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Implementing the Practice of Caring Leadership in a Senior Living Home Care Setting

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Abstract

Purpose

The purpose of this study was to implement a four-week educational practicum focused on the practice of caring leadership in a senior living home care setting and determine how this approach impacted the therapeutic interactions and leadership competencies of home care team members.

Background

Caring practice models have been implemented in various health care settings. However, little is known about what kinds of interventions can develop leadership effectively or how to evaluate the impact of leadership on health care providers' use of caring behaviors in professional practice.

Design

Descriptive, mixed methods.

Methods

The Caring Assessment for Caregivers (CACG) instrument and the Leadership Practices Inventory – Self (LPI-S) instrument measured change in therapeutic interactions and leadership skills, respectively, before (pre-survey N = 24) and after (post-survey N = 15) facilitating multi-site practicum sessions for caring leadership practice enculturation.

Findings

Among practicum participants, the mean change from baseline for the LPI-S and CACG subscales represented statistically significant improvement in all variables ($P=0.0009$ LPI-S; $P=0.006$ CACG). The themes and subthemes identified suggest leadership and relational expertise can be described within the context of professional, relationship-based practice.

Conclusion

The caring leader practicum intervention, a low-cost, workplace approach, was successful in impacting the outcome variables in a short 4-week time period.

Implementing the Practice of Caring Leadership in a Senior Living Home Care Setting

The health care imperative is a complex duality comprised of the need to stay clinically competent in technical skills and the need to personally interact with the human being for whom the provider is caring. When the technical aspects are favored, the development of human relationships is placed secondary to the task at hand (Duffy, 2005; Flöjt, Hir, & Rosengren, 2014; Shorr, 2000). In this moment, when administrative tasks supersede professional commitments, health care providers must reevaluate, allocate, and accept individual responsibility for decision-making about patient care priorities (Glebocki & Fitzpatrick, 2013; Koloroutis, 2004; Wessel & Manthey, 2015). Caring leadership addresses the dual nature of health care work as it requires that providers understand and value the human connection, are aware of their own strengths and limitations, and know how to lead with compassion and empathy within the context of a caring relationship (Kouzes & Posner, 2012; Williams, McDowell, & Kautz, 2011).

The project site, a senior living community, operates with the intent of bringing leadership into professional practice and driving the care paradigm through patient-provider engagement (J. Peters, personal communication, 2015). There are several perceived factors that impede the provision of professional, relationship-based care. A lack of time to engage in relational practice has been cited as a primary, frequent barrier (Glebocki & Fitzpatrick, 2013). Other factors include poor allocation of responsibility for relationships and an absence of presence and sensitivity to the vulnerability of others (Koloroutis, 2004; Wessel & Manthey, 2015). Home care team members generally believe that they do not have enough time to engage in anything more than the task at hand, and consequently, there are minimal or compromised

efforts exercised in executing the professional responsibilities required for caring leadership in practice.

Purpose

The purpose of this study was to implement a four-week educational practicum on the practice of caring leadership in a senior living home care setting and determine how this approach impacts the therapeutic interactions and leadership competencies of home care team members.

Literature Review

Today's health care system has benefited immeasurably from advances in technology. This powerful factor has driven significant strides in the treatment of many formerly untreatable diseases so that health profession education and practice have become mutually dependent on technology (Malloch, Sluyter, & Moore, 2000; Williams, McDowell, & Kautz, 2011). In clinical practice, the time spent with patients is the minimum required to assess and treat, usually by means of medication or some other technological alternative (Malloch, Sluyter, & Moore, 2000). Greater emphasis is placed on the technical components of the work than on the relational components, resulting in a lost sense of purpose and meaning for the provider (Duffy, 2005; Malloch, Sluyter, & Moore, 2000; Williams, McDowell, & Kautz, 2011). In addition, a relationship-oriented approach has been found to produce greater cohesion and productivity among teams than a task-based application (Burke et al., 2006).

The task-centered, mechanical practice of many health care providers is not what would be expected of educated, caring professionals (Shorr, 2000; Stuart, Jarvis, & Daniel, 2008). Day-to-day patient care tasking is performed in a perfunctory manner. For example, notes are charted, phones are answered, and treatments are administered (Shorr, 2000). Administrative work is not

seen to contribute to one's professional development, whereas patient care is a priority and the most personally satisfying work task (Flöjt, Hir, & Rosengren, 2014; Stuart, Jarvis, and Daniel, 2008). Relationships with patients, families, and colleagues need to be manifested through the health care providers' professional skills and task prioritizations. Shifting the focus back to a relational practice approach requires caring interactions and leadership competencies (Kouzes & Posner, 2012).

The constant turbulence within the health care system rapidly presents providers with stimuli, interruptions, and competing priorities. Health care providers in all roles must effectively manage numerous demands to make timely, accurate decisions affecting human lives (Pipe et al., 2009). The technical strains of daily operations are major factors mitigating the wellbeing and professional satisfaction in challenging work environments (Dewar & Cook, 2014; Pipe et al., 2009). There is a link between the cultural health of the workplace and the welfare of staff, and healthy workplaces are directly correlated with healthier patients (Dewar & Cook, 2014). Relational care is an authentic connection between a vulnerable human being and a caring provider. The complexities of the health care system do not diminish the need for crucial relational care. In fact, the need for higher level caring skills and knowledge has escalated (Steele-Moses, Koloroutis, & Ydarraga, 2011). It is through specific shared leadership practices that health care providers may promote and foster a meaningful, productive practice environment (Westen et al., 2002).

The stakes of achieving success are extraordinarily high in health care. Providers must cope successfully with the administrative constraints of the work environment to produce quality patient outcomes and achieve professional goals. Stress negatively impacts individual and organizational performance (Pipe et al., 2009). Stress may also impact the nature of the caring

relationship and healing environment, interfering with a provider's ability to observe, listen to, understand, and know the patient, thereby reducing the opportunity to connect with and advocate for the patient (Manojlovich, 2005; Pipe et al., 2009).

Effective stress management has important implications for competent professional performance. Health care providers caring for self and for others have the potential and means to demonstrate compassionate leadership. Watson (1999) conceptualized mindfulness as a way of nurturing the self so that one's leadership could be more caring and effective by extension. High-performance leadership and results benefit from self-reflection (Watson, 1999). By learning to be fully present with oneself, providers can become more completely present and engaged with others and with situations as they emerge, thereby increasing their positive leadership impact through better teamwork, collaboration, communication, and decision-making (Pipe et al, 2009; Watson, 1999).

Although the need to develop leadership capacity has been emphasized in literature (Dewar & Cook, 2014; Gifford et al., 2013; Manojlovich, 2005; Westen et al., 2002; Williams, McDowell, & Kautz, 2011), little is known about what kinds of interventions can develop leadership effectively or how to evaluate the impact of leadership on health care providers' use of caring behaviors in professional practice. Few studies have examined the impact of relational and professional expertise on health care process outcomes. The research that does exist focuses specifically on nursing practice and patient measures (Pipe et al., 2009; Watson, 1999; Williams, McDowell, & Kautz, 2011; Wong & Cummings, 2007). Research that has examined the relationship between leadership and caring theory in health care practice is minimal (Koloroutis, 2004; Kouzes & Posner, 2012; Tonges & Ray, 2011). Accomplishing professional, relationship-

based practice demands the organizational alignment of philosophy, vision, values, structure, and relationships. Caring leadership provides a framework for this alignment and integration.

Theoretical Framework

The theoretical framework was guided by Swanson's midrange theory of caring (1993) and Kouzes and Posner's leadership theory (2012). Swanson asserts that "caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (1993, p.165). Derived from research, Swanson's structure of caring provides a coherent explanation of the links between caring processes and patient wellbeing. There are five processes for caring and therapeutic interactions. The first two processes, Maintaining Belief and Knowing, provide the philosophical foundation for establishing respectful relationships. The other three processes, Being With, Doing For, and Enabling/Informing, can be thought of as the "how" of interaction. All five processes are components of caring relationships (Tonges & Ray, 2011).

The leadership theory of Kouzes and Posner (2012) is grounded on the belief that leadership is a relationship that is value-based with a foundation of integrity. The theory consists of a set of principles that address the leadership responsibilities and intrinsic motivations necessary for leaders to accomplish their personal best within health care practice. There are five core practices embedded in this theory that are positively related to both the effectiveness of leaders and the level of commitment, engagement, and satisfaction of those being led (The Leadership Challenge, 2017). The five practices of exemplary leadership include: Inspire a Shared Vision, Challenge the Process, Encourage the Heart, Model the Way, and Enable Others to Act. These practices serve as a guide for nurturing the leadership capacity in anyone.

Attaining this form of leadership requires mastery of the caring skills central to developing, growing, and maintaining relationships with others (Williams, McDowell, & Kautz, 2011).

Caring leadership marries these theories to create an effective basis for implementing leadership in professional, relationship-based practice. Integrating the five caring processes and the five practices of exemplary leadership codifies a set of values that turn the concept of caring leadership into practical behaviors that can be applied by anyone, at any level, willing to step up and accept the challenge to lead (Williams, McDowell, & Kautz, 2011). These theories are adapted to caring leader behaviors and utilized as the framework for this study (Table 1).

Table 1 <i>Theoretical Framework</i>		
Five Caring Processes (Swanson, 1993)	Five Leadership Principles (Kouzes & Posner, 1995)	Caring Leader Behaviors (Adapted)
Maintaining Belief	Inspire a shared vision	A caring leader finds meaning in challenges and participates in solutions.
Knowing	Challenge the process	A caring leader strives to understand an event as it has meaning to others.
Being with	Encourage the heart	A caring leader is emotionally present and available to another.
Doing for	Model the way	A caring leader provides help and service to others as appropriate.
Enabling and Informing	Enable others to act	A caring leader facilitates another’s development and passage through events and transitions.

Maintaining belief and inspire a shared vision. When health care providers embrace and believe in caring behaviors, they possess confidence in accepting new opportunities and

possibilities. Providers are willing to lead with purpose and maintain an optimistic attitude when they work as a team (Kouzes & Posner, 2012). Together, they are incited to go the distance and realize their vision for caring leadership.

Knowing and challenge the process. When health care providers see and feel first hand why a change needs to occur, they are properly motivated to lead and engage in the process (Creative Health Care Management, 2011). They focus on what matters most, realizing their capacity to be accountable for their contributions, and they make that very clear in their actions and decisions as caring leaders.

Being with and encourage the heart. The privilege of engaging in health care work is having the position and relationship to interact with others in a way that supports and develops their potential (Swanson, 1993). If this privilege is ignored or overlooked, caring leadership is absent. Authentic connections with others can and must happen – that is the caring leadership prerogative.

Doing for and model the way. Doing for involves actions on the part of the health care provider that are performed on behalf of and to benefit another, such as performing competently and skillfully. Caring leaders understand it is not just about ministering to a person's needs, but employing therapeutic communication skills that provide opportunities for others' wellbeing (Swanson, 1993).

Enabling and informing and enable others to act. Enabling involves creating an environment in which caring relationships can occur. In such an environment, caring leaders engender caring and compassionate service by encouraging others, instilling hope, removing obstacles, and living their vision and values moment-to-moment, day-by-day (Koloroutis, 2004).

Enabling is the prerequisite to bringing out the best in everyone and realizing a caring leadership-based culture.

Caring leadership is essential to the success of home care team members cultivating and enriching the human condition, and ultimately creating the culture and environment necessary for a successful practice setting.

Design

This study was descriptive and used a mixed methods design. Quantitative measurement included evaluation of participant relational and professional proficiencies while qualitative measurement included reflection and assessment of participant awareness and priority actions. This mixed methods approach allowed for exploration of the research question, “In home care team members, how does a caring leader practicum experience impact engagement in a professional, relationship-based practice?” Capturing home care team members caring intentions and leadership competencies was essential.

Setting

Six senior living home care communities, all owned by the same management company, located across four moderate-sized cities in a Midwest state of the United States.

Participants

A convenience sample consisting of all team members employed at any one of the six senior living home care settings who were eligible to participate in this study as caring leadership is inclusive and not limited to a single position, level, or organizational structure. For purposes of this study, job roles were categorized as direct care and indirect care. Nursing team members, including registered nurses (RNs), were defined as direct care participants. Managers/directors, including all team members who functioned in a non-nursing capacity, were defined as indirect

care participants. Participants were recruited during work hours by several methods. Research flyers were sent to each community and posted in every department. The research assistant, a non-nursing administrator in the organization, sent email communications and visited every community to encourage voluntary participation from all job roles. Team members interested in being considered for study participation were directed to contact the research assistant by phone or email. 39 participants were recruited, 24 participated in the pre-survey and 15 participated in the post-survey. Of the 39 total participants, 7 successfully completed both the pre- and post-survey.

Ethical Considerations

Approval to conduct this study was obtained from the Institutional Review Board (IRB) at St. Catherine University and the participating organization where participants were recruited. Written informed consent was obtained from each participant. Responses to surveys were confidential and declining participation did not impact employment status or relations with St. Catherine University. IRB approved documentation included the following: Information and Consent Form, Demographic Questionnaire, and Research Flyer.

Procedures

Individuals were required to submit consent prior to proceeding to the demographic questionnaire and survey instruments. The demographic questionnaire was used to collect general information about each participant. Data was collected at two time points via SurveyMonkey, one week prior to and four weeks following the caring leader practicum experience. The baseline data was collected in October 2016 to January 2017 with the final data collected from February 2017 to March 2017. The varied timing of data collection was due to scheduling of the multi-site practicum sessions.

A large conference room was available within four selected senior living home care communities for completion of the caring leader practicum experience. The four communities were selected based on location, two in the east metro and two in the west metro. Participants and employees attended the practicum experience at or nearest their work site. The practicum experience was conducted by the researcher, and structured like that of a department meeting, lasting one hour in duration, and included the following agenda: foundation, knowledge, and principles of caring leadership; implementation management; building and strengthening relationships; and leading change in everyday practice. No data was collected from the practicum. At the end of the caring leader practicum experience, each participant received an operational guide of the learnings presented. Concepts were reinforced through weekly email distributions over a four week period following the practicum and until final data collection.

Instruments

The Caring Assessment for Caregivers (CACG) instrument measured the participants' capacity for caring interactions and evaluated individual awareness and priority actions. The CACG has been tested for its reliability and validity in measurement of therapeutic interactions (Steele-Moses, Koloroutis, & Ydarraga, 2011). The CACG includes 25 items measured on a 5-point response scale with anchors 1 (highly task oriented) to 5 (high degree of relational orientation). The instrument also contains two questions of reflection for qualitative analysis: 1) "What does this mean to me?" and 2) "Two priority actions I will take are." The CACG was treated as a five-factor scale where items were summed and divided by 5 per subscale and 25 in total, yielding a mean score that ranged from 5 to 25 and 25 to 125 accordingly. Developers of this survey granted permission for use in this research.

The Leadership Practices Inventory – Self (LPI-S) instrument measured participants' capacity for leadership competencies. The LPI-S has been tested, verified, and validated for its measurement of leadership skills and development (Posner, 2015). The LPI-S includes 30 items measured on a 10-point response scale with anchors 1 (almost never) to 10 (almost always). The LPI-S was treated as a five-factor scale where items were summed and divided by 6 per subscale and 30 in total, yielding a mean score that ranged from 6 to 60 and 60 to 300 accordingly. Permission was granted to use the LPI for purposes of this study.

Data Analysis

Quantitative Methodology

Descriptive statistics analyzed means and ranges of all variables, including participant demographics. Paired *t* tests compared LPI-S mean scores before and after the caring leader practicum for all participants as well as CACG mean scores before and after the caring leader practicum for all participants. Independent *t* tests compared LPI-S mean scores of direct care participants and indirect care participants before and after the caring leader practicum as well as CACG mean scores of direct care participants and indirect care participants before and after the caring leader practicum. All statistics were modeled and analyzed using Microsoft Excel 2010 with the assistance of a statistician.

Qualitative Exploration

The method guiding qualitative analysis was based on the work of Colaizzi (1978). Colaizzi's strategy in descriptive phenomenology was used to elicit exhaustive description of team members' experience and engagement in professional, relationship-based practice before and after the caring leader practicum. The following sections represent Colaizzi's process for phenomenological data analysis of this study (Shosha, 2012).

Familiarization with narrative text. Individual responses were captured through SurveyMonkey and transcribed by the research assistant, word-for-word. Following transcription, individual responses were read several times to gain a complete sense of the whole content.

Extracting significant statements. The research assistant extracted pertinent narrative texts from each respondent and organized data into a Microsoft Excel 2010 spreadsheet, coding responses based on participant number. The research assistant and researcher reviewed the significant statements and reached consensus. 62 significant statements were extracted from the 72 narrative texts.

Formulating meaning. Meanings were formulated from the significant statements. Each underlying meaning was coded in one category to reflect an exhaustive description. Similarly, the research assistant and researcher compared the formulated meanings with the original meanings maintaining the consistency of descriptions. 61 formulated meanings were derived from the 62 significant statements.

Clustering themes. All formulated meanings were grouped into categories that reflected a unique structure of theme clusters. Subthemes emerged, providing underlying support to major themes. All themes were internally convergent and externally divergent; each formulated meaning fell into a single theme cluster that was distinguished from other structures (Shosha, 2012). Data saturation was achieved after final review and validation of narrative text and developed themes.

Exhaustive description. Themes and subthemes were analyzed in consideration of the research question. The research assistant and researcher reviewed all themes in the context of “richness” and “completeness” to provide sufficient description and confirmation that exhaustive

description reflected team members' caring leadership experience. 13 theme clusters emerged which were grouped into 4 emergent themes.

Validating the data. As a final step, the research assistant contacted participants individually by email to verify the accuracy of identified themes, with the intent that if any new data were revealed, it would be incorporated into the exhaustive description.

Results

Demographics

Demographics of study participants are outlined in Appendix A. The requirements to practice professional nursing in the state of Minnesota include registered nurse licensure and an associate degree or higher degree in nursing (Revisor of Statutes, 2016). Each direct care participant met these qualifications. There were no exclusions or stipulations for indirect care participants.

All participants who completed both the pre- and post-survey were female, Caucasian, and seventy-one percent were at least thirty-one years of age, although two indicated that they were in the 20 to 30 age range. Twenty-nine percent of participants were licensed RNs with one participant indicating forty-one years of RN practice experience. Employment as an RN at the work site ranged from 0 to 24 months.

Of the 24 participants that participated in the pre-survey, 17 were excluded due to failure to consent or complete the survey in its entirety. Of the 15 participants that participated in the post-survey, 1 was excluded due to incompleteness. Only 7 participants successfully completed the pre- and post-surveys, with the majority being indirect care participants. Pearson correlation was not performed given the limited number of direct care participants ($n = 2$) for accurate

comparison of total years of RN licensure and total LPI-S/CACG score and total months of RN employment at site and total LPI-S/CACG score.

Scores

The total means scores for the LPI-S and CACG increased pre- to post-intervention. However, there was no statistically significant difference in the change from baseline ($P = 0.112$ LPI-S; $P = 0.083$ CACG). In comparing total means scores between direct care and indirect care participants, indirect care participants achieved higher scores on the LPI-S than direct care participants while direct care participants achieved higher scores on the CACG than indirect care participants. There was no statistically significant difference in total scores between groups. In considering the change from baseline for the LPI-S and CACG subscales, the mean change represented statistically significant improvement in all variables ($P = 0.0009$ LPI-S; $P = 0.006$ CACG). The mean change from baseline for the subscales is displayed in Figure 1 and Figure 2.

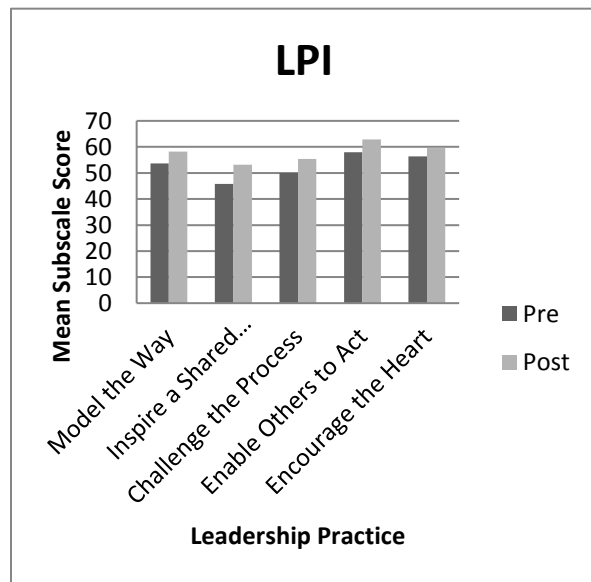


Figure 1. LPI-S subscales mean change from baseline

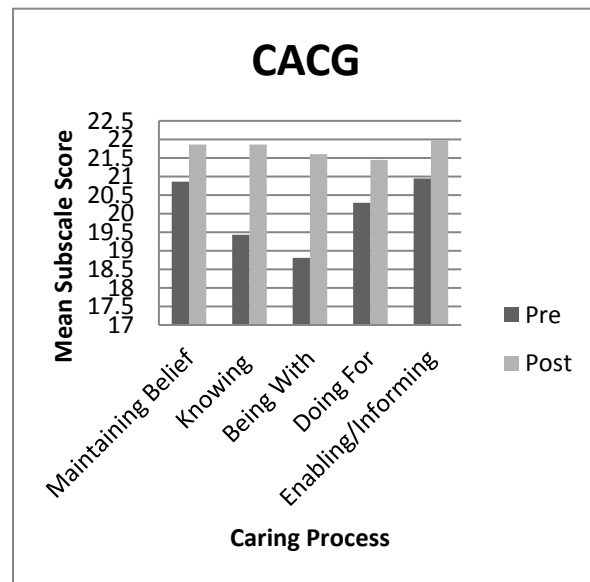


Figure 2. CACG subscales mean change from baseline

The significantly improved scores for the LPI-S included all subscales: Model the way, Inspire a shared vision, Challenge the process, Enable others to act, and Encourage the heart. The significantly improved scores for the CACG included all subscales: Maintaining belief,

Knowing, Being with, Doing for, and Enabling/Informing. Table 2 shows the change from baseline scores in totality, by subscale, and between groups.

Table 2							
<i>Change from Baseline</i>							
	N	Total Mean Score	Direct Care	Indirect Care	P	Mean Subscale Score	P
<u>LPI-S</u>							
Pre	7	226.1	175.5	246.4	0.112	52.8	0.0009*
Post	7	247.7	225.5	256.6		57.8	
<u>CACG</u>							
Pre	7	99.4	196	100	0.083	20.1	0.006*
Post	7	109.9	214	111		21.7	
The bold signifies a significant change from baseline to 4 weeks							
For each scale or subscale, based on a 2-sample t test comparison of change from baseline scores.							
*Significant at a 0.05 level							

Indirect care participants had greater participation levels from pre- to post-survey, with 16 of 24 (67%) and 13 of 15 (87%) participants, respectively. The difference in participation was not statistically significant ($P = 0.108$) between direct and indirect care participants.

Themes

Using Colaizzi’s process of descriptive phenomenology, findings were guided by thematic mapping. Four themes emerged from data analysis and the following discussion focuses on the formulated meaning of each theme.

Theme # 1: Leadership is embodied in caring relationships

A key aspect of leadership is centered in relationships – a relationship with self and personal self-development and a relationship with those being led (Kouzes & Posner, 2012).

Caring is one of the absolute foundations of leadership. Caring leadership drives engagement, a lack of caring creates leadership by directive. As a relationship, leadership requires a connection between people over matters of the heart (Kouzes & Posner, 2012). In a health care environment, caring leaders act with purpose and maintain a clear focus on care and service to self and others. Caring leaders participate in quality of practice when they solve problems creatively to get results, and model and support the changes they desire (Glembocki & Fitzpatrick, 2013).

Lead with care and conscious intention. To lead with positive intention requires mindfulness – a deepened capacity for attention and present moment awareness (Kearney, Mount, Weininger, Harrison, & Vachon, 2009). The goal of mindfulness is to empower individuals with a means of responding consciously rather than automatically to both internal and external circumstances (Kearney et al., 2009; Pipe et al., 2009). A study participant states, “Being conscious of my actions and their effects on others will help me to be a caring leader and making sure to put my best foot forward in every encounter I have with staff, residents, and family.” Conscious responses are beneficial whether the event is associated with urgent or routine matters, stress or grief, as well as positive experiences such as self-efficacy and caring (Cohen-Katz, Wiley, Capuano, & Baker, 2005; Pipe et al., 2009).

A caring philosophy is most powerful for health care providers when it is accompanied by a consciousness of purpose, clarity of role, competency in managing relationships, and a commitment to touching each patient and family in uniquely meaningful ways (Koloroutis, 2004). A survey participant describes the importance of accepting personal accountability and consciously acting in alignment with organizational priorities, “My actions greatly impact new residents/family members in understanding the [organization’s] vision and mission as a counselor and advocate.” Initiating and sustaining therapeutic relationships with patients and

families is central to caring environments (Koloroutis, 2004). This privileged bond between providers and receivers has been referred to as a sacred space (Wright & Syre-Adams, 2000).

Theme # 2: Self-care is fundamental to authentic leadership

Self-care is an essential part of the therapeutic mandate. Self-care is grounded in personal awareness of one's own state of being, including his or her emotional, physical, and spiritual needs (Glembocki & Fitzpatrick, 2013). Self-knowing, which is fundamental to self-care, is a prerequisite to emotional maturity, healthy interpersonal relationships, and the capacity for empathy (Kearney et al., 2009; Wessel & Manthey, 2015). Without a clear understanding of one's self, a provider's emotional reactions may adversely impact his or her capacity for caring leadership. The relationship with self is essential to maintaining one's optimal health, for having empathy for the experience of others, and for being a productive member of the organization (Glembocki & Fitzpatrick, 2013).

Opportunity for further self-development.

It is important that health care providers maintain a level of knowledge that allows them to be the best educators of patients, families, and colleagues (Glembocki & Fitzpatrick, 2013). Education is an integral part of the leadership process; caring leaders never stop teaching, and they never stop learning. One study participant demonstrates this developmental orientation by stating, "I am on my way to being a caring leader, but there are still areas I wish to improve upon." Even the most experienced providers, who have had many opportunities to apply their knowledge and skills in practice, continue to grow and change as a result of new knowledge.

The education standard of the American Nurses Association (ANA) includes competencies that pertain to nurses, but may apply to other health care providers as all roles are accountable for an ongoing commitment to remain competent and safe in the health care

profession (ANA, 2010). This survey response directly aligns with the ANA standard, “I wish to expand my education as it is important to maintaining my competence to care for others.” The educational competencies of the ANA include the following: participating in ongoing educational activities; demonstrating a commitment to lifelong learning through self-reflection and inquiry; seeking experiences that reflect current knowledge; acquiring new knowledge and skills; participating in formal and informal consultations to address practice issues; and sharing educational findings, experiences, and ideas with others (ANA, 2010).

A relationship with self allows for a deeper understanding of self-knowing resulting in a better understanding of how to articulate needs that can support personal growth that will be reflected in professional practice. If providers are distracted by inner conflict, they cannot effectively take care of others. Professional growth allows for care of the mind (Glembocki & Fitzpatrick, 2013).

Desire to show up as one’s best self.

Dewey describes the self as not something readymade, but rather something in continuous formation through choice of action (1997). In everyday practice, health care providers must have an understanding of the self that will allow him or her to lead in a more purposeful and authentic way. Self-understanding is exemplified in one research participant’s response, “I must maintain personal awareness of how I perform my job, always.” The self should be seen as a work in progress that must continually be re-authored as one grows and develops (Eriksen, 2009). Self-understanding from within is captured in the concept of self-authorship, which is the idea that the self is the source of one’s direction and value (Eriksen, 2009).

Theme # 3: Leadership as emotional intelligence that reflects one’s commitments.

Goleman (1995) described emotional intelligence as a capacity for recognizing one's own feelings and those of others. Emotional intelligence is a key relational skill and fundamental to empathy. This kind of emotional literacy means that feelings are not dismissed or suppressed, but rather acknowledged as significant and worthy of consideration. Emotional intelligence gives health care providers a greater understanding of themselves and their professional commitments, particularly when faced with the complexities of patient and family situations (Spear, 2015). Managing emotions and relationships with others is imperative to furthering the organizational mission and vision.

Practice genuine presence in every interaction.

Humanistic values underpin presence in practice. These values provide a framework to facilitate the mutuality of the interaction, enabling the health care provider and patient to understand each other's perspective within a shared experience (Welch & Wellard, 2005). Embedded in humanistic values is the concept of caring for another, and thus supporting the worth of that person. Much has been documented regarding the positive influence of providers' caring for another and the subsequent health and healing of that person (An & Jo, 2009; Cumbie, 2002; Doona, Chase, & Haggerty, 1999; Rankin & DeLashmutt, 2006). A research participant indicates their intended action to be present, "I will take time to be present in each conversation or interaction regardless of what is on my to-do or priority list." Doona et al. (1999) asserted that a provider must make a commitment to care through a willingness and openness to enter another person's situation by offering the gift of true presence.

Personal resolve to maintain integrity.

Trust is considered the foundation of positive organizational cultures and, in essence, defines healthy workplaces (Khatri, Halbesleben, Petroski, & Meyer, 2007). Trustworthy leaders

instill a sense of commitment and pride in work that is manifested in increased engagement in the exploration of new ideas, a willingness to speak up about problems and make suggestions for change, and greater sensitivity to others' words and ideas (Wong & Cummings, 2009). The moral challenges of a fast-paced workplace are highlighted in a participant response, "There is always an environment with the make it happen ASAP mentality and it's good for many applications, but it isn't always the right or best choice." Effective leaders identify what they require to practice safely, ethically, and responsively within their work environment (Cummings, Hayduk, & Estabrooks, 2005). Such a model of leadership focuses on the positive role modeling of honesty, integrity, and high ethical standards in the development of relationships (Wong & Cummings, 2009).

Theme # 4: Supportive professional environment as a means to successful leadership culture.

Implementation of effective leadership not only affects the health care workforce and the profession but the health care delivery system and society as a whole (Schmalenberg & Kramer, 2008). Creating a healthy work environment for professional practice is crucial to maintaining an adequate engaged health care workforce. The stressful nature of the profession often leads to burnout, disability, and high absenteeism and ultimately contributes to the escalating shortage of health care providers (Shirey, 2006). Leaders must implement the right structures and best practices so that health care providers can engage in the work processes and relationships that are empirically linked to quality outcomes (Schmalenberg & Kramer, 2008).

Work interdependently to create a culture of learning and mutual support.

Kramer, Schmalenberg, and Maguire (2010) identify the promotion of interdisciplinary collaboration as an essential organizational structure to a healthy work environment. This

structure focuses on learning how to collaborate and how the right culture promotes collaboration. Collaborative planning, practice, and decision-making are based on the understanding that the care required of patients and families is too complex for any one role to plan and do. In a collaborative structure, providers learn to appreciate the competence of one another, learn what each role brings to the patient experience, learn how each role defines their scope of practice and where that scope overlaps, and learn how to work interdependently in practice (Kramer, Schmalenberg, and Maguire, 2010; Schmalenberg & Kramer, 2008). A study participant reinforces this understanding by stating, “I must continue to learn and grow in my own experience and help other nurses and care team members by understanding their approach to care.” Leaders must invest in high quality practice, provide resources to support the ongoing contributions of others, and bolster organizational structures to achieve a professional work culture (Kramer, Schmalenberg, and Maguire, 2010).

Seek and participate in opportunities for organizational improvement.

Leaders play a pivotal role in creating an environment and culture in which employees can become fully engaged. Theoretical and empirical research has demonstrated associations between strong leadership and a range of desirable outcomes such as high performance, commitment, and creativity (Manning, 2016; Popli & Rizvi, 2016; Zhang & Bartol, 2010). Engagement is both a desired outcome of effective leadership and a catalyst for other positive attitudes and behaviors (Manning, 2016; Othman, Hamzah, Abas, & Zakuan, 2017). A participant response concurs with the present research on engagement, “I will communicate more effectively with team members and acknowledge when a team members is doing a good job and has gone above and beyond to help a resident, family, or fellow colleague.” Empowering leadership significantly connects the relationship between motivation and engagement (Zhang &

Bartol, 2010). Recognizing and harnessing employee strengths can fundamentally contribute to organizational innovation, effectiveness, and survival.

Summary

Themes and subthemes identified through qualitative exploration suggest leadership and relational expertise can be described within the context of professional, relationship-based practice. However, home care team members recognize the importance of self-efficacy and identify opportunities for further education, performance, and competence development so as to realize their capacity to be caring leaders and transform the organization's culture. Home care team members do not differentiate caring practice from leadership and consider caring leadership to be an effective framework for leading with caring intention and conscious action each day. The caring leader practicum intervention, a low-cost, workplace approach, was successful in impacting outcome variables in a short 4-week time period.

Discussion

One of the most revealing findings was that the participation levels of both direct and indirect care participants were much lower than originally anticipated. This was significant when considering the large pool of potential participants (39/150) employed at the research site. The degree of participation was such that the study procedures were modified so that participants had four separate opportunities to complete the recruitment process and attend the caring leader practicum experience, either in-person or by video conference, and were compensated for doing so outside of scheduled work hours. Home care team members were given the opportunity to participate in this research endeavor, but the majority did not accept. One of the main purposes of caring leadership is to call forth the leader within (Kouzes & Posner, 2012). Team members had a choice to step up and accept the challenge to lead, yet most did not take action. The

conundrum is that caring leadership is a practice accessible to anyone, but only those willing to assume and exercise the responsibility necessary for engagement will realize their capacity and become caring leaders. Even considering the voluntary nature of this study, it is a matter of responsibility that must be accepted by each individual. Those who did participate in the intervention, primarily management team members, improved their caring practices and leadership competencies, by a total of 10.5% and 9.54% respectively, over the 4-week timeframe. However, it is possible that this participant sample had higher baseline scores than the general population would, given their recognized accountability. Future participation in a caring leader practicum experience should include management team members, in addition to direct care providers, to reinforce desired behaviors and drive outcome variables.

The findings of this study are consistent with the literature on leadership impact and caring behaviors in health care (Dewar & Cook, 2014; Gifford et al., 2013; Williams, McDowell, & Kautz, 2011; Westen et al., 2002). Leadership was found to positively impact home care team members' engagement in professional, relationship-based practice. Previous research, using the same LPI instrument, reported increases in nurse leadership behavior development after participation in a leadership program based on similar leadership principles (McNeese-Smith, 1996; Westen et al., 2002). Although study methods varied, Manojlovich (2005) measured the work effectiveness of nurses and found that leadership contributed to the effects of caring efficacy on practice behaviors. Leadership at all levels has a positive influence on professional health care practice. The significance of caring practices was also exhibited in a study on relationship-centered appreciative leadership, which found that participants experienced enhanced self-awareness, greater ability for reflection, and an ethos of continuing learning and improvement following program participation (Dewar & Cook, 2014). A similar, emergent

theme among home care team members was an expressed desire for further education and practice improvement so as to achieve their personal best. This program was like that of the caring leader practicum as it encouraged participants to think differently and to be reflective and engaged in shaping the cultural climate in which leadership could flourish (Dewar & Cook, 2014; Williams, McDowell, & Kautz, 2011)..

Consistent with theory, caring leadership as a practical model of development that intentionally focuses on the intrinsic motivations rather than on the extrinsic sources of the person can be useful regardless of professional role or organizational structure (Kouzes & Posner, 2012; Swanson, 1993). The interaction between intrinsic and extrinsic factors may determine whether a provider's practice behaviors are either relationship-focused or more task-oriented (Malloch, Sluyter, & Moore, 2000; Manojlovich, 2005; Stuart, Jarvis, & Daniel, 2008). A caring leader practicum, an experiential learning approach, was feasible and effective for home care team members. However research suggests that a supportive professional environment, in addition to the educational practicum, is essential to sustain caring leader behaviors in the health care setting (Dewar & Cook, 2014; Pipe et al., 2009; Westen et al., 2002). Caring leadership interventions can positively impact the professional and relational expertise of health care providers, cultivating and liberating their potential to be caring leaders.

Strengths and Limitations

This work represents an innovative approach to systematically study the impact of a structured educational intervention on home care team members' engagement in professional, relationship-based practice. The approach was a descriptive, mixed methods design, giving it distinct advantages over much of the empirical work in caring leadership to date. The design was selected to address methodological criticisms of previous work in caring leadership efficacy by

evaluating a multi-site intervention for complete practice enculturation across organizational roles. At the project site, practice standards reflect the values and priorities of home care team members and provide direction for professional, relationship-based care and a framework for the evaluation of this practice. Team members are expected to be aware of the professional standards and are held responsible and accountable for practicing accordingly. This model of competency-based home care education promotes the mastery of caring leadership.

Several limitations must be identified. The relatively small sample assumes a large degree of error in the observed effect size. Considerations for the future should include encouraging practicum attendance as part of workplace training or providing multiple practicum sessions per site to improve sample size, particularly among hourly employees. Generalizability of quantitative findings was restricted due to selection bias as those recruited may have been highly motivated to participate. The survey length was extensive and may have limited response rates and successful completion of the pre- and post-survey process (Polit & Beck, 2006). There was limited ability to closely monitor the frequency and duration of caring leader practice among participants as well as no long-term comparison to assess durability of observed changes pre- to post-intervention. Social desirability response effect bias was also present as participants rated their own behaviors and may have described certain strategies perceived to be best practice (Podsakoff & Organ, 1986). This bias may have been further exaggerated by the fact that the Caring Assessment for Caregivers instrument was specific to nursing and not directly applicable to indirect care participants. Measures were taken to reduce bias, such as ensuring confidentiality and using a research assistant to collect survey data and to validate themes within the qualitative analysis. The study findings suggest that a larger sample size may have improved the ability to

find significant results, and thus these findings have been identified as requiring careful interpretation, in order to minimize these limitations.

Conclusions

Participation in a caring leader practicum experience increased home care team members' caring interactions and leadership competencies, and ultimately engagement in professional, relationship-based practice. Even within a 4-week timeframe, these variables were impacted by the intervention. The feasibility and effectiveness of this approach is particularly important, given the technical strains in today's health care system. This approach is consistent with caring and leadership theory (Kouzes & Posner, 2012; Swanson, 1992).

Caring leadership is a measureable and practical set of behaviors. However, personal accountability is essential to achieving the leadership capacity required for caring leadership practice. Transformative change calls for a new model of leadership. The call for leadership is a call for a new way of thinking, being, and doing from a relationship-focused lens. This new model encourages caring leaders to emerge from all levels of the organization and it enables others through a fundamental respect for each person's vital contributions and practice outcomes. It is possible to create environments that allow caring leaders to live the organizational values and promote flourishing of the human spirit in the workplace (Williams, McDowell, & Kautz, 2011). Caring leadership ultimately creates a cultural shift that guides action and anchors successes.

A short, workplace program on caring leadership strategies may be an effective approach for other roles and professions as well. Future research may focus on comparing the 4-week intervention to an extended, long-term practicum, evaluating other approaches to achieving caring leadership in professional practice, and exploring organizational outcomes such as

retention and performance. Implications for health care professionals include the following: (1) acknowledging the intense nature of administrative tasking and its impact on the relationship with self, colleagues, and patients/families, (2) exploring viable ways of translating caring leader behaviors into moment-to-moment living, (3) and exerting leadership influence to create organizational environments supporting caring practice models.

In a caring leadership environment, the organization's culture supports the transformation of professional practice and empowers providers to embrace their potential and achieve their personal best as caring leaders. It is a personal and interpersonal journey of transformation.

References

- American Nurses Association. (2010). *Nursing: Scope and standards of practice* (2nd Ed.). Silver Spring, MD: Author.
- An, G., & Jo, K. (2009). The effect of a nursing presence program on reducing stress in older adults in two Korean nursing homes. *Australian Journal of Advanced Nursing*, 26(3), 79-85.
- Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York; London: Free Press.
- Burke, C. S., Stagl, K. C., Klein, C., Goodwin, G. F., Salas, E., & Halpin, S. M. (2006). What type of leadership behaviors are functional in teams? A meta-analysis. *Leadership Quarterly*, 17(3), 288-307. doi:10.1016/j.leaqua.2006.02.007
- Cohen-Katz, J., Wiley, S., Capuano, T., & Baker, D. M. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout. *Holistic Nursing Practice*, 19(2), 78-86.
- Creative Health Care Management. (2011). *Relationship-based care leader practicum*. Minneapolis, MN: Creative Health Care Management.
- Cumbie, S. A. (2001). The integration of mind-body-soul and the practice of humanistic nursing. *Holistic Nursing Practice*, 15(3), 56-62. doi:10.1097/0000465020010400000010
- Cummings, G., Hayduk, L., & Estabrooks, C. (2005). Mitigating the impact of hospital restructuring on nurses: The responsibility of emotionally intelligent leadership. *Nursing Research*, 54(1), 2-12. doi: 10.1097/00006199200501000 00002
- Dewar, B., & Cook, F. (2014). Developing compassion through a relationship centred

- appreciative leadership programme. *Nurse Education Today*, 34(9), 1258-1264.
doi:10.1016/j.nedt.2013.12.012
- Doona, M. E., Chase, S. K., & Haggerty, L. A. (1999). Nursing presence: As real as a milky way bar. *Journal of Holistic Nursing*, 17(1), 54-70. doi:10.1177/089801019901700105
- Duffy, J. R. (2005). Implementing the quality-caring model© in acute care. *JONA: The Journal of Nursing Administration*, 35(1), 4-6. doi:10.1097/00005110-200501000-00002
- Dvir, T., Eden, D., Avolio, B. J., & Shamir, B. (2002). Impact of transformational leadership on follower development and performance: A field experiment. *The Academy of Management Journal*, 45(4), 735-744. doi:10.2307/3069307
- Eriksen, M. (2009). Authentic leadership: Practical reflexivity, self-awareness, and self-authorship. *Journal of Management Education*, 33(6), 747-771.
doi:10.1177/1052562909339307
- Flöjt, J., Hir, U. L., & Rosengren, K. (2014). Need for preparedness: Nurses' experiences of competence in home health care. *Home Health Care Management & Practice*, 26(4), 223-229.
- George, B., Sims, P., McLean, A. N., & Mayer, D. (2007). *Discovering your authentic leadership*. United States: Harvard Business School Press.
- Gifford, W. A., Davies, B. L., Graham, I. D., Tourangeau, A., Woodend, A. K., & Lefebvre, N. (2013). Developing leadership capacity for guideline use: A pilot cluster randomized control trial. *Worldviews on Evidence-Based Nursing*, 10(1), 51-65. doi:10.1111/j.1741-6787.2012.00254.x
- Glebocki, M.M. & Fitzpatrick, J.J. (2013) *Advancing professional nursing practice: Relationship-based care and the ana standards of professional nursing practice*. Minneapolis, MN: Creative Health Care Management.
- Goleman, D. (1995). *Emotional intelligence —Why it can matter more than IQ*. New York, NY:

Bantam Books.

Gong, Y., Huang, J., & Farh, J. (2009). Employee learning orientation, transformational leadership, and employee creativity: The mediating role of employee creative self-efficacy. *The Academy of Management Journal*, 52(4), 765-778.

doi:10.5465/AMJ.2009.43670890

Kearney, M. K., Mount, B. M., Weininger, R. B., Harrison, R. L., & Vachon, M. L. S. (2009). Self-care of physicians caring for patients at the end of life. *Journal of the American Medical Association*, 301(11), 1155-1165.

Khatri, N., Halbesleben, J. R. B., Petroski, G. F., & Meyer, W. (2007). Relationship between management philosophy and clinical outcomes. *Health Care Management Review*, 32(2), 128-139. doi: 10.1097/01.hmr.0000267789.17309.18

Koloroutis, M. (2004). *Relationship-based care: A model for transforming practice*. Minneapolis, MN: Creative Health Care Management.

Kouzes, J., & Posner, B. (2012). *The leadership challenge*. San Francisco, CA: Jossey-Bass.

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly*, 34(1), 4-17. doi: 10.1097/naq.0b013e3181c95ef4

Malloch, K., Sluyter, D., & Moore, N. (2000). Relationship-centered care: Achieving true value in healthcare. *JONA: The Journal of Nursing Administration*, 30(7/8), 379-385. doi:10.1097/00005110200007000000014

Manning, J. (2016). The influence of nurse manager leadership style on staff nurse work engagement. *Journal of Nursing Administration*, 46(9), 438-443. doi:10.1097/NNA.0000000000000372

- Manojlovich, M. (2005). The effect of nursing leadership on hospital nurses' professional practice behaviors. *Journal of Nursing Administration, 35*(78), 366-374.
doi:10.1097/0000511020050700000009
- McNeese-Smith, D. (1996). Increasing employee productivity, job satisfaction, and organizational commitment. *Hospital & Health Services Administration, 41*(2), 160-175.
- Othman, A. K., Hamzah, M. I., Abas, M. K., & Zakuan, N. M. (2017). The influence of leadership styles on employee engagement: The moderating effect of communication styles. *International Journal of Advanced And Applied Sciences, 4*(3), 107-116.
doi:10.21833/ijaas.2017.03.017
- Pipe, T.B., Bortz, J.J., Dueck, A., Pendergast, D., Buchda, V., & Summers, J. (2009). Nurse leader mindfulness meditation program for stress management: A randomized controlled trial. *Journal of Nursing Administration, 39*(3), 130-137.
- Podsakoff, P.M., Organ, D.W. (1986). Self-reports in organizational research: Problems and prospects. *Journal of Management, 12*(4), 531–544.
- Polit D.F. & Beck C.T. (2006). Analyzing quantitative data. In D.F. Polit & C.T. Beck (Eds.), *Essentials of nursing research methods, appraisal and utilization* (6th Ed., p. 396–426). Philadelphia, PA: Lippincott Williams & Wilkins.
- Popli, S., & Rizvi, I. A. (2016). Drivers of employee engagement: The role of leadership style. *Global Business Review, 17*(4), 965-979. doi:10.1177/0972150916645701
- Posner, B. (2015). *Bringing the rigor of research to the art of leadership: Evidence behind the five practices of exemplary leadership and the leadership practices inventory*. Retrieved from

- <http://www.leadershipchallenge.com/UserFiles/Bringing%20the%20Rigor%20of%20Research%20to%20the%20Art%20of%20Leadership.pdf>
- Rankin, E. & DeLashmutt, M. (2006). Finding spirituality and nursing presence. *Journal of Holistic Nursing*, 24(4), 282- 288.
- Revisor of Statutes. (2016). *2016 minnesota statutes*. Retrieved from <https://www.revisor.mn.gov/statutes/?id=148.171>
- Schmalenberg, C., & Kramer, M. (2008). Essentials of a productive nurse work environment. *Nursing Research*, 57(1), 2-13. doi:10.1097/01.NNR.0000280657.04008.2a
- Shirey, M. R. (2006). Authentic leaders creating healthy work environments for nursing practice. *American Journal of Critical Care*, 15(3), 256-267.
- Shorr, A.S. (2000). Has nursing lost its professional focus? *Nursing Administration Quarterly*. 25(1), 89–94.
- Shosha, G. A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal*, 8(27), 31-43.
- Spear, M. (2015). Leadership and emotional intelligence: Does it matter? *Plastic Surgical Nursing*, 35(2), 55-57. doi:10.1097/PSN.0000000000000088
- Steele-Moses, S., Koloroutis, M., & Ydarraga, D. M. (2011). Testing a "caring assessment for care givers" instrument. *Creative Nursing*, 17(1), 43-50. doi:10.1891/1078-4535.17.1.43
- Swanson, K. (1993). Nursing as informed caring for the well-being of others. *Journal of Nursing Scholarship*, 25(4), 352-357.
- The Leadership Challenge. (2017). *The five practice of exemplary leadership model*. Retrieved from <http://www.leadershipchallenge.com/about-section-our-approach.aspx>
- Tonges, M., & Ray, J. (2011). Translating caring theory into practice: The carolina care model.

- Journal of Nursing Administration*, 41(9), 374-381.
doi:10.1097/NNA.0b013e31822a732c
- Watson, J. (1999). *Postmodern nursing and beyond*. New York; Edinburgh: Churchill Livingstone.
- Welch, D. & Wellard, S. (2005). The phenomenon of presence in contemporary nursing practice: A literature review. *Australian Journal of Holistic Nursing*, 12(1), 4-10.
- Wessel, S. & Manthey, M. (2015). *Primary nursing: Person-centered care delivery system design*. Minneapolis, MN: Creative Health Care Management.
- Westen, B., Schmidt, M., Zielke, J., Duthie, N., Gehring, L. L., Brukwitzki, G...Rodgers, B. (2002). Developing staff nurse shared leadership behavior in professional nursing practice. (on the scene). *Nursing Administration Quarterly*, 26(3), 44-59.
- Williams, R. L., McDowell, J. B., & Kautz, D. D. (2011). A caring leadership model for nursing's future. *International Journal for Human Caring*, 15(1), 31-35.
- Wong, C. A., & Cummings, G. G. (2009). The influence of authentic leadership behaviors on trust and work outcomes of health care staff. *Journal of Leadership Studies*, 3(2), 6-23.
doi: 10.1002/jls.20104
- Wright, S., & Sayre-Adams, J. (2000). *Sacred space: Right relationship and spirituality in healthcare*. Edinburgh: Churchill Livingstone.
- Zhang, X., & Bartol, K. M. (2010). Linking empowering leadership and employee creativity: The influence of psychological empowerment, intrinsic motivation, and creative process engagement. *Academy of Management Journal*, 53(1), 107-128.
doi:10.5465/AMJ.2010.48037118

Appendix A

Participant Demographics

Subject Code	Pre-Post Survey N = 7	Caring Leader Practicum N = 47
Age	20 - 30 (2)	
	31 - 40 (3)	
	41 - 50 (1)	
	51 - 60 (0)	
	61+ (1)	
Gender	Female (7)	
Race/Ethnicity	Caucasian (7)	
RN Licensure	n = 2	
Years of RN Licensure	0 - 10 (1)	
	11 - 20 (0)	
	21 - 30 (0)	
	31 - 40 (0)	
	41+ (1)	
Months of Employment as RN at Site	0 - 12 (1)	
	13 - 24 (1)	
	25 - 36 (0)	
	37 - 48 (0)	
	49+ (0)	