided by Mind Garden (2022). The term “benchmark data” reflects the Research Validated Benchmarks utilized by Mind Garden in the following descriptive. The benchmark score for transformational leadership and the related five “I” s of transformational characteristics: Builds Trust (IIA), Acts with Integrity (IIB), Encourages Others (IM), Encourages Innovative Thinking (IS), and Coaches and Develops People (IC) ranged from 3.0 (fairly often) - 4.0. (Frequently, if not always). Data was presented

at group levels as the small number of participants makes identification of participants possible at the local level (Table 4).

Table 4

Pre-Intervention MLQ Average Leader and Rater Scores and Associated Standard Deviations

MLQ Scale and Subscale Characteristics	**Frequency Questions**	**Bench-mark**	**Range: Leader**	**Range: Rater**	**Mean Leader**	**Mean Rater**	**SD Leader**	**SD Rater**
Transformational Leadership		3.0-4.0	2.9-3.7	2.5-3.3	3.3	2.8	0.3	0.3
Builds Trust (IIA)	10,18,21,25	3.0-4.0	2.8-4.0	2.5-3.5	3.1	2.8	0.5	0.4
Acts with Integrity (IIB)	6,14,23,34	3.0-4.0	2.5-4.0	2.2-3.5	3.2	2.8	0.4	0.3
Encourages Others (IM)	9,13,26,36	3.0-4.0	2.0-3.8	2.4-3.5	3.2	2.8	0.4	0.3
Encourages Innovative Thinking (IS)	2,8,30,32	3.0-4.0	2.5-3.8	2.4-3.5	3.3	2.7	0.4	0.2
Coaches and Develops People (IC)	15,19,29,31	3.0-4.0	3.0-4.0	2.2-3.3	3.6	2.7	0.4	0.4
Transactional Leadership								
Contingent Reward (CR)	1,11,16,35	2.0-3.0	2.3-3.5	2.3-3.1	3.0	2.6	0.4	0.3
Management by Exception Active (MBEA)	4,22,24,27	1.0-2.0	2.5-3.5	1.2-2.5	2.0	2.0	1.0	0.4
Passive Avoidant								
Management by Exception Passive (MBEP)	3,12,17,20	None	0-1.3	0.3-1.3	0.5	0.7	0.5	0.3
Laissez-Faire (LF)	5,7,28,33	0.0-1.0	0-0.6	0.2-1.0	0.2	0.5	0.5	0.3
Outcomes of Leadership								

Generates Extra Effort (EE)	39,42,44	3.5-4.0	2.0-4.0	2.3-3.3	3.2	2.8	0.5	0.3
Effectiveness (EFF)	37,40,43,45	3.5-4.0	2.0-4.0	2.5-3.7	3.3	2.9	0.5	0.5
Generates Satisfaction (SAT)	38, 41	3.5-4.0	2.5-4.0	2.8-3.6	3.5	3	0.5	0.3
MLQ Scale and Subscale Characteristics	Frequency Questions	Bench-mark	Range: Leader	Range: Rater	Mean Leader	Mean Rater	SD Leader	SD Rater
Transformational Leadership		3.0-4.0	2.9-3.7	2.5-3.3	3.3	2.8	0.3	0.3
Builds Trust (IIA)	10,18,21,25	3.0-4.0	2.8-4.0	2.5-3.5	3.1	2.8	0.5	0.4
Acts with Integrity (IIB)	6,14,23,34	3.0-4.0	2.5-4.0	2.2-3.5	3.2	2.8	0.4	0.3
Encourages Others (IM)	9,13,26,36	3.0-4.0	2.0-3.8	2.4-3.5	3.2	2.8	0.4	0.3
Encourages Innovative Thinking (IS)	2,8,30,32	3.0-4.0	2.5-3.8	2.4-3.5	3.3	2.7	0.4	0.2
Coaches and Develops People (IC)	15,19,29,31	3.0-4.0	3.0-4.0	2.2-3.3	3.6	2.7	0.4	0.4
Transactional Leadership								
Contingent Reward (CR)	1,11,16,35	2.0-3.0	2.3-3.5	2.3-3.1	3.0	2.6	0.4	0.3
Management by Exception Active (MBEA)	4,22,24,27	1.0-2.0	2.5-3.5	1.2-2.5	2.0	2.0	1.0	0.4
Passive Avoidant								
Management by Exception Passive (MBEP)	3,12,17,20	None	0-1.3	0.3-1.3	0.5	0.7	0.5	0.3
Laissez-Faire (LF)	5,7,28,33	0.0-1.0	0-0.6	0.2-1.0	0.2	0.5	0.5	0.3
Outcomes of Leadership								
Generates Extra Effort (EE)	39,42,44	3.5-4.0	2.0-4.0	2.3-3.3	3.2	2.8	0.5	0.3
Effectiveness (EFF)	37,40,43,45	3.5-4.0	2.0-4.0	2.5-3.7	3.3	2.9	0.5	0.5
Generates Satisfaction (SAT)	38, 41	3.5-4.0	2.5-4.0	2.8-3.6	3.5	3	0.5	0.3

Note: Range represents the scale of responses across the group from lowest to highest Frequency score relative to the specific scale or subscale based on rater group. Leader represents selected rater group. Results are based on aggregate data per group.

Within the transactional leadership domains of rewards achievement (benchmark 2.0-3.0) and management by exception (benchmark 1.0-2.0), the mean score across self-rater and the rater group fell within established benchmarks based on scoring. The mean scores of those above the leader and lateral to fell within benchmark parameters, as reflected by scoring. The group below the leader revealed a score of 0.2 above the benchmark in each associated transactional leader category. Passive/Avoidant Leadership style, reflective of management by exception passive (MBEP) (no established benchmark) and laissez-faire (LF) behaviors (benchmark 0.0-1.0) reflected scores within benchmark based on mean group scoring among self-raters, raters, those above, lateral to and below the rater. Individual level and rater data aligned with the scoring in each category as reflected on an aggregate level. This data suggests the nurse managers' behaviors within the areas of transactional and passive/avoidant leadership are as expected based on scoring (See Table 4).

Within the domain of overall transformational leadership, based on the mean score, self-raters evaluated themselves higher in overall transformational leadership style (3.3) compared to the mean score provided by group raters (2.8). In the area of the five I's which makeup transformational leadership, mean self-rater scores fell within benchmark across all characteristics: builds trust (IIA) 3.1; acts with integrity (IIB) 3.2; encourages others (IM) 3.2; encourages innovative thinking (IS) 3.3, and the highest score noted in coaches and develops people (IC) 3.6. Mean group rater scores revealed a

lack of meeting benchmarks in any of the TL characteristic areas related to transformational leadership. Mean group rater scores revealed the following opportunities relative to benchmark scores among the five "I's": builds trust (IIA) 2.8; acts with integrity (IIB) 2.8; encourages others (IM) 2.8; encourages innovative thinking (IS) 2.7, and coaches and develops people (IC) 2.7. Encourages innovative thinking and coaches and develops others scored the lowest among raters, yet self-rater mean scores reflected the highest scores in these areas based on the mean.

The three lowest mean scores per self-rater group (although within benchmark) were noted in the areas of building trust (IIA) at 3.1, acts with integrity (IIB) at 3.2, and encourages others (IM) at 3.2. The lowest mean scores per rater group were recognized in the areas of encourages others (IC) at 2.7 and encourages innovative thinking (IS) at 2.7 with the other three areas each reflecting a mean score of 2.8. According to Bass & Avolio (2015), one's self-perceived leadership style is often overestimated by self-raters masking one's true leadership style, citing rater evaluation results as conveying the most meaningful data. Utilization of a multilevel approach is critical in identifying a manager's actual leadership style/competencies (Bass &. Avolio, 2015).

The following results were noted in analyzing the data based on average scores per the following groups self-raters, raters above, lateral to, and below the leader. Self-rater mean data remained unchanged. Mean scores of the "above" rater group revealed the top three areas of opportunity in the following categories: coaches and develops people (IC) 2.4; encourages innovative thinking (IS) 2.4; and encourages others (IM) 2.4. Each of these scores fell below benchmark. Mean scores of the "lateral" rater group reflected opportunities primarily in encourages innovative thinking (2.6) with the

remaining “I” competencies yielding the identical scores at 2.9; all below benchmark. Mean scores of the “below” raters group showed opportunities in coaching and developing people (IC) 3.0; encouraging innovative thinking (IS) 3.1, and acts with integrity (IIB) 3.1, while all fell within benchmark (see Table 5).

Table 5

Pre-Intervention Average Transformational Leadership Style and Characteristic Scores per Rater Group with Standard Deviations

Pre-Intervention MLQ	Benchmark	Mean Leader	Mean Above	Mean Lateral	Mean Below	SD Leader	SD Above	SD Lateral	SD Below
Transformational Leadership		3.3	2.5	2.8	3.1	0.3	0.4	0.4	0.3
Builds Trust (IIA)	3.0 - 4.0	3.1	2.5	2.9	3.2	0.5	0.5	0.5	0.3
Acts with Integrity (IIB)	3.0 - 4.0	3.2	2.6	2.9	3.1	0.4	0.6	0.3	0.1
Encourages Others (IM)	3.0 - 4.0	3.2	2.4	2.9	3.2	0.4	0.6	0.4	0.3
Encourages Innovative Thinking (IS)	3.0 - 4.0	3.3	2.4	2.6	3.1	0.4	0.4	0.4	0.3
Coaches and Develops People (IC)	3.0 - 4.0	3.6	2.4	2.9	3.0	0.4	0.5	0.6	0.4
Outcomes of Leadership									
Generates Extra Effort (EE)	3.5 - 4.0	3.2	2.5	3.0	3.1	0.5	0.8	0.7	0.5
Effectiveness (EFF)	3.5 - 4.0	3.3	2.2	3.1	3.4	0.5	0.5	0.6	0.3
Generates Satisfaction (SAT)	3.5 - 4.0	3.5	2.6	3.1	3.4	0.5	0.4	0.7	0.3

Note: MLQ Pre-Intervention data. The above table reflects the mean scores and SDs related to the leader, those above, lateral to and below the nurse manger.

Outcomes of Leadership were evaluated and defined as follows. Generates Extra Effort (EE) in followers, defined as the desire of the follower to exceed performance and

expectations (Mind Garden, 2022). Is Productive (EFF) is reflective of leadership efficiency in effectively meeting others' job-related needs, representing the team to superiors, demonstrates organization, and lead an effective team (Mind Garden, 2022). Generates Satisfaction (SAT) demonstrates warmth, encouragement, authenticity, openness, and honesty with excellent social and interpersonal skills (Mind Garden, 2022). In the outcomes category, rated frequencies of 3.5 to 4.0 represent the established benchmark. Overall, both self and rater groups mean scores across all domains in this category fell below validated benchmarks, with the self-raters scoring an average 0.4 - 0.5 points higher than reflected by rater group' averages. The average self-rating score for the 14 leaders in the area of extra effort came in at 3.2, while the average frequency score of the rater group reflected a score of 2.8. In the area of productivity, average self-rater scores reflected a score of 3.3 compared to the rater group average of 2.9. Under the category of generalized satisfaction with leadership, the average self-rater frequency reflected a score of 3.5 versus a score of 3.0 as reflected by the rater group. The results per rater group were all below benchmark. The scores reflect the opportunities in TL characteristics, which then translates into the outcomes of leadership.

Mean scores of self-raters and those at each rater level (above, lateral to, and below) provided further insight as average score of those "below the leader" scored nurse leader participants significantly similar to the leader. While the most significant discrepancy was noted between self-rater average scores and those above the self-rater followed by the average scores of those laterals to the nurse manager/leader group. The mean results under the category of outcomes of leadership reflected the following. Under the related competencies associated with generating extra effort, the following

average scores were recognized: self-rater 3.2, above rater 2.5, lateral to rater 3.0, and below rate 3.1. Under the category reflecting productivity, the following average scores reflected: self-rater 3.3, above rater 2.2, lateral to rater 3.1, and below rater 3.4. In the areas of generates satisfaction, the following average scores were revealed: self-rater 3.5, above rater 2.6, lateral to rater 3.1, and below rater 3.4.

Targeted areas of developmental focus were identified within the five "I"s of transformational leadership. Areas of needed developmental concentration were identified based on the following: areas of lowest mean performance scores per rater group; areas of the most significant benchmark variance as identified by rater mean scores, anecdotal comments included within the MLQ results as offered by raters; and individual developmental needs based on specific results per individual and reflective rater scoring. Based on this assessment, the following areas were identified as areas of targeted opportunity for development for the group: Coaches and Develops People: Individualized Consideration (IC)/Encourages Others: Inspirational Motivation (IM) and Encourages Innovative Thinking: Intellectual Stimulation (IS). IC and IM are combined under the Art of Leading and therefore were counted as one area for coaching purposes. The other targeted area reflected was IS, culminating in the two areas of developmental focus. These areas of opportunity were also reflected at the individual level for 11 of the 14 leaders (79%). For the remaining three individuals (21%), areas of required development targeted Acts with Integrity (IIB) and Builds Trust (IIA). These areas were then utilized to inform the individual developmental, coaching plans.

CSF for Managers

Within the CSF there are four domains: executing, strategic thinking, influencing, and relationship building. Each domain has a subset of strengths ranging from 8-9 per domain. Based on results, the 14 participatory leaders shared many of the top five strengths. Seventeen of 34 strengths were represented among the group's top 5 strengths. The information was reviewed on an aggregate and individual level relative to the top five strengths. For purposes of this section, aggregate data was utilized as to not identify the participants as each individual's strengths are unique to the individual. Among the participant leaders, the following domains and strengths were revealed. At an aggregate level within the domain of Strategic Thinking, a total of eight strengths are assigned. Within this domain areas of top five strengths identified among the group included 7 participants aligned with "learner," three with "input," and one with "intellection." In the Execution Domain, a total of nine strengths have been identified. Based on this domain, the following strengths were identified: ten aligned with "responsibility," eight with "achiever", six with "arranger", six with "belief," three with "restorative" two with "deliberative," and one with "consistency." The Influencing Domain aligned with eight strengths with one individual aligning with the strength "significance" within this domain. The last domain, Relationship Building, has nine aligned strengths. The group exhibited strengths within the following areas: four with "positivity," three "individualization," three "developer," two "harmony," two "connectedness" and two "adaptability." Low frequency, those strengths exhibited by 1-2 persons within a strength domain, as identified among the top five strengths included: significance, harmony, consistency, intellection, deliberative, connectedness, and adaptability (see Table 6).

Undetected strengths were noted within the following domains. Within the domain of strategic thinking, the following undetected strengths were noted: analytical, context, futuristic, ideation and strategic. In the executing domain, the following strengths were not detected: discipline and focus. Within the influencing domain, the following strengths did not surface activator, command, competition, communication, maximizer, self-assurance, and woo. Lastly, the following strengths were not reflected in relationship building: empathy and includer.

Information provided by CSFs report included individual data which revealed areas of noted challenges related to the use of each identified strength and how the strength should be utilized in the role of leader to support further development in areas of opportunity.

Table 6

Top Five Areas of Strengths Among Leaders

Domains	Characteristics	Interpretive Meaning	Leader Top 5 Strengths
Strategic Thinking	Analytical	Possesses a global view- reflects on causal relationships	0
	Context	Appreciates context from a historical perspective	0
	Futuristic	Looks to the future and what will the future bring-visionary	0
	Ideation	Looks for connection between differing ideas	0
	Input	Likes to accumulate things by archiving things even relationships	3
	Intellection	Introspective	1

	Learner	Enjoys learning and not focusing on outcomes from learning	7
	Strategic	Creates alternative means to proceed	0
Executing Domain	Achiever	Satisfied when busy and productive	8
	Arranger	Enjoys putting the puzzle together and maximize productivity	6
	Belief	Consistent core values dictate life's purpose	6
	Consistency	Treating everyone the same based on clear processes and rules	1
	Deliberative	Serious contemplation in decision making	2
	Disciplined	Crave routine and structure	0
	Focus	Prioritization and acting are primary	0
	Responsibility	Committed to honesty and loyalty	10
	Restorative	Problem solving experts	3
Influencing Domain	Activator	Converts thoughts to action	0
	Command	Takes control and makes decisions	0
	Communication	Easily converts thoughts to words	0
	Competition	Measures progress and performance	0
	Maximizer	Stimulates excellence	0
	Self-Assurance	Takes risk while clear in decision making	0
	Significance	Independent and prioritizes based on impact	1
	Woo	Connectiveness with others	0
Relationship Building	Adaptability	No problem going with the flow	2

Connectedness	Faith in the connectedness of all things	2
Developer	Cultivate the potential in others	3
Empathy	Ability to relate to others	0
Harmony	Like consensus and avoids conflict	2
Includer	Accepting and inclusive of others	0
Individualization	How persons can work cohesively together	3
Positivity	Enthusiastic in all things	4
Relator	Cherish close relationships	6

Note: N= 14 leaders. The table represents the top five strengths among the nurse leader group. The number reflects the number of times the strength was reported within the top strengths among the nurse leader group.

Coaching

Of the fourteen nurse leaders who participated in the pre-intervention MLQ and CSF surveys, 12 participated in coaching sessions. Inconsistent attendance of 4 out of the 12 was noted, while eight remained consistent. Attempts to re-establish dates and times to make up for missed coaching sessions did not result in attendance for those who demonstrated inconsistent attendance. Of the four, one attended three sessions, two attended four sessions, and one attended five sessions. The remaining eight completed all eight weeks of the coaching sessions.

Post-Intervention Demographics

Post-intervention there were eight nurse leader survey respondents. Five were female and three males. Cultural self-recognition revealed five were Jamaican, one British, one Filipino, and one Latin American. Five held master's degrees and three held

bachelor's degrees. All eight were currently in the role of nursing manager. Six reported 20 years or greater as a registered nurse, one 15-19 years, and one 0-4 years. Five reported 15-19 years as a nurse manager, two reported 10-14 years, and one reported less than 1 year.

Post-Intervention MLQ

The MLQ post-intervention survey included eight nurse leaders and a total of 63 raters out a possible 72 (88%) participated. The initial analysis plan was to utilize a paired t-test to compare pre-and post-intervention data with a consideration for use of the Cohen's d formula to evaluate the effect of the intervention. The small sample size and participation rate yielded a sum that was not useful statistically outside of local context. A significant issue prohibiting the paired t-test was the rater participation post versus pre-survey. The use of Cohen's d was therefore utilized to compare pre-and post-intervention MLQ results. Effect sizes reflect one of the most important outcomes associated with empirical studies (Lakens, 2012) as it does not just demonstrate an affect, but the magnitude of the affect. Effect sizes are used to report a standardized metric, which communicate the practical significance of results and provide comparison standardized effect across studies (Lakens, 2012) and are more useful than p-values. Effect, which is measured using Cohen's d, is a quantitative measure of the significance of the experimental effect (Lakens, 2012). This measure is frequently used in the field of psychology and medical education. The equation is expressed as follows: Cohen's d = Group A Mean – Group B mean /Pooled Standard Deviation. The value can be used when comparing effects across studies (Lakens, 2012). The Cohne's d effect size correlates with the relationship between the two variables being measured (Lakens,

2012). Cohen's d effects are quantified as follows: d=0.2 represents a small effect size, 0.5 represents a medium effect size, and 0.8 is considered a large effect size (Lakens, 2012). Less than 0.2, the effect is trivial. According to Lakens (2012), small effect sizes can reflect large consequences, therefore, practical consequences of the effect must be part of the interpretation of Cohen's d results.

The pre-MLQ intervention self-rater mean scores and associated standard deviations were compared to post-MLQ intervention leader mean scores and associated standard deviations (see Table 7). The process was replicated utilizing overall rater mean scores and associated standard deviations obtained from the pre and post MLQ. The MLQ data results were entered into software accessed through https://lbecker.uccs.edu/ (Becker, L. (n.d.). Effect Size Calculators, University of Colorado (Colorado Springs) to calculate Cohen's d effect and provided by statistician, Matthew Jones. Each group, self-raters, and raters were evaluated utilizing this process. The following narrative description and table below compares pre and post MLQ results of the leadership and raters. Cohens'd among the self-rater group suggested no change in the areas of builds trust (0.0), acts with integrity (0.0), or encourages innovative thinking (0.0) based on results. Cohen's d effect results reflective of encourages others was 0.3 suggesting a minimal effect. In the area of coaches and develops people Cohen's d result was 1.8 suggesting a possible large effect size within this category. Cohen's d results under outcomes of leadership within the self-rater group were as follows: generates extra effort 0.2, suggestive of a minimal effect change; effectiveness 0.0 suggestive of no impact; and generates satisfaction 0.7 suggestive of a medium effect size.

In the rater group, Cohen's d result was suggestive of a small effect in overall transformational leadership (0.3) and associated characteristic areas including coaches and develops (0.2) and acts with integrity (0.3). Within the following characteristic areas results came in just below 0.5, which indicates a medium effect, in the area of builds trust (0.4), encourages others (0.4), and encourages innovative thinking (0.4). The outcomes of leadership domain revealed a small impact in effectiveness (Cohen's d =0.2) and a medium effect (0.5) related to generates extra effort.

Table 7

Pre and Post MLQ Survey Results and Cohen's d Comparisons

Behaviors	Bench	Pre-Mean Leader	Pre-Mean Rater	Pre-SD Leader	Pre-SD Rater	Post-Mean Leader	Post-Mean Rater	Post-SD Leader	Post-SD Rater	Cohen's d Leader Group	Cohen's d Rater Group
TL	3.0-4.0	3.3	2.8	0.3	0.3	3.3	2.9	0.3	0.4	0.0	0.3
Builds Trust (IIA)	3.0-4.0	3.1	2.8	0.5	0.4	3.3	3.0	0.5	0.2	0.0	0.4
Acts with Integrity (IIB)	3.0-4.0	3.2	2.8	0.4	0.3	3.2	3.1	0.4	0.4	0.0	0.3
Encourages Others (IM)	3.0-4.0	3.2	2.8	0.4	0.3	3.1	3.0	0.4	0.6	0.3	0.4
Encourages Innovative Thinking (IS)	3.0-4.0	3.3	2.7	0.4	0.2	3.3	2.9	0.4	0.6	0.0	0.4
Coaches and Develops People (IC)	3.0-4.0	3.6	2.7	0.4	0.4	3.4	2.8	0.3	0.5	1.8	0.2
Outcomes of Leadership											
Generates Extra Effort (EE)	3.5-4.0	3.2	2.8	0.5	0.3	3.1	2.6	0.4	0.5	0.2	0.5
Effectiveness (EFF)	3.5-4.0	3.3	2.9	0.5	0.5	3.3	3.0	0.5	0.7	0.0	0.2

Generates Satisfaction (SAT)	3.5-4.0	3.5	3	0.5	0.3	3.2	3.1	0.4	0.3	0.7	0.3

Note: Results of Cohen's d were rounded to the nearest tenth. Software to perform Cohen's d results calculated using Effects Calculator located at https://lbecker.uccs.edu/. Bench refers to Benchmark.

Participant Comments

Although verbal feedback and evaluation of the assessment and coaching process were not solicited, of the nurse leaders, 8 out of 12 reported that the "experience had made them feel more confident", requested a continuation of the meetings beyond the timeframe of the officially established coaching sessions, "wished someone had assisted me earlier in my career", asked "can this be done for all new leaders" and "liked the idea of building on my strengths than focusing totally on my weaknesses". Four out of 12 of the coachees remained diligent in follow through of assignments and would reach out between sessions for assistance. Five of the 12 asked for additional materials such as books, journals, and online resources to assist them in their journey of continuous development.

Discussion

Pre- and post- intervention MLQ results suggest some effect of EB individual, intentional coaching as a method to develop nurse leaders. Practical clinical applications included the desire of participants to improve confidence and competence in an effort to create sustainability. The use of strengths as a starting point for development was positively received by nurse leaders. The nurse leaders were thirsty for leadership development with a core group craving development through coaching interactions. Feedback from the facility CNO and other senior leaders acknowledged behavioral

performance improvement in four of the nurse leaders. Improved self-awareness related to actions and associated staff responses resulted in nurse leaders being more intentional in their communication and behaviors. EB individualized, intentional coaching sessions allowed for customized learning experiences to best support the learner in an environment where pride and ego emanate within the diverse cultural landscape. The evolution of TL behavioral changes experienced by the leader should influence their teams by creating a cascading effect positively impacting their teams (Gottlieb et al., 2012; Key-Roberts & Budreau, 2012). The work performed can be utilized to forecast future work with individuals within the select cultural environment. Although the project has been completed, ongoing development of the nurse leaders will be provided to those who continue to seek this pathway to development.

Limitations

Many variables contributed to the limitations of the project. Several participants reported a lack of clarity and understanding related to survey questions intent. Coaching length and timeframes were abbreviated due to time constraints of the project lead due to the nature of the project and project. The sample size was small with 60% (12 out of 20) of managers not following through to completion. The impact of the coronavirus and boarder closure over the past two and a half years did not allow the nurse managers to travel. Since the reopening of the island during the latter part of spring, extended vacation periods lasting from 2-6 weeks for nurse leaders, the potential loss of unused vacation time if not utilized, and compassion leave resulted in challenges related to coaching and survey participation. Lack of structured schedules and workflow processes were impactful as often it was necessary to remind coachees of their coaching sessions at time

of the appointment. Pre- and post-intervention survey participation among managers and rater groups varied pre- and post-intervention relative to a sample size, which was already small. Lastly, ego and pride are culturally prevalent within the vastly enculturated society resulting in the lack of acknowledgement by some nurse leaders related to the gravity of the need for development.

Implications/Recommendations

Leadership assessment is essential to understanding baseline leadership style and characteristics in order to meet the specific developmental needs of the leader. This project's use of the MLQ and CSF offered an innovative approach to develop leadership competency through coaching. Further exploration of interventions focused on nurse leader competency development is an ongoing need. Leadership outcome data related to the MLQ needs to be further explored related to this and other projects. Evidence based individualized, intentional coaching should be continued along with consideration of a follow up MLQ reassessment to fully understand the impact of this model of coaching development beyond the intent of this project.

This work serves as a possible legacy project. It is a platform to address future organizational wide leadership development. Fellow Doctor of Nursing Practice students interested in leadership development would prove helpful in carrying the project forward and expanding upon the work which has already been done as a framework for leadership development is needed for succession planning, growing existing leaders, and create a path for hired leaders from day one.

Conclusion

All aims of the project were met. Through the use of the CSF and the MLQ assessments nurse managers were made aware of their innate strengths, leadership styles, competencies, and opportunities. The MLQ served to provide feedback from leader-selected raters above, lateral to and below the leader to obtain an evaluation from a perspective outside of the manager alone. The results of each assessment served to inform the development of intentional, individual evidence based (EB) coaching plans incorporating areas of strengths, styles, and competency opportunities to guide the EB coaching plans and sessions. Post-intervention, the impact of the EB individualized, intentional coaching was reassessed by redeployment of the MLQ to pre-assessment participants and raters only. Over the course of the project, recruitment was not difficult; yet, participation was exceptionally challenging at times. Although interest in the project and support from the organization's CNO were present, it was difficult to establish priorities amidst organizational initiatives and demands. Correspondingly, the project offered the opportunity to collaborate with diverse cultural groups within a healthcare setting. The long-term impact of the project is unknow, yet it offered a framework for leadership development where none previously existed.

Table 1

Table 1

Multifactor Questionnaire Domain/ Subcategories Descriptive

Domains / Subcategories	Characteristics	Abbreviations
Transformational Leadership:		
The five "I's" of Transformational Leadership		
Builds trust Idealized Influence - Attributes	Inspire power and pride in their followers by focusing on the interest of the group	IIA
Acts of integrity Idealized Influence-Behaviors	Share their most important values and beliefs. Work to build a commonly shared vision or mission. Consider moral and ethical consequences	IIB
Encourages others Inspirational Motivation	The leader Nurse managers currently motivates those around them. Team spirit, enthusiasm, and optimism are displayed by the leader and group.	IM
Encourages innovative thinking Intellectual Stimulation	Leader behaves in ways to motivate those around them. No ridicule or public criticism of individual mistakes. Solicitate new ideas and creative solutions from followers	IS
Coaches and develops people Individualized Consideration	Followers are developed to higher levels of potential through the creation of new learning opportunities. Individual needs and differences are considered.	IC
Transactional Leadership		
Constructive	Rewards Achievement Contingent Reward	CR
Corrective	Monitors deviations & mistakes Management-By-Exception: Active	MBEA
Passive - Avoidant Behaviors		
Passive	Fights Fires Management by Exception: Passive	MBEP
Avoidant	Avoids Involvement Laissez-Faire	LF
Outcomes of Leadership		
Generates Extra Effort	Followers wish to strive for superior performance acting beyond job expectations.	EE

Is Productive	The leader effectively represents their team at higher organizational levels and are efficient in meeting organizational objectives and generate high efficiency at all domains in which they are involved	EFF
Generates Satisfaction	Generate satisfaction in their followers. The leader is warm, authentic, nurturing, open, and honest with good interpersonal social skills.	SAT

Table 3

Table 3.

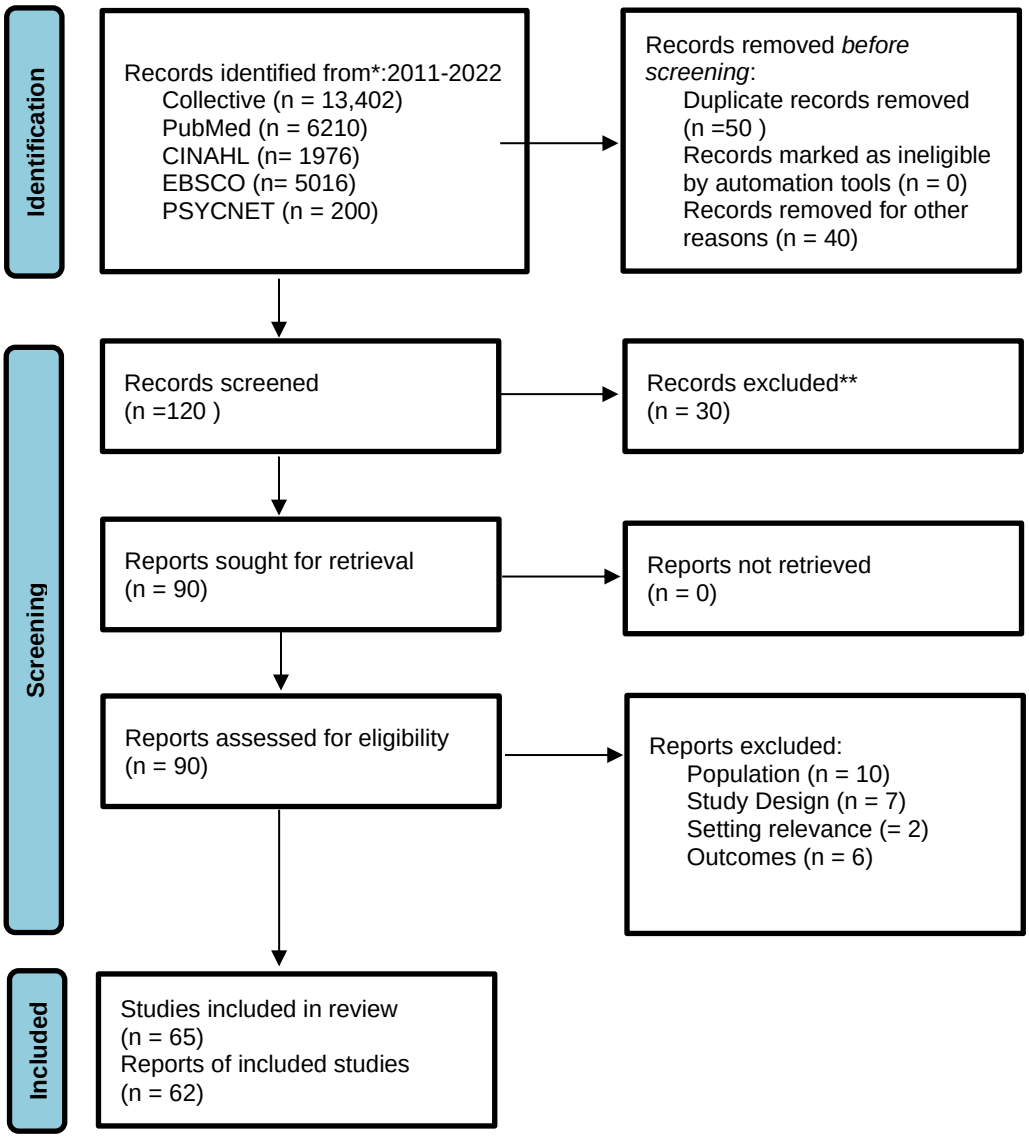
Pre- and Post-Intervention Demographic Data

Demographics	Pre-Intervention n=14	Post-Intervention n=8
Sex		
Male	3	3
Female	11	5
Culture		
Jamaican	9	5
Caymanian	2	0
British	1	1
Latin American	1	1
Filipino	1	1
Educational level		
BSN	4	3
MSN	10	5
Role		
Nurse Manager	12	8
Supervisor	2	0
Yrs. as RN		
>=20 yrs.	8	6
15-19 yrs.	1	1
10-14 yrs.	2	0
2-4 yrs.	1	1
< 1 yr.	2	0
Yrs. as Nurse Leader		
15-19 yrs.	8	5
10-14 yrs.	4	2
5-9 yrs.	1	0
1-4 yrs.	1	1

Appendix A

Figure 1

Figure 1: *PRISMA Flowchart*



Appendix B

- -

HEALTH SERVICES AUTHORITY
CAYMAN ISLANDS
Caring People. Quality Service.

HSA Ethics Committee

Tel: (345) 244 8600
Fax: (345) 244 2998

95 Hospital Road, PO Box 915
Grand Cayman KY1-1103, CAYMAN ISLANDS

6 May 2022

Dear Ms. Linda Shepherd,

Your research proposal: "*Developing Influential Nurse Leaders: Utilizing Strengths and Style Assessments to Create Individualized, Intentional Coaching".*

This letter serves to inform you that the Ethics Committee of the Cayman Islands at HSA has approved the above stated proposal.

We are satisfied with your attention to detail as well as the overall presentation of the document and wish you success with your research.

Regards,

Shawn Biscette
Research Secretary – HSA Ethics Committee
My health. My team. My choice.

Appendix C

JAMES MADISON UNIVERSITY

NOTICE OF EXEMPT APPROVAL

DATE:	May 19, 2022
TO:	Linda Shepherd, DNP, Nursing Department Jeannie Corey, School of Nursing
FROM:	Lindsey Harvell-Bowman, Associate Professor, IRB Panel
PROTOCOL TITLE:	Developing Influential Nurse Leaders: Utilizing Strengths and Style Assessments to Create Individualized, Intentional Coaching
FUNDING SOURCE:	HSA (Health Services Authority)
PROTOCOL NUMBER:	22-3464

The request for an exempt determination for the above-referenced study has been approved. The study was determined to be research that is exempt from Institutional Review Board (IRB) review under 45 CFR 46.104 Category 2, 3. The project as described in the application may proceed without further oversight.

Exempting an activity from review does not absolve you from ensuring that the welfare of the subjects participating in the research is protected and that methods used and information provided to gain subject consent are appropriate to the activity. You are reminded that any changes in your protocol that affects human subjects must be submitted to the IRB to determine if review and approval will be required *before* implementing new procedures.

Please direct any questions about the IRB's actions on this project to the IRB Chair:

Dr. Lindsey Harvell-Bowman
harve2la@jmu.edu (540) 568-2611

Lindsey Harvell-Bowman

OFFICE OF RESEARCH INTEGRITY
MSC 5738
HARRISONBURG, VA 22807
540.568.7025 PHONE

Appendix D

JAMES MADISON UNIVERSITY

NOTICE OF APPROVAL FOR HUMAN RESEARCH

DATE:	July 18, 2022
TO:	Linda Shepherd, DNP, Nursing Department Jeannie Corey, School of Nursing
FROM:	Lindsey Harvell-Bowman, Associate Professor, IRB Panel
PROTOCOL TITLE:	Developing Influential Nurse Leaders: Utilizing Strengths and Style Assessments to Create Individualized, Intentional Coaching
FUNDING SOURCE:	HSA (Health Services Authority)
PROTOCOL NUMBER:	22-3464

Approval Date: May 19, 2022 Expiration Date: N/A

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the amendment to protocol entitled: Developing Influential Nurse Leaders: Utilizing Strengths and Style Assessments to Create Individualized, Intentional Coaching. The proposed modifications have been approved for the procedures and subjects described in the amendment request. This protocol must be reviewed for renewal on a yearly basis for as long as the research remains active. Should the protocol not be renewed before expiration, all activities must cease until the protocol has been re-reviewed. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.
This approval is issued under 's Federal Wide Assurance 00007339 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the Committee's Assurance, please do not hesitate to contact us.
Please direct any questions about the IRB's actions on this project to the IRB Chair:

Dr. Lindsey Harvell-Bowman
harve2la@jmu.edu (540) 568-2611

Lindsey Harvell-Bowman.

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Appendix E

Cost of Project Tools

Associated Cost Expenditures	Participant Number	Cost per Participant	Base Cost	Tax	Total cost
Pre-intervention only					
Clifton Strength Finders with online access code for assessment (Survey for Managers)	20	$39.99	$799.80	$32.00	$831.80
Pre- and Post-Intervention					
Multifactor Leadership Questionnaire (minimum of 20 participants includes infinite raters at no additional cost) Pre-intervention	20	$100.00	$2,000.00	NA	$2,000.00
Multifactor Leadership Questionnaire (minimum of 20 participants includes infinite raters at no additional cost) Post-intervention	20	$100.00	$2,000.00	NA	$2,000.00
MLQ Group Rater Report (pre & post)	2		$150.00	NA	$300.00
Consent set-up fee for pre and post (one-time fee)			$50.00	NA	$50.00
Demographic question inclusion (6) questions (one-time fee)	6		$20.00	NA	$120.00
Demographic question build (6) (one-time fee)	6		$10.00	NA	$60.00
MLQ Manual Purchase	1	NA	$50.00	NA	$50.00
		$239.99	$5,079.80	NA	$5,411.80

Note: All calculations in U.S. dollars. All tools are provided and accessed online through secure online platforms.

Appendix F

Letter Requesting Project Tool Funding

March 24, 2022

Linda Shepherd
1392 Lakeview Drive
Pulaski, Virginia 24301

Dr. Brown,

Unstable nursing leadership proliferates burnout, lack of engagement, and has been associated with a higher incidence of hospital acquired conditions (Bormann & Abrahamson, 2014). To minimize burnout and accentuate success, it is essential for nurse managers to possess the needed leadership skills and competencies required to be successful within their jobs. As the nurse manager role continues to morph, it also requires a new and enhanced skill set (Goktepe et al., 2018; Heinen & al., 2019) as well as ongoing agility and adaptation to meet ongoing demands of an ever-changing healthcare landscape (Severinsson et Holm, 2012). Ongoing prioritization is also critical as the span of responsibility within the role is often vast with little assistance (Borden 2018). Nurse managers own the initiation and implementation of multiple strategic initiatives aimed at numerous domains including internal and external customer satisfaction; quality care outcomes; the integration of evidence-based care into bedside practice; nursing recruitment, retention, performance excellence, and engagement of staff at the bedside, while balancing responsibility for successful financial performance (Asiri et al., 2016; Fennimore & Wolfe, 2011; Spiva et al., 2021). According to DiGirolamo & Tkach (2019) a large number of individuals in managerial roles struggle to just be a "good" manager as it is estimated that 50% or more of those employed in managerial roles lack the needed skill sets to obtain success. Issues such as short-term thinking, limited mind sets, lack of wanting to surrender control, underdeveloped competencies, emotional intelligence, inability to motivate others, and insufficient interpersonal skill sets have contributed to their inability to embrace success (DiGirolamo & Tkach, 2019; Kotter, 2008).

The goal of the project is to identify individual strengths through the Clifton Strength Finders pre-intervention in conjunction with the Multifactor Leadership Questionnaire (MLQ) (which will be utilized to identify leadership styles and skill set) to inform individualized, intentional coaching sessions targeted at utilization of strengths to close identified gaps in leadership styles and competency, with the ultimate goal of enhancing self-awareness and development. The MLQ will be performed by the managers and selected raters to provide 360-degree feedback both pre- and post-intervention phases to compare the impact of the intervention. The American Organization of Nurse Leaders Nurse Manager Learning Domain Framework will be utilized as the primary framework for the project. Similar methodology has been utilized in other employment sectors with great success and could be a springboard for future

onboarding of nurse managers and other managerial staff as well as a means to develop others through succession planning.

The following outlines the pricing for the assessments which will be provided through their parent companies. Press Ganey is the parent company of Clifton Strengths Finders assessment and Mind Garden is the parent company of the MLQ assessment. Both are exceptionally reliable and validated tools.

I am reaching out to you to request funding for both assessment tools to move forward with this project. Formal quotes are being obtained from the parent companies for your consideration. Below is an estimated cost based upon the organizational website documented quotes.

The **Clifton-Strengths assessment** will only be administered pre-intervention serving as a baseline assessment of the individual's operational strengths.The Clifton-Strengths Assessment for Managers licensure cost is $39.99 per participant, with a minimal purchase requirement of 20 licenses, culminating in a cost of ($39.99 per participant x 20 licenses) = $799.80 US dollars. Tax = $32.00, thus the **total cost for the CSF assessment = $831.80 US dollars.** The survey tool is offered through its parent company Press Ganey. (Press Ganey does not provide a quote. The Quote was obtained via electronic shopping cart).

The **MLQ** requires a similar licensing purchase to utilize the survey tool. The MLQ also requires a minimal of 20 participants and provides limitless raters at no extra charge. The cost of the MLQ is $100.00 US dollars per individual pre-intervention ($100.00 x 20 participants) = $2000.00 and then again post- intervention ($100.00 x 20 participants) = $2000.00 for a cumulative cost of ($2000.00 + $2000.00) = **$ 4000.00 US dollars** total questionnaire cost.

MLQ Group rater reports are $150.00 per report. Two reports will be required one pre- and post -interventions. Associated cost = $150.00 x 2= **$300.00 US dollars** total rater report cost.

MLQ Custom fees include informed consent = $50.00, demographic information inclusion= $20.00 per question ($20.00 x 6= 120.00), and a text build at $10.00 each x 6= $60.00. Total = $50.00 + $120.00 + $60.00 = **$230.00 US dollars for customization**.

Online cost of the MLQ = ($4000.00 + $300.00) + $230.00 = **$4530.00 US dollars**.

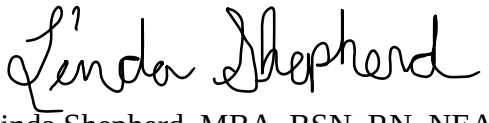
Rater participation is included in the cost, therefore, there are no additional fees for their participation either pre or post intervention. This tool is offered through MindGarden.com. No taxes are associated with the MLQ licensure purchase.

An additional cost included the purchase of a **Multifactor Leadership Questionnaire Third Edition manual** and sample test by the research lead at **($50.00 US. Dollars**) (not included in the above cost)

Cumulative cost of both assessments = CFS ($831.80) + MLQ ($4530.00) + MLQ manual ($50.00) = $ **5411.80 US dollars**

Please reach out to me for any questions.

Thank you in advance for your assistance.



Linda Shepherd, MBA, BSN, RN, NEA-BC
DNP student James Madison University

Appendix G

Mind Garden MLQ Approval Letter

Multifactor Leadership Questionnaire TM

Third Edition

Manual and Sample Set

Bruce J. Avolio and Bernard M. Bass
University of Nebraska and SUNY Binghamton

Contributions by:
Dr. Fred Walumbwa
Weichun Zhu
University of Nebraska—Lincoln
Gallup Leadership Institute

mfnd garden

Published by Mind Garden, Inc.
info@mindgarden.com
www.mindaarden.com

Appendix H

Mind Garden Approval Letter: Part 2

For use by Linda Shepherd only. Received from Mind Garden, Inc. on November 17, 2021

mind garden

www.mindgarden.com

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Instrument: XXXXX

The few sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below.

Sample Items:

XXXXX

Copyright: XXXXX

Sincerely,

Appendix I

Multifactor Leadership Questionnaire

Leader Form

My Name: _____ Date: _____

Organization ID #: _____ Leader ID #: _____

This questionnaire is to describe your leadership style as you perceive it. Please answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.**

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits you. The word "others" may mean your peers, clients, direct reports, supervisors, and/or all of these individuals.

Use the following rating scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

1.	I provide others with assistance in exchange for their efforts	0	1	2	3	4
2.	I re-examine critical assumptions to question whether they are appropriate	0	1	2	3	4
3.	I fail to interfere until problems become serious	0	1	2	3	4
4.	I focus attention on irregularities, mistakes, exceptions, and deviations from standards	0	1	2	3	4
5.	I avoid getting involved when important issues arise	0	1	2	3	4
6.	I talk about my most important values and beliefs	0	1	2	3	4
7.	I am absent when needed	0	1	2	3	4
8.	I seek differing perspectives when solving problems	0	1	2	3	4
9.	I talk optimistically about the future	0	1	2	3	4
10.	I instill pride in others for being associated with me	0	1	2	3	4
11.	I discuss in specific terms who is responsible for achieving performance targets	0	1	2	3	4
12.	I wait for things to go wrong before taking action	0	1	2	3	4
13.	I talk enthusiastically about what needs to be accomplished	0	1	2	3	4
14.	I specify the importance of having a strong sense of purpose	0	1	2	3	4
15.	I spend time teaching and coaching	0	1	2	3	4

Continued ➔

Not at all	Once in a while	Sometimes	Fairly often	Frequently, If not always
0	1	2	3	4

16. I make clear what one can expect to receive when performance goals are achieved 0 1 2 3 4
17. I show that I am a firm believer in "If it ain't broke, don't fix it." 0 1 2 3 4
18. I go beyond self-interest for the good of the group 0 1 2 3 4
19. I treat others as individuals rather than just as a member of a group 0 1 2 3 4
20. I demonstrate that problems must become chronic before I take action 0 1 2 3 4
21. I act in ways that build others' respect for me 0 1 2 3 4
22. I concentrate my full attention on dealing with mistakes, complaints, and failures 0 1 2 3 4
23. I consider the moral and ethical consequences of decisions 0 1 2 3 4
24. I keep track of all mistakes 0 1 2 3 4
25. I display a sense of power and confidence 0 1 2 3 4
26. I articulate a compelling vision of the future 0 1 2 3 4
27. I direct my attention toward failures to meet standards 0 1 2 3 4
28. I avoid making decisions 0 1 2 3 4
29. I consider an individual as having different needs, abilities, and aspirations from others 0 ..... 1 2 3 4
30. I get others to look at problems from many different angles 0 1 2 3 4
31. I help others to develop their strengths 0 1 2 3 4
32. I suggest new ways of looking at how to complete assignments 0 1 2 3 4
33. I delay responding to urgent questions 0 1 2 3 4
34. I emphasize the importance of having a collective sense of mission 0 1 2 3 4
35. I express satisfaction when others meet expectations 0 1 2 3 4
36. I express confidence that goals will be achieved 0 1 2 3 4
37. I am effective in meeting others' job-related needs 0 1 2 3 4
38. I use methods of leadership that are satisfying 0 1 2 3 4
39. I get others to do more than they expected to do 0 1 2 3 4
40. I am effective in representing others to higher authority 0 1 2 3 4
41. I work with others in a satisfactory way 0 1 2 3 4
42. I heighten others' desire to succeed 0 1 2 3 4
43. I am effective in meeting organizational requirements 0 1 2 3 4
44. I increase others' willingness to try harder 0 1 2 3 4
45. I lead a group that is effective 0 1 2 3 4

Appendix J

Multifactor Leadership Questionnaire
Rater Form

Name of Leader: _____ Date: _____

Organization ID #: _____Leader ID #: _____

This questionnaire is used to describe the leadership style of the above-mentioned individual as you perceive it. Answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.** Please answer this questionnaire anonymously.

Important (necessary for processing): Which best describes you?

___ I am at a higher organizational level than the person I am rating.
___ The person I am rating is at my organizational level.
___ I am at a lower organizational level than the person I am rating.
___ Other than the above.

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits the person you are describing. Use the following rating scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

The Person I Am Rating. . .

1.	Provides me with assistance in exchange for my efforts	0	1	2	3	4
2.	*Re-examines critical assumptions to question whether they are appropriate	0	1	2	3	4
3.	Fails to interfere until problems become serious	0	1	2	3	4
4.	Focuses attention on irregularities, mistakes, exceptions, and deviations from standards	0	1	2	3	4
5.	Avoids getting involved when important issues arise	0	1	2	3	4
6.	*Talks about his/her most important values and beliefs	0	1	2	3	4
7.	Is absent when needed	0	1	2	3	4
8.	*Seeks differing perspectives when solving problems	0	1	2	3	4
9.	*Talks optimistically about the future	0	1	2	3	4
10.	*Instills pride in me for being associated with him/her	0	1	2	3	4
11.	Discusses in specific terms who is responsible for achieving performance targets	0	1	2	3	4
12.	Waits for things to go wrong before taking action	0	1	2	3	4
13.	*Talks enthusiastically about what needs to be accomplished	0	1	2	3	4
14.	*Specifies the importance of having a strong sense of purpose	0	1	2	3	4
15.	*Spends time teaching and coaching	0	1	2	3	4

Continued →

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

16.	Makes clear what one can expect to receive when performance goals are achieved	0	1	2	3	4
17.	Shows that he/she is a firm believer in "If it ain't broke, don't fix it."	0	1	2	3	4
18.	*Goes beyond self-interest for the good of the group	0	1	2	3	4
19.	*Treats me as an individual rather than just as a member of a group	0	1	2	3	4
20.	Demonstrates that problems must become chronic before taking action	0	1	2	3	4
21.	*Acts in ways that builds my respect	0	1	2	3	4
22.	Concentrates his/her full attention on dealing with mistakes, complaints, and failures	0	1	2	3	4
23.	*Considers the moral and ethical consequences of decisions	0	1	2	3	4
24.	Keeps track of all mistakes	0	1	2	3	4
25.	*Displays a sense of power and confidence	0	1	2	3	4
26.	*Articulates a compelling vision of the future	0	1	2	3	4
27.	Directs my attention toward failures to meet standards	0	1	2	3	4
28.	Avoids making decisions	0	1	2	3	4
29.	*Considers me as having different needs, abilities, and aspirations from others	0	1	2	3	4
30.	*Gets me to look at problems from many different angles	0	1	2	3	4
31.	*Helps me to develop my strengths	0	1	2	3	4
32.	*Suggests new ways of looking at how to complete assignments	0	1	2	3	4
33.	Delays responding to urgent questions	0	1	2	3	4
34.	*Emphasizes the importance of having a collective sense of mission	0	1	2	3	4
35.	Expresses satisfaction when I meet expectations	0	1	2	3	4
36.	*Expresses confidence that goals will be achieved	0	1	2	3	4
37.	Is effective in meeting my job-related needs	0	1	2	3	4
38.	Uses methods of leadership that are satisfying	0	1	2	3	4
39.	Gets me to do more than I expected to do	0	1	2	3	4
40.	Is effective in representing me to higher authority	0	1	2	3	4
41.	Works with me in a satisfactory way	0	1	2	3	4
42.	Heightens my desire to succeed	0	1	2	3	4
43.	Is effective in meeting organizational requirements	0	1	2	3	4
44.	Increases my willingness to try harder	0	1	2	3	4
45.	Leads a group that is effective	0	1	2	3	4

Appendix K

Clifton Strength Finders

Clifton Strength Finders is a proprietary assessment. In communication with The client services department, I was informed on March 29, 2022, that Gallup, the parent company of Clifton Strength Finders, does not provide samples of the assessment nor does the company share how the results are calculated.

Appendix L

Demographic Information for Collection

Pre-Intervention/ Post-Intervention Survey

Pre-Intervention /Post-Intervention Survey

Demographic Information

Gender

1. Male
2. Female
3. Choose not to specify

Native Culture

1. American
2. Canadian
3. Caymanian
4. Filipino
5. Great Britain
6. Indian
7. Jamaican
8. Latin American
9. Samoan
10. Other

Highest level of education completed

1. Associate or Technical degree
2. Bachelor's Degree
3. Master's Degree
4. Doctoral Degree

Current role

1. Nurse Supervisor
2. Nurse Manager
3. Nurse Director
4. Other

Number of years as a registered nurse

1. 0-4years
2. 5-9 years
3. 10-14 years
4. 15-19 years
5. 20 or more years

Number of years as a nursing leader

1. Less than 1 year
2. 1-4 years
3. 5-9 years
4. 10-14 years
5. 15-19 years
6. 20 or more years

Appendix M

Nurse Leader Invitation to Survey: MLQ/CSF

Nurse Leaders,

You are being invited to voluntarily participate in a nursing leadership development project that is being conducted by Linda Shepherd, MBA, BSN, RN, NEA-BC /Doctoral Candidate with James Madison University. The study involves participation in two online assessments.

1. ***Clifton Strengths Finders (CSF)*** -assesses one's 10 top innate strengths that are unique to you as an individual. Time to complete is approximately 15-30 minutes.

2. ***Multifactorial Leadership Questionnaire (MLQ)*** assesses one's leadership style. Time to complete is approximately 30-60 minutes. In addition to participating in the self-survey, you will also have the opportunity to invite colleagues to participate in the survey. The purpose of this is to gain insight on how others view your leadership style. By initiating an email request through the MLQ platform, an email request will be sent to the persons identified by you, requesting they complete the same assessment as you completed on yourself as a means of providing feedback. Your self-assessment and feedback will all be available to you. Anonymity of all individuals participating in the assessments will be protected through assignment of unique identifiers to all participants. Time to complete is approximately 30-60 minutes.

You may choose to volunteer to participate in one or both. For each assessment, your individual results will be available to you and are protected by a unique identifier issued by each online assessment provider. You are encouraged to take your time in making your decision regarding participation and are welcome to ask questions any time before, during, or after the study. Please direct any questions you may have to Linda Shepherd at shephelm@dukes.jmu.edu or in person.

The survey is anticipated to open in two weeks. Once the survey is opened, participating in one or both assessments imply written consent to participate in the project. Remember, there are not wrong or right answers only preferences!

Should you be interested and wish to learn more about the project, further detailed information and opportunity for questions will be provided daily at the nursing huddle starting on Monday.

Thank you for your time and consideration,

Linda Shepherd

Appendix N

Nursing Huddle Communication Content- Question and Answer Guide

This document will serve to guide the project lead in responding to anticipated questions regarding the project. The Nursing Huddle is a virtual platform utilized for information exchange among nurse managers and leaders at the project facility. The platform is set for 30-60 minutes depending on the information that needs to be covered.

What is the study all about?

- Assisting nurse leaders grow through the identification of strengths and leadership style and then using one's strengths and leadership styles to create individual, intentional coaching plans as a means to develop one's strengths to enhance further leadership development.

Once I decide to participate, how do I get started?

- Emails will be sent to all prospective participants business email addresses the first day of the survey deployment and consecutive days thereafter for the entire 2 weeks during which the survey is open. (Once you have completed the requested survey/s or have chosen not to participate, you may disregard the automated emails).
- You will receive **two e-mails:**

A. The Clifton-Strengths Finders Assessment:
measures innate strengths, evaluating 34 areas of leadership skill and performance. Each individual's unique top ten strengths will be identified through this assessment. 177 question assessment.

1) Each nurse leader will receive an email from support@mail.gallup on my behalf, which will contain instructions on establishing an account (creation of a login and associated password) (at no charge) through Gallup's online platform for the purpose of enabling accessibility to your individual results once they are available and establishing a unique identifier associated with your account to protect your identify and information.
2) **IMPORTANT:** during the open dates of the assessment, it is imperative if you do not receive an email from support@mail.gallup, that you check your business spam or junk mail to assure the information reaches your email inbox. If you need further assistance, contact me in person or at shephelm@dukes.jmu.edu
3) A link will also be provided in the business email for purposes of accessing and beginning the assessment along with instructions on how to perform the assessment.
4) ***Consent for voluntary participation is implied upon access of the assessment for completion and will be include a statement on the email.***
5) Demographic information collection will be part of the assessment
6) Next, complete the assessment by following the established link and instructions.

B. The Multifactor Leadership Questionnaire:

is a 45-question assessment which will identify leadership style and areas of strength based on your preferences. The Multifactor Leadership Questionnaire (MLQ) (MindGarden, Inc. is the parent company and *Transform* is the electronic forum for the online assessment).

1. Each nurse leader will receive an email to their business email account from MindGarden.com/Transform (the online platform for the MLQ assessment) on my behalf, which will contain instructions on establishing an account (creation of a login and associated password) (at no charge) through the online platform. This is needed for the purpose of enabling accessibility to your individual results once they are available and establishing a unique identifier which will be associated with your account to protect your identify and information.
2. If you do not receive the email communication, please check you junk or spam folders associated with your business email or contact me in person or at shephelm@dukes.jmu.edu
3. A link will be provided within the email to access the assessment along with instructions on performing the assessment.
4. ***Consent for voluntary participation is implied upon access of assessment for completion and will be an included statement on the email communication, which provides access to the survey.***
5. A request will also be provided to identify raters by inputting their business email addresses. Raters are colleagues who you identify that will have the opportunity by voluntarily participate and engage in the assessment by completing the survey reflective of your individual leadership style.
    - By providing the business email addresses of those selected (3 staff, 3 senior leaders, and 3 ancillary managers), an invite to participate in the assessment will be sent on your behalf to these individuals. These individuals engage in the same survey as the nurse leader to provide insight on the identified leader's leadership style thus providing a 360-degree assessment).The email will also include a request for their voluntary participation in the assessment process, inclusive of who they will evaluating, what they will be assessing (leadership style of the individual generating the email invite) when (reflecting the two-week survey open window), where (online) and why (to provide insight). The email will make clear that participation is strictly voluntary and access to the assessment implies consent for participation.
    - Information regarding anonymity for all accessing and completing the survey will be provided with each participant assigned a unique identifier.
    - Information on this process and reasoning will be provided in advance of the rater participants receiving the email from the nurse leaders. This will be done by the project lead.
    - These individuals **will not have access** to your results or the results of others.

- The result of these assessments will be generated and shared only with yourself and the primary researcher without identification of those who completed the assessment.

6. Access to your results will be available through the online platform upon completion of the window for the survey which is 2 weeks.
7. Results will be shared only with the primary project lead and you as the primary participant. All information will remain confidential and **only** aggregated, unidentifiable results will be shared.

How will the results be utilized?

Confidentiality **- Clifton Strengths**

1. Results of the assessment can be retrieved through the "reports" tab within an hour of completion of the survey.
2. Individual results are confidential and will **only** be shared with the individual and primary researcher as part of the assessment. Anonymity will be protected and **only** aggregated; unidentifiable results will be shared.
3. **ONLY** the participant has the right to share their individual results with others should the individual be so inclined.
4. **Multifactor Leadership Questionnaire:** The assessment will be performed twice-once before development coaching and then repeated post-coaching. The participatory nurse leader will again have access to their own results as well as the project lead. Results will be reviewed individually with each nurse manager participant and remain confidential. Raters who participated in the initial survey will be asked again to voluntarily participate in the assessment, completing the assessment on the same identified leader as during the initial survey. Emails will be generated again, following the same process as performed during the initial assessment with the exception being establishing an account through MLQ as the previous account will remain active until completion of the study. Participation in this study is also voluntary for all parties.

Individual, intentional coaching sessions to build on strengths:

Results of both studies will be utilized to develop individualize, intentional coaching plans building upon individuals' strengths to enhance leadership style and areas where you can utilize your strengths more robustly.

What will the coaching look like? And how much time will be involved?

1. I will meet with each nurse leader participant individually for 1 hour to discuss assessment results.
2. Jointly, we will develop a coaching plan based on these results.
3. Coaching will transpire 30 minutes each week for a period of 8 weeks in individual coaching sessions.

   All information regarding coaching will be main confidential – only aggregate, unidentified participant data will be shared.

What are the potential benefits of the project and specifically coaching?

Benefits include understanding one's innate strengths, how to harness these unique strengths to one's benefit as well as understand one's leadership style, how one's style can be augmented through building on strengths and learning new ways to operate to create role enhancement.

Potential Risk and Discomfort:

The study has minimal risks. There is potential for cross cultural misunderstandings and miscommunications.

Can I opt out of the coaching sessions?

Yes. All participation is volunteer at all levels of the project.

Participation Time:

Participation time varies. The Clifton-Strengths Finder assessment takes approximately 15 minutes. The MLQ takes approximately 30 minutes.

Open Window for initial assessment completion:

2 weeks from the day of the initial deployment of the survey release

Timeframe for Data Collection:

The start date is May 2022 and will conclude in November 2022.

Is there compensation for participation?

No, there is no compensation for participation.

If I voluntary participate in the study, do I have the right to discontinue participation without penalty at any time?

Your participation in the study is totally voluntary. You have the right to change your mind and leave the study at any time without providing a reason and without penalty. Any new information which may alter your thoughts on participation has been provided to you. You understand that no one will be notified of your participation and/or withdrawal or discontinuation of participation.

Who will see my results?

Only you and the primary project lead. Only group data will be reported, meaning the analysis will include only aggregate data. Results will be statistically compiled. No names will be utilized in any report of the study results. Analyzed aggregate data may be published in professional journals or presented at professional conference.

Questions Regarding the Study and/or Removal from the Research Process:

Please contact the Principal Investigator, Linda Shepherd

How much time will be required for participation in the project? 8.5 hours

Appendix O

Communication to Rates

Email for Safety Huddle / Frontline Nurse Manager Staff

All,

As part of an evidence-based project being conducted with nursing leadership, it is possible you may receive an email communication (through your HSA account) from nursing managers requesting you to provide valuable feedback. The request will be generated from MindGarden.com /Transform, (Mind.Garden's online platform), requesting you to serve as a "rater" for the identified nurse leader by completing the secure online assessment. The link to the survey along with survey instructions will be included in the email. The intent of the assessment is to provide feedback on leadership style. The assessment is composed of 45 questions and is estimated to take 30 minutes. Participation is voluntary. All feedback is anonymous and compiled with other feedback to create a singular collective report for each nursing manager. Through the secure platform and privacy settings, one will be able to identify who said what. No names or identifiers will be utilized. All information is to remain strictly confidential. Your feedback is greatly valued and will provide for a more robust survey process.
Should you decide to participate in the survey, you can do so by accessing the assessment link. By accessing the link, this will be considered your consent for survey participation.

A request for rater assessment participation will transpire in June 2022 and again at the conclusion of the project in September 2022. Keep in mind, there are no right or wrong answers, only preferences by which leaders lead!

Should you receive a request to participate in the survey and have questions, you can contact me at shephelm@dukes.jmu.edu.

Thank you for your time and consideration of participation.

Linda Shepherd

Appendix P

Coaching Template

Intentional, Individual Coaching Development Plan For: NO.

Appendix

Evidence-Based, Intentional, Individualized Coaching Plan ID no.

WHAT: Development Goals	HOW: Action Steps You Will Take to Meet Your Goals	WHO: Resources to Support Goal Achievement	WHEN: Accountability
Outline the skills, knowledge, and competencies that represent excellent performance in your current job role. Based on assessment results, select at least two areas you would like to develop further. Below include specific goals, describing how or what you want to change to improve. Incorporate identified strengths upon which to build to support your development. What can be done differently that would make the greatest impact on my work? What developmental priorities will support you in improving individual leadership and management competencies or that of the organization?	*. Identify the actions that should not be engaged in, those that should be engaged in, and those that should be continued.* **Leveraging Strengths :** **Top 5 Identified Signature Strengths :** / **How will this strength help me achieve my goals?** 1. 1. 2. 2. 3. 3. 4. 4. 5. 5.	How can I utilize my coach, peers, and others to assist in tracking progress, obtain feedback and advice, and support my ongoing learning and development?	**Date when I will begin taking action to meet my goals?** **When do I expect to see progress?** **How will progress be evaluated?**
Goal 1:	***II. Plan Actions:***		**Goal 1**
Goal 2:	**Situation** / **Action** **1.** **1.**		**Goal 2**
Goal 3:	**2.** **2.**		**Goal 3**
Goal 4:	***III. Anticipated barriers***		**How will the developmental plan be updated?**
	Barrier / **Solution** **1.** **1.**		**How often will I meet with my coach to update my developmental plan?**
	2. **2.**		**How will I leverage what I learn?**
	3. **3.**	***Acknowledgement***	
		What will be the impact of meeting my developmental goals?	
		How will the organization benefit from me meeting my goals?	
		How will we celebrate meeting my goals?	

Appendix Q

Evidence-Based, Individualized, Intentional Coaching Plan Example

WHAT: Development Goals	HOW: Develop Strengths to Meet Your Goals	WHO: Resources to Support Goal Achievement and Action Steps
Outline the skills, knowledge, and competencies that represent excellent performance in your current job role. Based on assessment results, select at least two areas you would like to develop further. Below include specific goals, describing how or what you want to change to improve. Incorporate identified strengths upon which to build to support your development. **What can be done differently that would make the greatest impact on my work? **What developmental priorities will support you in improving individual leadership and management competencies or that of the organization?	**Identify your strengths and how you will use these strengths to build on developing in areas of opportunity identified through the MLQ?**	**How can I utilize my coach, peers, and others to assist in tracking progress, obtain feedback, and advice, and support my ongoing learning and development?** 1. Share a desire for honest feedback 2. Share insights and reflection on behavior and challenges 3. Engage in and perform self-reflection on communication styles and active listening capabilities while creating concise messaging 4. Utilize feedback and coaching sessions to expand growth within current and future roles. 5. Utilize tools learned in coaching sessions
Intellectual Stimulation (IS): Engage others to accomplish goals **Goal 1**: Engage in relationship management activities through applying communication principles learned during coaching sessions targeted at promoting and engaging your team by Oct. 9, 2022 as demonstrated by improved team member satisfaction reflected in unit satisfaction survey targeted for Oct.30, 2022	**1. Relator :** You build strong relationships with your team. Encourage and help your team build strong relationships to obtain the best results across your team. Engage in daily rounding on staff and talk up staff . Use relator skill set to supply encouragement and engage with staff on a personal level, not just on a work level. By connecting on a human level, you encourage working g relationships that will promote unit success.	

Intellectual Stimulation (IS): Facilitate Change **Goal 2:** Engage in improved understanding and utilization of change management principles principles to assist the team inclusive of change management principles to assist the team in navigating change successfully as reflected in unit satisfaction survey targeted for Oct. 30, 2022.	**2. Learner:** You push others outside their box as you are willing to learn new things. You are reliable during times of change. Adding additional pressure to learn can make team members feel like you are dissatisfied with them in their development. Consider learning styles and encourage those who would like to develop. Engage others input to make them feel included. This can assist in learning from others and stimulate effective change.	* Team building requires ongoing effort. Communication is the key to relationship building through emotional intelligence. **Action:** Expand on self-reflection and awareness regarding communications with staff collectively and individuals. What went well and what did not.
Intellectual Stimulation (IS): Problem Solving and Contingency Planning **Goal 3**: Develop contingency plans and set a vision for the future of your department developing 2 short term and 2 long term goals by the end of the coaching sessions.	**3. Consistency:** You are aware of the need to treat people the same. You crave stable routines and clear rules that others can follow. This perspective provides a safe, predictable culture for your team. Identify team and individual contributions that best represent operational effectiveness. Such recognition reinforces the value of consistency and adhering to best practices. Establish standard operating procedures to help you team become a highly functioning team who can help you develop a vision for the unit.	* Multiple changes are occurring in the facility. Staff are challenged with change and revert to prior behaviors. **Action:** Work on communication skills, influencing abilities, assess unit readiness for change, involve staff in changes, evaluate outcomes and promote innovation to help successfully navigate change as focused upon in coaching sessions. ***Action:** Assigned reading: "Conscious Coaching: The Art and Science of Building Buy In" (Bartholomew, B., 2017) Chapters: Getting to know yourself and Strategic use of your personal traits.
Intellectual Stimulation (IS):Shared Decision Making. **Goal 4**: Engage in shared decision making by facilitating the foundational principles of shared governess and just culture in the department prior to the conclusion of coaching sessions on Oct. 9 and assess through staff feedback to leader.	**4. Deliberative:** You are best described by the serious care you take in making decisions. You see things others do not. Ask for input from team members before making decisions. Share and reinforce their contributions to the decision as to employ increase employee engagement and participation.	* Short term planning versus long term. **Actions**: Plan a vision for the future and plan for accomplishing this plan in the short and long term. Submit for discussion with the coach prior to the conclusion of coaching sessions.

Inspirational Motivation (IM) & Individualized Consideration (IC): Effective Communication Goal 5: Engage in staff meetings to share updates, ask for feedback, and seek clarity in messaging through verbal communication on this forum and at daily huddles. Provide self-reflection and feedback to coach weekly on self-performance.	**5. Achiever:** You enjoy being busy and productive. You are highly motivated. Recognize team improvement and individual performance. Start meaningful communications with team members about their goals and how they can partner with you to accomplish goals for the unit. Recognize success is not in a vacuum. Communication and clarity in communication and being informed -help teams accomplish significant goals.	*Shared decision making is minimal at this time. Engaging staff in decision making and shared input improves buy in and ownership. **Actions:** Engage in shared leadership to foster staff growth, responsibility, and create employees who will go above and beyond using techniques learned in coaching sessions

Learning Aids	**Anticipated Barriers**	
Book: "The Influencer: The New Science to Leading Change" Grenny, J., Patterson, K., Maxfield, D., McMillan, R., Switzler, A. (2013)	Barriers 1. Time for coaching 2. Distractions 3. Conflicts 4. Response of staff	Solution 1. Designate the time for coaching weekly 2. Invest in self- have someone cover for you 3. Notify and reschedule coaching in a pinch 4. Must continue to repeat new behaviors to establish change and trust

Goals	**WHEN: Accountability**	**Acknowledgement**
Participate in post-MLQ Weekly review progress with coach Be focused and fully present during coaching – no cellphone	**Date I will begin to act on my goals** *TODAY* **When do I expect to see progress?** *With time and repeated behaviors* **How will progress be evaluated?** *Feedback from others, self-reflection* *MLQ results post, and provision of deliverables* **How will the developmental plan be updated?** *Collectively with coach* **How can I leverage what I learn?** *Succession planning and coaching others*	**What will be the impact of my meeting my developmental goals ?** *Improved performance* **How will the organization benefit from me meeting my goals?** *Will make me more satisfied and productive* **How will we celebrate meeting my goals?** *Trip out for coffee!*

Appendix R

Coaching Consent

Consent to Participate in Coaching Sessions

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Linda Shepherd from James Madison University. The purpose of this study is to assist in ongoing leadership development through coaching targeted at building upon your inherent strengths and identified leadership style. This study will contribute to the Linda Shepherd's completion of her doctoral project.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This portion of the study consists of face-to-face coaching sessions that will be administered to individual participants at a location agreeable to the coach and coachee. You will be asked to engage in the coaching sessions as part of ongoing development through providing reflection, feedback, and tactics to enhance your development.

Time Required

Participation in this part of the study will require 240 minutes of your time. The sessions will be conducted weekly for 30 minutes over the span of two months (4 weeks per month x 2 months= 8 sessions) (8 sessions x 30 minutes = 240 minutes)

Risks

The investigator does not perceive more than minimal risks from your involvement in this study.

The investigator perceives the following are possible risks arising from your involvement with this study include the potential for cross-cultural misunderstandings and miscommunications; therefore, cultural sensitivity practices will be incorporated throughout the study.

Benefits

Potential benefits from participation in this study include the ability to enhance nurse manager knowledge and competency inclusive of understanding one's innate strengths, utilizing these strengths to engage others, promote ongoing success within a leadership role and personal life, understanding one's leadership style, knowledge of optimal leadership styles, and nurse manager competency augmentation and development. Each of these elements is critical to achieving quality patient and organizational outcomes

within HSA. Successful execution of this project will provide participants an impactful, sustainable journey to ongoing leadership development which will support HSA in successfully accomplishing its goals.

Incentives

You will not receive any compensation for participation in this study.

Confidentiality

The results of this project will be presented to nursing leaders/participants, JMU faculty, and HSA leadership utilizing aggregate data only. The results of this project will serve to be aggregate only with no personal identifying information provided. The project lead retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the project lead. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Conflict of Interest

I have no financial interest's involvement relative to The Cayman Islands Health Services Authority, a company which could potentially benefit from the outcomes of this research. If you have questions or concerns relative to data integrity or research participant, please see the below contact information.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion please contact:

Researcher's Name: Linda Shepherd
Department; Nursing
James Madison University
Email Address:SHEPHELM@dukes.jmu.edu

Advisor's Name: Dr. Jeannie Corey
Department: Nursing
James Madison University
Telephone: (540) 493-6632
Email Address: coreyjs@jmu.edu

Questions about Your Rights as a Research Subject

Dr. Lindsey Harvell-Bowman
Chair, Institutional Review Board
James Madison University
(540) 568-2611
harve2la@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

_____
Name of Participant (Printed)

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

This study has been approved by the IRB, protocol # 22-3464.

Appendix S

International Research

Complete this form if the proposed research will be conducted outside of the United States and submit with the Human Research Review Request form.

Responsible Researcher(s): Linda Shepherd
Project Title: Developing Influential Nurse Leaders: Utilizing Strengths and Styles Assessments to Create Individualized, Intentional Coaching

1. In which country will the research be conducted?
   The Cayman Islands

2. Describe the rationale for selection of this site.
   Was introduced to Cayman Islands Health Services Authority by my preceptor, Dr. Monty Gross, in 2020. In discussions with the Chief Nursing Officer at HSA, she expressed concerns relative to the nursing leadership at the facility and anecdotally shared observations of gaps in leadership development. She requested my assistance in identifying these gaps and assistance with leadership development, which mirrored my project. Therefore, the natural selection of this site for my project.

3. Describe the ways in which cultural norms and/or local laws differ between the host site and the United States. Consider the differences in consent procedures, age of majority, autonomy of individuals, group consent, and/or parental consent. Include an explanation of what cultural sensitivities will be required to conduct this study.
   The government and local laws align with those in the UK as the Cayman Islands remain under British rule. Through a thorough investigation, there are no local/governmental laws that prohibit the study. The IRB proposal has been submitted to the equivalent of the US IRB process, the Health Service Authority's Ethics Committee. Approval was provided through an attached letter on May 6, 2022, for the project. The participants are all English speaking and familiar with consent processes. Cultural sensitivity will need to be exercised through communication as to not create a cultural misunderstanding.

4. Describe any aspects of the cultural, political, or economic climate in the country where the research will be conducted which might increase the risks for participants. Describe the steps the researcher will take to minimize these risks:

   There is the potential for cross cultural misunderstandings and miscommunications. Cultural sensitivity practices will be incorporated throughout the course of the project. The project lead has many years of

experience in working with other cultures and ethnic groups serving as an International Short Term Medical Missions Coordinator for over 16 years and serving in approximately 15 countries on short term mission trips serving from 2 weeks to 1 month. In addition, the project lead has engaged in multiple performance evaluations over the past 30 years and therefore will engage with study participants using heightened sensitivity and focus on strengths to close gaps in opportunities for growth.

5. Describe how the researcher will obtain culturally appropriate access to this community.
   The project lead has been engaging with the managers of the organization and Chief Nursing Officer for over the past year and a half through DNP work.

6. What is the primary language of the potential research subjects?
   English.

7. Is the researcher fluent in the primary language? If no, please explain how the researcher will communicate with the subject population during recruitment, consent, and completion of the study.
   Yes.

8. There are instances in which an ethics committee (IRB equivalent) or other regulatory entity must review and approve the research. Please provide information about the committee or entity reviewing this project.
   The Health Services Authority Ethics Committee has reviewed the project proposal as written for the IRB and has provided approval for the project as of May 5, 2022. (See attached letter).

9. If the researcher is a student, describe how the faculty advisor and student will communicate to ensure there is adequate oversight of the project.
   The student and faculty member will be in constant communication and will be included on communications on all aspects related to the study. The project lead's preceptor will also be involved as he is associated with the organization.

Appendix T

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI

COMPLETION REPORT - PART 2
COURSEWORK

** NOTE: Scores, Da Transcript reflect the most current quiz completions, including quizzes on optional (supplemental) course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the

- **Name** Linda Shepherd (ID:
- **Institution** James Madison University (ID:
- **Institution** SHEPHELM@dukes.jmu.e
- **Institution** Nursin
- **Phone** 540239070

- **Curriculum** Human
- **Course Learner** Social/Behavioral Research
- **Stage** Stage 1 - Basic
- **Descriptio** Choose this group to satisfy CITI training requirements for Investigators and staff involved Social/Behavioral Research with human

- **Record** 4515731
- **Report** 19Se-
- **Current** 9

REQUIRED, ELECTIVE, AND SUPPLEMENTAL	MOST	SCOR
Students in Research (ID:	19Sep-	4/5
James Madison University (ID:	18Sep-	No
Defining Research with Human Subjects - SBE (ID:	18Sep-	5/5
The Federal Regulations - SBE (ID:	19Sep-	4/5
Belmont Report and Its Principles (ID:	18Sep-	3/3
Assessing Risk - SBE (ID:	19Sep-	5/5
Informed Consent - SBE (ID:	19Sep-	5/5
Privacy and Confidentiality - SBE (ID:	19Sep-	5/5
Research with Prisoners - SBE (ID:	19Sep-	5/5
Research with Children - SBE (ID:	19Sep-	5/5
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research	19Sep-	4/5
History and Ethical Principles - SBE (ID:	18Sep-	4/5

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program identified above or have been a paid Independent

Verify: www.citiprogram.org/verify/?k5b141376-001c-447e-a5c2619dc38583776-

Collaborative Institutional Training Initiative (CITI
Email: support@citiprogram.
Phone: 888-529-
Web: https://www.citiprogram

Appendix U

CITI Completion Certificate

CITI PROGRAM

Completion Date 19-Sep-2021
Expiration Date 18-Sep-2024
Record ID 45157316

This is to certify that:

Linda Shepherd

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Human Research
(Curriculum Group)
Social/Behavioral Research Course
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

James Madison University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w936f8f21-242a-4f21-9ebe-cf2353ed465c-4515731 6

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