Empowering Nurses to Lead Interprofessional Collaborative Practice Environments Through a Nurse Leadership Institute

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Abstract

A year-long Nurse Leadership Institute (NLI) for emerging leaders in primary care clinics and acute care environments was developed, implemented, and evaluated. The NLI’s goal was to foster empowerment in interprofessional collaborative practice environments for nurses in the three cohorts of NLIs. The NLI was framed around the Five Leadership Practices of modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart. To create a professional learning environment, foster community, and enhance leadership skills, the Lean In Circle materials developed by Sandberg were adapted for content reorganization and discussion. Minimal literature exists specifically addressing nursing leadership professionals’ development based on Sandberg’s Circle materials. The findings of the three NLI cohorts reported in this article begin to fill this existing knowledge gap. Participants reported a significant increase in leadership skills. Recommendations for refinement of future NLI offerings are provided.


Competency in interprofessional communication is vital for health care providers to deliver quality health care (Institute of Medicine, 2010) and interprofessional collaborative practice (IPCP) settings require skilled communicators (Oelke, Thurston, & Arthur, 2013). Because nurses comprise the largest segment of professionals in the health care industry, it is important that nurses demonstrate interprofessional communication skills and feel empowered to lead IPCP environments. However, there is significant variability in practicing nurses’ readiness and competency to engage in IPCP or lead interprofessional teams (Oelke et al., 2013). Hierarchical health system power structures that exclude empowered nurse leaders’ challenge nurses’ readiness and competency to lead IPCP (Rao, 2012). Therefore, enhancing IPCP team effectiveness requires that nurses accentuate their talent in building and sustaining relationships within their health care systems (Faulkner & Laschinger, 2008; Huber, 2013; Shirey, 2009). Given that nursing education only recently embraced interprofessional education (IPE), much of the current nursing workforce is naive to the competencies required to engage in IPCP as full partners of health care teams (National League for Nursing, 2016).

IPCP is defined as various health care professionals’ collective collaboration with patients, families, caregivers, and communities to produce superior care (World...
Health Organization, 2010). Interprofessional collaborative practice holds significant potential in achieving the Institute for Healthcare Improvement's triple aim to improve health care outcomes, decrease costs, and enhance the patient experience (Brandt, Lutfiyya, King, & Chioreso, 2014). To achieve these goals, nurses must develop leadership abilities to actively participate in IPCP decision making processes (Adeniran, Bhattacharya, & Adeniran, 2012).

Successful IPCP requires each team member to collaboratively function and effectively assume situational leadership roles. It is important to develop nurse leaders to engage in IPCP (Oelke et al., 2013). One way to develop nurse leader talents is through a nurse leader institute. This article describes the development, implementation, and evaluation of a Nurse Leadership Institute (NLI) for nurses in primary care and acute care settings.

OVERVIEW

The NLI was dedicated to fostering nurse empowerment to facilitate skillful nurse functioning within an IPCP environment. The NLI year-long experience focused on developing nurse leadership tools that could be used by nurse leaders in interprofessional settings. From 2013 to 2016, three cohorts of nurses completed the NLI. This structured leadership program provided nurses with the opportunity for personal and professional growth, enhancement of their engagement in interprofessional dialogue, and improvement of their leadership abilities. A Health Resources and Service Administration (HRSA) grant received by the schools of nursing and medicine at a midwestern state university in collaboration with primary care clinics (PCCs) and a large acute health care organization supported the NLI. Following the Indiana University Institutional Review Board permission for the overall grant, the institute was developed. The implementation of the NLI to empower nurses to lead was one activity related to the primary grant goal of fostering the development of IPCP environments in PCCs and acute care environments in central Indiana.

NLI PARTICIPANTS

The NLI included three sequential cohorts of nurses, with 25 primarily female participants, over a 3-year period. Cohort 1 consisted of five RNs from PCCs. Cohort 2 consisted of five RNs from PCCs and four RNs from acute care settings. Cohort 3 consisted of six RNs from PCCs and five RNs from acute care settings. In total, 16 NLI participants were from PCCs and nine were from acute care settings. Most participants were baccalaureate-prepared RNs, whereas one nurse was a licensed practical nurse and four nurses were master's-prepared RNs.

Both primary and acute care nurses were included in the NLI due to significant differences in the challenges encountered by nurses in the two settings. Some of the differences in the two settings found during the NLI are discussed. An example of the setting differences could be the isolated areas where the PCCs are located. The isolation of these areas results in these centers having a limited number of RNs. The isolation and limited resources of PCCs result in high RN turnover and create additional challenges in scheduling patients, patient throughput or flow, and the clinics' ability to support patient volume. The distinction between the PCCs and the acute care environment demonstrates the additional leadership development challenges faced by RNs in PCCs.

OVERVIEW OF THE NLI MODEL

Kouzes's and Posner's (2012b) model, The Leadership Challenge, guided the NLI. The Leadership Challenge encompasses the Five Practices of Exemplary Leadership®, model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. See Table 1 for Kouzes's and Posner's Five Practices of Exemplary Leadership and Poster Presentations for definitions and examples of the Five Practices used in participant posters. As seen in the participants’ posters, these practices are applicable to a variety of settings and roles and supported the NLI’s objective of empowering nurses to embrace a leadership role. The four IPCP competencies—values/ethics, roles/responsibilities, interprofessional communication, and teams and teamwork—drove the NLI’s content topics and methodology (Interprofessional Education Collaborative Expert Panel, 2011).

An overview of the Five Practices of Exemplary Leadership, the IPCP competencies, leading change within systems, and mentor selection, were introduced to each NLI cohort at their kickoff workshop. Faculty threaded the Five Practices of Exemplary Leadership and the IPCP competencies through the curriculum modules using a variety of strategies to enhance the application of the practices in participants’ team projects. A nursing Leadership Advisory Council of state and nationally recognized leadership experts guided NLI development activities.

Over the course of a calendar year, participants in the NLI attended three live workshops (at the beginning, middle, and close of the institute), engaged in eight 1-hour long conference calls spread throughout the year, and worked regularly with a leadership mentor to support their professional growth and leadership skill development. The NLI curriculum design included online modules. Participants completed the Leadership Practices Inventory® (LPI) pre- and postattendance to identify their baseline and post-NLI leadership behaviors (Kouze-
A self-assessment instrument, the 30-statement LPI measures the frequency of participant’s leadership behaviors in Kouzes’s and Posner’s (2012a) model. The LPI measures The Five Practices of Exemplary Leadership: “The essential psychometric properties of the LPI were investigated using the LPI normative database, with nearly 2.8 million respondents in hundreds of scholarly worldwide studies. The LPI is robust and applicable across a variety of settings and populations” (Posner, 2016, p. 1). The LPI’s reliability and validity has been established, and the LPI has been used worldwide (Fornito & Camp, 2010).

<table>
<thead>
<tr>
<th>Practice</th>
<th>Definition</th>
<th>Poster Example</th>
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<tbody>
<tr>
<td>Model the Way</td>
<td>“Clarify values by finding voice, affirm shared values of group, and set the example by aligning actions with shared values.”</td>
<td>Putting evidence into practice (PEP) rounding—Rounding with a purpose Integration of medical scribe in a pediatric primary care practice Teaching medication side effects: It’s the right thing to do Improving unit hospital consumer assessment of healthcare providers and systems (HCAHPS) Producing highly effective federally qualified health care center’s (FQHCs) medical teams in primary care settings Working towards high reliability</td>
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<td>Inspire a Shared Vision</td>
<td>“Envision the future by imagining exciting and ennobling possibilities. Enlist others in a common vision by appealing to shared aspirations.”</td>
<td>Putting evidence into practice (PEP) rounding—Rounding with a purpose Integration of medical scribe in a pediatric primary care practice Teaching medication side effects: It’s the right thing to do Improving unit hospital consumer assessment of healthcare providers and systems (HCAHPS) Producing highly effective federally qualified health care center’s (FQHCs) medical teams in primary care settings Working towards high reliability</td>
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<tr>
<td>Challenge the Process</td>
<td>“Search for opportunities by seizing the initiative and looking outward for innovative ways to improve. Experiment and take risk by constantly generating small wins and learning from experience.”</td>
<td>Putting evidence into practice (PEP) rounding—Rounding with a purpose Improving unit hospital consumer assessment of healthcare providers and systems (HCAHPS) Producing highly effective federally qualified health care center’s (FQHCs) medical teams in primary care settings Healthy heroes—Fighting childhood obesity Cardiac medical critical care professional leadership model</td>
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<tr>
<td>Enable Others to Act</td>
<td>“Foster collaboration by building trust and facilitating relationships. Strengthen others by increasing self-determination and developing competence.”</td>
<td>Building a better culture Bringing rounding to the bedside Structured orientation for new clinical employees</td>
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<tr>
<td>Encourage the Heart</td>
<td>“Recognize contributions by showing appreciation for individual excellence. Celebrate the values and victories by creating a spirit of community.”</td>
<td>Improving unit hospital consumer assessment of healthcare providers and systems (HCAHPS) Producing highly effective federally qualified health care center’s (FQHCs) medical teams in primary care settings Healthy heroes—Fighting childhood obesity Building a better culture Bringing rounding to the bedside Structured orientation for new clinical employees</td>
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Participants in the NLI also engaged in a team improvement project designed to apply Kouzes’s and Posner’s Five Practices to cultivate IPCP in their practice setting. The NLI participants developed posters and presented their projects at a year-end IPCP conference. Table 2 lists the content topics of the NLI curriculum.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Kouzes’s and Posner’s Five Practices of Exemplary Leadership®</th>
<th>Interprofessional Collaborative Practice Competencies Addressed</th>
<th>Content/Discussion</th>
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<tbody>
<tr>
<td>Prework</td>
<td>Overview of Kouzes’s and Posner’s Leadership Practices Inventory® (LPI®) Completion</td>
<td>Overview of competencies provided</td>
<td>Introduction to program</td>
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<td></td>
<td></td>
<td></td>
<td>Leading change within systems</td>
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<td></td>
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<td></td>
<td>Mentor selection considerations</td>
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<td>Live Workshops</td>
<td>• Kouzes &amp; Posner Overview (kickoff)</td>
<td>All</td>
<td>Leadership discussion</td>
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<tr>
<td></td>
<td>• Review status of projects and progress specific to Five Practices (mid-year)</td>
<td></td>
<td>Sharing reflections on leadership experiences prior to and during Nurse Leadership Institute</td>
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<td></td>
<td>• Discussion of Personal LPI® results (kickoff and final)</td>
<td></td>
<td>Debriefing on the impact of the Nurse Leadership Institute experience on their personal development and workplace (final workshop)</td>
</tr>
<tr>
<td>Online Modules (Monthly)</td>
<td>All modules had a specific focus</td>
<td>Threaded throughout modules:</td>
<td>Use of The Leadership Challenge book (Kouzes &amp; Posner, 2012b) and accompanying workbook (Kouzes &amp; Posner, 2012c)</td>
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<td></td>
<td>• Model the Way (Modules 1-2)</td>
<td>• Values/Ethics</td>
<td>Suggestion for Conversations with Mentor included in each module</td>
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<td></td>
<td>• Inspire a Shared Vision (Module 3)</td>
<td>• Interprofessional Communication</td>
<td>Personal audio stories specific to Five Practices threaded throughout the following:</td>
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<td></td>
<td>• Challenge the Process (Module 4)</td>
<td>• Teams/Teamwork</td>
<td>• Strength, Weakness, Opportunity Threat analysis</td>
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<td></td>
<td>• Enable Others to Act (Module 5)</td>
<td>• Roles/Responsibilities</td>
<td>• Specific, Measurable, Attainable, Relevant, and Time-bound objectives</td>
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<td>• Encourage the Heart (Module 6)</td>
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<td>• High reliability healthcare</td>
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<td></td>
<td>• Synthesis of all areas (Modules 7-8)</td>
<td></td>
<td>• Complex Adaptive System Theory</td>
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<td>• Stakeholder analysis</td>
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<td>• Change readiness</td>
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<td>• Emotional Intelligence</td>
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<td>• Cost-benefit analysis</td>
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<td>• Appreciation expression</td>
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<td>• Sacrifice, risks, difficult conversations</td>
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<td>• Leadership synthesis personal story</td>
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<td>• Leadership risk personal story</td>
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<td></td>
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<td>• Reflection on lessons learned and Nurse Leadership Institute year</td>
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THE NLI CURRICULUM ORGANIZATION

The NLI curriculum included prework, live workshops, online modules, and leadership improvement projects. Supporting the curriculum were conference calls, participant mentors, and a Leadership Advisory Council. Table 2 identifies curriculum content and the connections with Kouzes's and Posner's model and the IPCP competencies.

Prework

Prior to attending the first live workshop—the kickoff—participants completed the LPI and read the overview of the Kouzes’s and Posner’s (2012a) Leadership Challenge®. The content of the readings introduced participants to leading system change. Participants were also directed to begin exploring the opportunity of selecting a leadership mentor during the NLI.

Live Workshops

Curriculum implementation began with a kickoff workshop in which facilitators described the grant and the goals of the NLI and engaged participants in interactive dialogue with focused questions based on the Five Practice’s leadership content (Kouzes & Posner, 2012b). Participants completed a strengths, weakness, opportunity, and threat (SWOT) analysis of their organization (DeSilets, 2008) to assist in their selection of their leadership project and development of specific, measurable, attainable, relevant, and time-bound (SMART) goals (Revello & Fields, 2015). Each participant received a textbook (Kouzes & Posner, 2012b), a workbook (Kouzes & Posner, 2012c), an access code to the online LPI (Kouzes & Posner, 2012a), and a journal. At the second and third (final) live workshops, participants continued to engage in lively dialogue and provided examples of leadership experiences in their clinical settings and during mentoring. Participants discussed details of the leadership project and poster (see Improvement Project section below).

Conference Calls

One-hour long conference calls occurred eight times throughout each year of the NLI. Participants discussed the application of the Five Leadership Practices® in their health care settings. Stories were shared about the implementation of each practice, and participants asked questions, discussed the mentorship experience, and described leadership project opportunities and progress.

Online Modules (Monthly)

Online learning enables nurses to have access to material at their convenience (Arving, Wadensten, & Johansson, 2014). Participants also benefit from interactive learning within a community of peers, including RN and faculty interaction (Arving et al., 2013; Smith, 2010). One benefit of the online environment for the NLI was the convenient access to materials by participants from different geographic locations around central Indiana. The NLI online format was intended to facilitate discussion, support, and community building rather than focusing solely on learning content. Digital leadership stories in online learning were envisioned to enhance participant engagement and reflective thinking (Yang & Wu, 2012). By listening to stories from a variety of nurse leaders and participants, the NLI participants could visualize the application of concepts to real-world situations. Participants could also learn from the stories, reflect on their learning, and apply their learning to their practice settings.

Mentoring Relationships

As the literature supports the importance of mentoring during leadership development (Tabloski, 2016), NLI participants selected a leadership mentor. To more easily facilitate mentor selection, participants were provided an adapted mentoring manual at the first live workshop (Rawl, 2014; Williamson, 2014), which explained how to select a mentor and expectations of mentoring (Barrett, 2002; Fawcett & Desanto-Madeya, 2012). The definition of a mentor was an established authority and leader in a higher position, serving as a teacher, guide, and coach to provide a leadership experience (Barrett, 2002; Fawcett & Desanto-Madeya, 2012). Mentoring relationship content included phases and potential relationships. Mentee responsibilities included open, regularly scheduled, and collaborative communication with the mentor. Other responsibilities include mentee goal development, investment in goal achievement, and proactively seeking advice and providing mentor feedback (Fawcett & Desanto-Madeya, 2012; Hart, 2012). Participants requested assistance from the faculty in obtaining a mentor if they were unable to identify or experienced difficulty in obtaining a mentor. After agreeing to mentor participants, mentors were offered a stipend for mentee support.

Improvement Project

Throughout the NLI, participants developed an improvement project in their workplace using the Five Practices of Exemplary Leadership (Kouzes & Posner, 2012b) and the IPCP competencies. To integrate NLI learning into practice, participants developed posters to disseminate their work at the final NLI workshop. The participants’ posters contained detailed information on the connection between the Five Practices of Exemplary Leadership (Kouzes & Posner, 2012b) and their IPCP workplace projects. The NLI team developed questions to help participants reflect on project success and lessons learned.
throughout their project development. Faculty provided questions and templates for poster development to guide participants in framing their leadership success. Participants in all NLI cohorts presented their project outcomes at poster sessions during the HRSA grant-supported final workshops. Presenting posters allowed the participants to display their development and presentation skills and offered participants an opportunity to view their cohorts’ work in a public setting. The participants received their improvement project posters to provide them with the opportunity to display the posters in their practice settings. Participants could then post their work at their practice sites (Table 1).

Leadership Advisory Council

As previously mentioned, four nursing leadership experts provided guidance during the development, evaluation, and revision of the NLI. As challenges occurred with NLI participant attendance and engagement, the advisory council provided suggestions to increase participant engagement. As part of the NLI, the advisory council members also shared personal audio stories about how their leadership growth connected to The Five Practices of Exemplary Leadership model (Kouzes & Posner, 2012b).

FORMATIVE EVALUATION AND CONTINUOUS IMPROVEMENT

As previously mentioned, the NLI delivery occurred three times. Offering the NLI several times allowed for opportunities to evaluate and refine the quality of the curriculum and program development over time. Lessons learned from the early cohorts were used to enhance the NLI in subsequent cohorts. Formative evaluation of feedback from participants and faculty resulted in the identification of improvement in the delivery of the Five Leadership Practices (Kouzes & Posner, 2012b). Strengths of the NLI methodology included the live workshops with incentives for participation, the application of the LPI (Kouzes & Posner, 2012a), and dissemination of the improvement project with poster presentations. Concerns related to the implementation of the NLI included RN selection to participate in the program (described below), unclear expectations from organizational leaders about the use of work time for participation, participant difficulty finding appropriate mentors, lack of engagement with conference calls and online methodology, and loss of participants due to staff turnover in the PCCs.

Limitations for RN Selection

Due to the small numbers of RNs employed in the PCCs, the participants had many competing priorities that interfered with robust program participation. Leaders in PCCs and acute care settings selected participants for NLI attendance. However, the position demands limited the participation of some RNs in the NLI. Allowing nurses to self-select enrollment in leadership programs may increase engagement in future leadership programs. Participants also had many competing priorities that interfered with robust program participation. Competing challenges were evident not only in the PCCs with low numbers of RNs but also in the acute care environment. Competing demands affected participation and thus engagement. Clearly identifying the time requirements prior to participation may assist participants in committing time to the NLI. Faculty and potential participants considering future programs should determine whether participants are able to devote adequate program time for successful program engagement.

Unclear Expectations of the Use of Work Time for Participation

Some participants expected to complete NLI activities during their work hours. However, participants encountered difficulty in accessing computers at work and finding time to spend in the online environment during work hours. Inadequate staffing, high staff turnover, and spikes in workload were barriers to NLI participation. The NLI team had to work hard to overcome these challenges. For example, the NLI team found that the online forums were underutilized; therefore, the delivery format was changed to conference calls. The original expectation of NLI faculty was that participants would engage in online asynchronous discussion module forums to stay connected as a cohort of peers. The cohort connection was not effective with this methodology. Faculty changed the NLI delivery method to monthly conference calls with online content reflection. Online discussion participation was designated as an optional versus a required portion of the NLI.

Addressing Challenges With Leadership Mentor Selection

Several NLI participants struggled to identify a nurse leader who could provide mentorship for their development. Furthermore, several months were required to establish effective mentoring relationships. The mentor–mentee relationship required mutual efforts by faculty, participants, and mentors. The faculty team discovered that early mentor contact encouraged relationships for some NLI participants. Face-to-face meetings could enhance utilizing mentor–mentee guidelines. Those participants who had face-to-face contact with mentors had stronger relationships and support. When necessary, NLI faculty assisted participants in finding a mentor and making the initial connection. Mentors and mentees deter-
mined together whether their relationship would continue throughout the NLI time frame.

**Lack of Engagement During Conference Calls**

In the first NLI cohort, the team noted that the participants did not readily engage in the conference call format of content delivery and discussion. The structure of the early telephone meetings consisted of scheduled monthly calls with participants, faculty, and the project manager. The calls were initially deliberately unstructured for participant discussion. However, because the NLI participants’ nursing and leadership experience levels varied, the less structured format did not foster lively conversation. Subsequently, the team made several major changes to the NLI delivery approach because of this lack of engagement. The NLI team’s goals were to create a professional learning environment, foster a sense of community, and provide an alternative way to enhance participants’ leadership skills. Because of these goals, the team adapted the Lean In Circle model for content reorganization and discussion (Leanin.org, 2013, pp. 1-12). The storytelling component of Leanin.org (2013, p. 5) fit well with the use of digital storytelling in the NLI. Moreover, Leanin.org (2014, p. 1) describes three approaches to engage women (as many nurses and most attendees were women)—community, education, and circles—which clearly reflected the goals of the NLI. Using these three approaches, the NLI aimed to build a peer group of emerging leaders and provide engaging professional development with the Institute applicable for all NLI participants, regardless of gender. Currently, a paucity of literature exists specifically addressing nursing leadership professionals’ development based on Sandberg’s Circle group organization (Sandberg, 2013, p. 173). The findings of the three NLI cohorts reported in this article begin to fill this existing knowledge gap.

During the time of implementing the NLI, the Circles model organization described in Leanin.org (2013) used two moderator guides—one for exploration meetings and one for education meetings (Table 3). To meet the objectives of the NLI, the team selected aspects from each Circles meeting guide that fit the overall NLI objectives, online delivery method, and telephone dialogue time. The Circles meeting methods included (a) review of the One Action previous month goal, (b) focused Five Practices of Exemplary Leadership (Kouzes & Posner, 2012b) questions, (c) dialogue about leader story application to content, and (d) a wrap-up of the One Action goal call (Leanin.org, 2014, p. 3). The participant One Action goal stretched the participant’s level of comfort, provided new skill practice, and was concluded within the month (Leanin.org, 2014, p. 3). In addition, the participants described personal progress of leadership development and their IPCP improvement projects.

The new meeting structure used the NLI participants to moderate the calls as experiential learning strategies. This structure directly fulfilled the IPCP competencies related to communication and teams or teamwork. The moderating activity was included to facilitate the develop-

| TABLE 3  
| LEAN IN CIRCLE MODERATOR GUIDE ELEMENTS\(^{a,b}\) |
| Lean In Circle Moderator Guide Elements | Elements Used in Nurse Leadership Institute Calls and Meetings |
| Education Kit (Leanin.org, 2013, pp. 1-12): | • Check-in |
| • Check-in |
| • Member Updates |
| • Guided Discussion (includes “one action” identification) |
| • Personal Discussions |
| • Wrap Up |
| Exploration Kit (Leanin.org, 2013 pp. 1-14): | • Member Updates (on projects) |
| • Check-in |
| • Member Updates |
| • One Action Updates |
| • Personal Stories (from group members) |
| • Wrap Up (set one action for next month) |

\(^{a}\) Items in bold font are elements from either the Education or Exploration Kit integrated into the Nurse Leadership Institute calls and meetings.

\(^{b}\) From Circle Education Kit for Moderators and Circle Exploration Kit for Moderators, by Leanin.org, 2013. Copyright 2013 by Leanin.org. Adapted with permission.
ment of earlier career nurse leaders who lacked experience in formally leading meetings. It also allowed nurses with experience in leading meetings to refine their skill sets.

Faculty assigned moderation of a telephone call for each NLI participant. Intending to create consistency, faculty developed moderator guidelines for participants to conduct telephone meetings. The guidelines included information about participant preparation, ground rules, and agenda details, and it allowed for skills practice in leading meetings. Participants provided a reflection on the lessons learned from their moderating experience (Table 3).

The monthly telephone calls and moderating experiences improved attendee participation. Continual encouragement of participants with face-to-face meetings, e-mail communication, and leadership support helped sustain participation and engagement. Frequent updates to the organizational leaders about the progress and benefits of the NLI helped the leaders support and encourage the participants to engage in the program.

**Loss of NLI Participation Due to Staff Turnover**

RN turnover in PCC and acute care settings impacts staff productivity, patient safety, job satisfaction, and the cohesiveness of health care teams. Loss of RNs has a negative impact on positive patient care outcomes (Ritter, 2011). RN turnover also affected participation in the NLI, especially from the PCCs. Cohort 1, comprising only RNs from the PCCs, lost two of five (40%) of its participants due to job changes (outside of the clinic). Cohort 2 included RNs from both PCCs and acute care, and two of nine (22%) of participants from PCCs did not complete the NLI. The lack of program completion was due to a job change or a return to school for an advanced nursing degree (nurse practitioner). Cohort 3 consisted of RNs from both PCCs and acute care, and five of 11 (45%) PCC RNs left the organization due to job change, return to school for advanced degrees, or work-related priorities. In total, nine (36%) of the 25 PCC RNs did not complete the NLI. Reasons for not completing the NLI were primarily job changes and returning to school for graduate nursing education.

**SUMMATIVE EVALUATION AND OUTCOMES**

Of the 25 nurses initially involved in the NLI, 12 completed the LPI (Kouzes & Posner, 2012a) both before and after participation in the NLI: five from PCCs and seven from acute care. (Table 4). A one-way repeated measures ANOVA was conducted to evaluate the null hypothesis that there was no change in participant’s LPI scores when measured before and after participation in the NLI (N=12). The results of the ANOVA indicated a significant time effect for each of the subscales (p<.05), with a Bonferroni adjustment for multiple statistical tests. The partial eta-squared for each pairwise comparison ranged between .367 and .696, which suggested good effect size. Thus, there is strong evidence to reject the null hypothesis. Cohorts 1 through 3 were collectively analyzed due to the small sample size per cohort. Therefore, differences between cohorts were not identified. The pattern of meaningful differences from pre- to post-NLI overall was largely consistent across cohort groups for most of the subscales (Table 5).

NLI participants expressed positive leadership growth and improved collaborative practice. For example, one nurse stated: “Finding shared values with others helps us to communicate with each other and form a bond.” Another participant spoke of the improved collaborative communication skills: “My ability to communicate clearly and serve as a liaison between patients and physicians improved and I feel more confident in requesting things from the support staff and delegating tasks.” NLI participants enabled others to act: “Building trust with
the team and encouraging others to use areas of expertise built confidence in the staff.” Other participants encouraged the heart: “Recognizing accomplishments and success with notes and words of encouragement ultimately forms a more cohesive unit and unites our shared vision of caring for our patients in the best way possible.” Many participants grew through challenging the process: “Challenging the process involved taking risks, but by breaking the process down and achieving small wins, the process of change can be realized.” Participants discussed the value of the mentoring relationship: “One of the most influential aspects of this opportunity was the ability to work with the mentor, allowing a relationship of true collaboration and learning to guide growth.”

**RECOMMENDATIONS FOR FUTURE LEADERSHIP DEVELOPMENT ACTIVITIES**

The NLI team concluded that the institute was valuable in improving leadership skills and participants’ capacity based on two factors: improvements in LPI (Kouzes & Posner, 2012a) data from the start of the program to completion and anecdotal participant feedback. The team added successful program aspects to later cohorts’ leadership development activities.

The successful features of the NLI include close engagement with leaders from preprogram to completion, consistent structure of delivery methods that allowed for flexibility, development of a concrete project to apply concepts and skills, and provision of a convenient way to understand and apply the Five Practices of Exemplary Leadership (Kouzes & Posner, 2012b).

Faculty and leaders supporting participants will need to provide clarity around program expectations, attendance, and participation requirements prior to program enrollment. Clear expectations and requirements may enhance participant commitment and engagement with the program. Enhanced participant support by faculty leaders may also lead to participants feeling more inclined to contribute. Combining a clear structure of content and meetings with some flexibility in delivery allowed the program team to guide productive participation with clear expectations. In parallel, clear structure with flexibility provided the team the ability to address unexpected changes and challenges without derailing the program. The inclusion of a realistic and applicable project is important to allow illustration of theory application, leadership modeling, course content integration, and participant reflections. Realistic, clear expectations allowed participants to feel a sense of accomplishment in goal achievement and to be able to share success with others through poster presentations. Finally, a relatable model used in a wide variety of minimally complex settings and roles allows early participant attendance, engagement, and application of leadership concepts in practice settings.

Several lessons learned from the NLI could be considered at the inception of a new program. A preassessment of each nurse participant site could include information about participant learning styles, technology access, schedule flexibility, and typical staff turnover trends. This would provide the program team important information on program customization. Accommodating workplace resources and norms, preparing for potential turnover, and understanding typical workplace changes prior to program development can help facilitators mitigate potential issues. Clear communication of program requirements and the benefits to the organization of enhanced RN leadership skills can be helpful in acquiring mutual understanding of the site leaders and participants. To better gauge leaders’ professional development interests, future programs could include a personal talent needs assessment. Examples of these needs could be related to communication strengths,
challenges with time management, and approaches to crucial conversations.

Future programs could also consider a separate cohort of nurses from PCCs, where only a few staff RNs have a wide range of responsibilities with little flexibility. Separate cohorts may enable these RNs to build a tighter network of support. Tailoring leadership programs for RNs working in PCCs may enhance collegial learning. Increasing the size of the cohorts in future programs could also provide further opportunities for nurse discourse in acute care and PCCs.

During the NLI, the nurses in PCCs faced more challenges in maintaining mentoring relationships due to distance from mentors and less flexibility in schedules. The acute care RNs had increased accessibility to mentors due to a larger number of available nurses willing to mentor them and nurse schedule flexibility. The PCC participants had difficulty identifying and connecting with a mentor and expressed challenges in maintaining consistent mentor contact. Turnover of the RNs in PCCs directly influenced their ability to dialogue with NLI participants. Not all RNs from PCCs completed the NLI. Challenges to participation influenced the size of the cohorts and the number of PCC participants. Telephone calls and workshops tended to favor acute care issues over PCC conversations due to the higher number of acute care nurses in the NLI. Challenges in the competing priorities in the PCCs limited their time for assignment completion, call participation, and workshop attendance.

CONCLUSION

The NLI was successful in developing leadership behaviors in participants. The Institute supported leadership behavior modeling in workplace projects. Work guiding nurse empowerment in IPCP was successful. A leadership program based on the NLI framework could be implemented across nursing practice settings. Recognizing the lack of engagement and participation by NLI emerging nurse leaders, content and processes were altered to enhance content delivery and facilitate learning.

Consideration of participant selection affects attendance and engagement. Identifying technology infrastructure in different settings prior to inception could guide content delivery considerations. Focus groups with the targeted audience could provide additional content and delivery suggestions prior to program development. Identifying how nurses in the settings best learn can also guide the foundation and scaffolding needed to facilitate leadership enhancement initially, versus refining the program content and delivery after program initiation. Exploring other leadership development models, technology, and learning management systems could also improve attendance participation, leading to improved engagement.

REFERENCES


