Leadership Behaviors of Frontline Staff Nurses

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Leaders are described as individuals who are committed and capable of making appropriate decisions, and who identify common goals and values with others. Leaders provide hope, guidance, vision, and direction to move forward and succeed, which is important for both leaders and followers (Bormann & Abrahamson, 2014; Burns, 1978; Maxwell, 1999). The Institute of Medicine’s (IOM, 2010) report, The Future of Nursing: Leading Change, Advancing Health, emphasizes that strong nursing leadership is necessary to improve patient safety outcomes and that the nursing profession must enhance its leadership role in health care redesign.

Although a number of studies have been conducted to examine leadership behaviors of nurse managers and executives (Cummings et al., 2010; New 2009; Oliver, Gallo, Griffin, White, & Fitzpatrick, 2014; Wong, Spence Laschinger, & Cummings, 2010), far less attention has been directed to the leadership behaviors of clinical nurses who provide day-to-day direction on the frontlines of care. These nurses possess many of the skills necessary to build healthy work environments that support professional practice, quality patient care, and outcomes. Therefore, this study examined the leadership behaviors of clinical staff nurses who have firsthand experience of the needs and desires of patients.

TRANSFORMATIONAL LEADERSHIP

Transformational leadership is described as highly suited for the nursing profession since it is empowering, caring, and ethical (Ross, Fitzpatrick, Click, Krouse, & Clavelle, 2014; Trofino, 1995). Transformational leaders...
in nursing have expertise and strong nursing knowledge, have a vision and can influence others, and can meet the challenges necessary for quality patient care and patient outcomes (Jooste, 2004). Transformational nursing leaders build teams and share the decision making process with the staff. The leaders change practice according to the feedback of the team. In addition, transformational nursing leaders effectively communicate to advocate for both patients and the profession (Thyer, 2003).

Transformational leadership theory is particularly applicable to the clinical nursing arena, which encompasses patient care demands, extended work hours, varied educational backgrounds, and the intense physical labor required of nurses. The transformational leadership style focuses on qualities that are necessary to meet current changing organizational and health care needs. Leadership behaviors must support high skill levels, align with organizational goals and vision, and promote decision making at the point of clinical care. Use of this leadership style may benefit both organizations and patients (New, 2009), and may improve nursing staff satisfaction.

STAFF NURSES AS CLINICAL LEADERS

Staff RNs are the clinical leaders at the bedside. Clinical nurses collaborate with the health care team, patients, and their families. They are the change agents who transform the patient experience. There are few studies in the literature related to the leadership behaviors of clinical staff nurses who often make primary decisions related to patient care and safety, even though proficient clinical nurses are developing leadership qualities in nursing practice (Valentine, 2002).

Recent research and evidence-based practice demonstrate that nurses who participate in clinical leadership can develop and practice transformational leadership qualities (Habel & Sherman, 2012). A study by Abraham (2011) evaluated the outcomes of a leadership program. Clinical nurses who are aware of their own leadership behaviors have the opportunity to transform through leadership training and development. With additional leadership development, clinical nurses may feel empowered, seek best nursing practices, and implement new patient care strategies. These clinical nurses joined committees, participated in scholarly projects and research, published articles, and provided quality patient care (Abraham, 2011). Clearly, staff nurses at the bedside have the power to influence patient outcomes and professional productivity.

Another study by George et al. (2002) examined a leadership development program with staff clinical nurses. The shared leadership program assisted clinical nurses in acting autonomously, advocating for patients by problem solving, and developing a shared vision to accomplish organizational goals. The clinical staff nurses developed leadership qualities necessary for technical competence and interpersonal growth. Clinical nurses noted improved confidence, feelings of empowerment and assertiveness, increased problem solving ability, and increased teamwork to improve patient outcomes (George et al., 2002).

Research findings (Gossett & DeTata, 1992; Redman, 2006; Trofino, 1995; Watts, 2010) indicate that leadership development programs may be necessary for clinical nurses to transition from staff to leader to meet the goals of the organization. Clinical nurses preparing to be future nursing leaders will contribute to successful quality patient care and will meet the needs of the health care organization (Redman, 2006). The new Magnet model supports clinical staff development in leadership (Bormann & Abrahamson, 2014). Competence-based programs provide personal and professional growth to clinical nurses. By using new knowledge, the practice environment becomes a rewarding and challenging experience for staff clinical nurses. Clinical nurses become specialists in their new knowledge by planning to meet the patients’ needs (Gossett & DeTata, 1992; Watts, 2010).

The challenges of health care reform have demonstrated the importance of keeping expert nurses at the bedside and promoting their professional development. Expert nurses are essential to health care cost containment and providing quality care (Kramer, Schmaling, & Maguire, 2008; Shapiro, 1998; Watts, 2010). These nurses are guided by immediacy, take measures to understand situations, deal with complex situations, manage multiple tasks, meet patient and family needs, and negotiate and collaborate with the health care team. Studies of expert clinical nurses have noted a positive correlation between retention and improved patient outcomes (Shapiro, 1998; Watts, 2010). Leadership development and training may be a key component to the changing health care environment and the nursing profession (Cook, 1999; Watts, 2010).

Leadership competencies including education, coaching, and mentoring may be beneficial to clinical nurses to develop experience in strategic decision making. Participation in clinically related work projects provide clinical nurses the opportunities to develop leadership behaviors with necessary guidance and support (Redman, 2006).

CLINICAL LADDER PROGRAMS

Clinical ladder programs provide a system within hospital organizations to reward and recognize excellence in practice. Experienced clinical ladder nurses may have increased levels of competence and problem
solving tactics, and may have the opportunity to mentor or be mentored. The knowledge that expert clinical ladder nurses possess may be useful in meeting the needs of the changing health care environment (Kramer et al., 2008; Watts, 2010). Clinical ladder programs for nurses were once considered to be a retention tool. Currently, clinical ladder programs provide nurses an opportunity for advancement while remaining at the level of patient care. Nurses participating in clinical ladder programs at higher levels of such ladders demonstrate analytical assessment and problem solving skills that are not always captured and passed on to others, even though mentoring is a source of growth and stimulation (Krugman, Smith, & Goode, 2000). In addition, these training programs also focus on being a role model and challenging and encouraging younger colleagues to participate in continuing professional education, certification, organizational membership, leadership, community service, committees, mentorships, coaching, and research activities.

Given this training, one would expect that nurses who are higher on the clinical ladder would demonstrate more leadership behaviors. In addition, one study evaluating career ladders for clinical staff nurses in ambulatory care noted significantly more activity in interdisciplinary and quality improvement projects (Nelson & Cook, 2008). Another study examined nurses’ clinical expertise and professional characteristics and found that clinical nurses develop expertise as a result of experience. Frequent exposure to similar types of patients leads to outcomes that are familiar to the caregiver (Bobay, Gentile, & Hagle, 2009). This research would suggest that older and more experienced clinical ladder nurses would show greater leadership behaviors, although the literature on burnout could argue that older and experienced nurses who do not advance in organizations might demonstrate fewer leadership behaviors and decreased feelings of personal accomplishments (Kovacs, Kovacs, & Hegedus, 2010; Robinson et al., 1991).

Therefore, identifying leadership behaviors present in clinical nurses who are frontline caregivers and patient advocates may clarify areas in which leadership changes can be enhanced. This study examined:

- Self-perceived leadership behaviors of RNs participating in a clinical ladder program.
- Differences in self-perceived leadership behaviors among nurses across levels of a clinical ladder program.
- Relationships between age and experience with leadership behaviors of nurses in a clinical ladder program.

**METHOD**

**Design**

A descriptive, correlational, cross-sectional study design was used as the research method. The study surveyed one group of clinical ladder nurses at one time.

**Setting**

The study setting was a large, tertiary care medical center in the northeastern United States. A total of 1,674 staff RNs were employed at the institution, and the clinical ladder program included 6.3% of the staff RNs.

**Sample**

A convenience sample of RNs was used. Inclusion criterion focused on active membership in the clinical ladder program. All clinical ladder nurses (N = 102), except the principal investigator (C.F.) who was employed at the institution, were invited to participate. The clinical ladder program had 41 participants in level 1, 27 participants in level 2, and 35 participants in level 3.

**Clinical Ladder Level**

The clinical ladder is based on accrual of points through active participation in the five focus areas of research, quality, education, service excellence, and leadership. The point requirement for RNs who apply for clinical ladder level 1 is 150 points from three of the five focus areas, 225 points from four of the five focus areas for level 2, and 300 points from across all of the five focus areas for clinical ladder level 3. Points for the clinical ladder program can be accrued from the following categories:

- Attainment of advanced degree in nursing.
- Specialty nursing certification.
- Approved nonrelevant certifications.
- Continuing education hours.
- Oral presentations.
- Poster presentations.
- Publications.
- Quality improvement projects.
- Committee memberships.
- Letters of commendation.
- Service excellence.
- Participation in community service.
- Assigned as clinical coach or mentor.
- Charge nurse fill in.
- Attendance at leadership development course.
- Professional awards.

Each category is assigned a point value and relevant focus areas (North Shore-Long Island Jewish Health System, 2010).
Instruments

All instruments used in this study were formatted for self-report. Leadership behaviors were assessed with the Leadership Practice Inventory (LPI) (Kouzes & Posner, 2003). The LPI is a 30-item assessment survey that provides a way for individuals to measure the frequency of their own leadership behaviors on a 10-point Likert-type scale. Higher scores exhibit behaviors used most often and represent strengths. Lower scores represent opportunities for improvement (Kouzes & Posner, 2003). Leadership behaviors are measured in five subscales:

- Modeling the way.
- Inspiring a shared vision.
- Challenging the process.
- Enabling others to act.
- Encouraging the heart.

The scores can be calculated as percentages, means, and standard deviations. Cronbach’s alpha for the total LPI of this study is reported as 0.95. Cronbach’s alpha for the LPI range from 0.69 to 0.85, with subscale alphas of 0.91 (enabling others to act), 0.86 (encouraging the heart), 0.91 (inspiring a shared vision), 0.86 (challenging the process), and 0.84 (modeling the way) (Posner, 2010). Test-retest reliability is reported as 0.93 (Houser, 2003; Patrick, Laschinger, Wong, & Finegan, 2011).

The demographic questionnaire assessed the variables of age, gender, ethnic background, marital status, education, certification, employment status, total years of RN experience, total years in current position, and total years with current organization. The leadership attributes assessed preceptor experience, previous leadership training, charge nurse experience, participation in committees, quality improvement projects, and the five focus areas of the clinical ladder program.

Procedure

After receiving institutional review board approval, the study was introduced at the monthly clinical ladder meeting. One week prior to sending the surveys, an introductory e-mail was distributed. All clinical ladder nurses received a paper packet that included the demographic questionnaire, the LPI self-report assessment survey, consent for participation, and a stamped addressed envelope for returning the questionnaire. A reminder e-mail was sent 2 weeks after the survey distribution.

RESULTS

Of the 102 clinical ladder RNs, 74 (72%) completed the demographic questionnaire and 73 (71%) completed the LPI survey. A description of the sample group was gathered from the completed surveys. The age range was 24 to 66 years (mean age = 42 years). Both female (n = 71, 96%) and male (n = 3, 4%) clinical ladder nurses enrolled in the research study. Eighty-six percent of the participants were baccalaureate-prepared nurses with nationally recognized certification in their specialty area. Twenty-four percent were currently enrolled in continuing formal education at the master’s degree level. More than 90% of nurses had preceptor, charge nurse, and quality improvement experience. Sixty-four percent of nurses had participated in leadership and interdisciplinary committees, 37% had previous leadership training, and 27% had previous management experience in nursing or another field. The clinical ladder nurses also participated in the focus areas of education (100%), research (78%), quality (97%), service excellence (92%), and leadership (88%; Fardellone & Click, 2013).

Mean LPI subscale scores are summarized in Table 1. Actual subscale scores ranged from 8 to 60. At least one nurse scored her own self-perceived leadership behavior with a maximum score of 10 for the six questions related to the subscale. The behaviors used in order of frequency were enabling others to act, modeling the way, and encouraging the heart; challenging the process and inspiring a shared vision were used somewhat less frequently, but mean scores were two thirds of the maximum value. Among all levels, enabling others to act was used most frequently whereas inspiring a shared vision had the larg-
The second research question compared mean LPI subscale scores across clinical ladder groups. Analysis of variance (ANOVA) revealed no significant differences in any of the mean subscale scores among levels 1, 2, and 3 of the clinical ladder nurse program. No significant differences between ladder levels for any of the mean subscale scores were found, even after adjusting for years of experience as an RN. Unadjusted means and standard deviations are summarized in Table 2.

The last research question examined the demographic factors associated with ladder level and LPI subscales. Age, years of experience as an RN, years with current organization, and years in current unit were all correlated with each other. Pearson correlation ranged from $r = .73$ to $r = .92$, $p < 0.0001$ for all correlations (Table 3).

Table 4 summarizes the correlation between LPI subscales and factors of age, years as an RN, years in current unit, and years with current organization. Nurses with more experience showed fewer leadership behaviors. Pearson correlation ranged from $r = -.26$ to $r = -.46$, $p < 0.05$.

DISCUSSION

The IOM (2010) report recognizes the need for the nursing profession to enhance its leadership role in health care redesign. This study provides new evidence evaluating leadership behaviors and provides insight into leadership behaviors that may affect patient outcomes. Clinical ladder nurses choose to remain at the forefront of care, advocate for patients, and become experts in clinical practice (Riley, Rolband, James, & Norton, 2009). Clinical ladder programs motivate staff nurses to enhance professional development and provide an opportunity for growth while remaining at the frontline of patient care (Krugman et al., 2000).

Clinical ladder nurses possess leadership behaviors noted in the LPI. Nurses’ highest average response was in the category “enabling others to act.” This behavior fosters collaboration and builds group strength by helping nurses to develop competence and self-determination. “Modeling the way,” which was the second highest average response, allows nurses to clarify values and set examples with shared values. The third highest average response, “encouraging the heart,” is a behavior that recognizes contributions and creates a feeling of community. The fourth response, “challenging the process,” looks for ways to improve and learn from experience. The least commonly endorsed response was “inspiring a shared vision,” which enlists others to imagine the future, share possibilities, and communicate the recommendations (Kouzes & Posner, 2003).

The findings from this study agree with Abraham’s (2011) results. Findings of this study indicate a deficit in leadership behaviors for clinical ladder nurses with greater experience, indicating a need for professional development to enhance leadership skills. By assisting clinical nurses, health care institutions and patients may benefit from the quality care provided at the bedside. Clinical nurses need to be aware of their own leadership behaviors and have the opportunity to transform...
through leadership training and development. Nurses who participated in the educational leadership program with theoretical knowledge, competencies, and opportunities to practice leadership skills demonstrated changed leadership skills and professional behavior following the education (Abraham, 2011).

The transformational leadership practices of chief nursing officers cannot be understated. In a study of Magnet hospital chief nursing officers, findings indicated that nurse executives influence quality clinical and patient care by creating structures and processes that support nurse empowerment and evidence-based practice. Study results noted greater transformational leadership behaviors with years of nursing leadership experience and advanced education, but the opposite was found in the current study relative to clinical ladder nurses. “Enabling others to act” and “modeling the way” were the top two practices of the chief nursing officers (Clavelle, Drenkard, Tullai-McGuinness, & Fitzpatrick, 2012).

Chief nursing officers with formal education and years of leadership experience scored significantly higher in “challenging the process” and “inspiring a shared vision” compared with clinical ladder nurses who scored lowest on these subscales. Whereas clinical ladder nurses are experienced in disease management, they seem to lack leadership behaviors. Health care organizations must determine whether staff nurses lack leadership behaviors due to educational barriers or a lack of participation in leadership projects and activities that promote transformational leadership qualities. Providing leadership development opportunities to clinical ladder nurses may introduce the qualities of transformational leadership, which are teachable qualities (Clavelle et al., 2012; Kouzes & Posner, 2003).

This study has provided baseline information to better understand the leadership behaviors of RNs who are frontline caregivers and patient advocates. Surprisingly, the clinical ladder nurses with more years of RN experience reported fewer leadership behaviors. This is in direct contrast to the findings of Clavelle et al. (2012). There is a need to address the educational gap of leadership training and to evaluate the obstacles that may be preventing frontline staff nurses from leading their patients to better health care outcomes.

In addition, this study validates the need to have nurse managers prepared at the graduate level. A master’s education prepares nurses to take critical action to solve complex problems in the changing health care environment (Scott & Yoder-Wise, 2013). Future nurse leaders must participate in formal education and develop appropriate attitudes and beliefs to be leaders in health care reform (Bish, Kenny, & Nay, 2012).

**STRENGTHS AND LIMITATIONS**

Strengths of this study include a response rate of 71%, use of a valid and reliable tool, and a diverse sample of clinical ladder nurses. This study provides baseline information for future research studies and may also provide valuable information for health care systems to plan for future leadership development to promote professional nursing practice. Although the response rate was adequate for questionnaire survey design (Dillman, 2000), the study may have been under-powered, with insufficient numbers of nurses in each of the clinical ladder groups to detect leadership subscale differences even though the mean scores suggest that the level 3 nurses may have scored lower on several subscales, but higher on role modeling behaviors.

Limitations of this study include the fact that the LPI was self-administered in evaluating self-perceived leadership behaviors. The LPI is also available as a 360° data collection method. Using that method may have enabled capture of strengths and weaknesses in leadership qualities because it evaluates how three other cowork-

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**TABLE 4**

**CORRELATION BETWEEN LEADERSHIP PRACTICE INVENTORY SUBSCALES AND DEMOGRAPHIC FACTORS**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Age (n = 70)</th>
<th>Years as RN (n = 73)</th>
<th>Years in Current Unit (n = 73)</th>
<th>Years With Current Organization (n = 73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modeling the way</td>
<td>−.17</td>
<td>−.26**</td>
<td>−.17</td>
<td>−.22</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>−.29**</td>
<td>−.39***</td>
<td>−.33***</td>
<td>−.44****</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>−.28**</td>
<td>−.38***</td>
<td>−.32***</td>
<td>−.38***</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>−.36***</td>
<td>−.46****</td>
<td>−.37***</td>
<td>−.39***</td>
</tr>
<tr>
<td>Encouraging the heart</td>
<td>−.15</td>
<td>−.27**</td>
<td>−.25**</td>
<td>−.22*</td>
</tr>
</tbody>
</table>

*p < 0.10. **p ≤ 0.05. ***p ≤ 0.01. ****p ≤ 0.001.
Leadership Behaviors of Nurses

1. Clinical ladder nurses with more years of RN experience reported fewer leadership behaviors.
2. Enabling others to act was the most frequent leadership behavior identified by clinical ladder nurses.
3. Professional development is necessary to enhance leadership skills in all areas of nursing practice.

is to use this study to compare experienced RNs to new graduate nurses. These data may provide evidence to correlate leadership behaviors from professional experience and academic training, and may be beneficial in the development of leadership education and competencies (IOM, 2010).

Strengthening leadership capabilities within nursing is important as health care continues to evolve and grow. This study has added to the knowledge base on leadership within clinical ladder nursing programs. Ensuring that nurses develop their skills and leadership competencies over time will impact patient outcomes and will be a critical component of health care redesign going forward. Nurses who choose to remain at the frontline of patient care make extra efforts to improve the lives of their patients every day.

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