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Exploring Occupational Stress among Nurse Leaders: Factors Influencing Nurse Leader Retention and Organizational Commitment

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EXPLORING OCCUPATIONAL STRESS AMONG NURSE LEADERS: FACTORS INFLUENCING NURSE LEADER RETENTION AND COMMITMENT

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

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BY

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To the Dean for the School of Nursing:

I am submitting a dissertation written by **Nnenna A. Emelogu** and entitled **"Exploring occupational stress among nurse leaders: Factors influencing nurse leader retention and organizational commitment"**. I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing.

Dr. Joan Engebretson, Dissertation Committee Chair

We have read this dissertation
and recommend its acceptance:

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Accepted:

Dean for the School of Nursing

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Abstract

Background: Nurse leader sustainability is essential to organizational climate and patient care outcomes. The state of science of nurse leader sustainability warrants critical examination. Current research exists examining the impact of occupational stress among frontline nurses. However, research is scarce exploring occupational stress among nurse leaders. *Purpose:* To narrow knowledge gaps by exploring perceptions of occupational stress among nurse leaders and their responses to stress. *Design/Sampling:* A generic qualitative descriptive approach was used to explore perceptions of occupational stress among nurse leaders. The final sample consisted of 17 participants. *Analysis:* Thematic content analysis was used to categorize themes derived from the data. Data organization employed coding schemes to identify, label, and categorize concepts or themes. *Findings:* Ten theme clusters subsumed under six emergent themes, *"Always under pressure"*; *"Lack of work/life balance"*; *"My senior leadership does not support me"*; *"Fear"; "My senior leadership does support me"; "Organizational commitment".* *Conclusion:* Establishing and sustaining healthy work environments for the nurse leader generates a cascading effect on the organization. A heightened awareness of the elements that trigger occupational stress is a task that the organization must become astute to. It is imperative nurse leaders understand their response(s) to occupational stress directly impacts the organization, staff, and patient outcomes.

Keywords: *nurse leader, nurse manager, occupational stress, job stress, well-being*

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Summary of the Study

There is current research exploring the effects of occupational stress among frontline staff nurses. However, there is a lack of knowledge and understanding regarding the effects of occupational stress among nurse leaders. The goal of this dissertation was to narrow knowledge gaps by exploring perceptions of occupational stress among nurse leaders and to gain an in-depth understanding of the nurse leader's perceptions of their responses to occupational stress.

This study used a generic qualitative descriptive approach to explore perceptions of occupational stress among nurse leaders. The dissertation is comprised of two sections 1) the research proposal and 2) a first manuscript of the key findings. The research proposal outlined one specific aim 1) to understand perceptions of occupational stress among nurse leaders. The study remained on schedule with IRB approval. Interviews were completed in January 2019 and analysis was completed in March 2019.

The manuscript includes results for the aim of the study, which was accomplished through the use of thematic content analysis (Appendix G). Themes were described and supported by participant exemplars, depicting perceptions of occupational stress among nurse leaders (Appendix K). The results of the study are relevant to nursing practice in that it identified perceived sources and consequences of occupational stress as experienced among nurse leaders. Implications to nursing research are also included in the manuscript.

Proposal

Specific Aim

The status quo of nurse leader durability and value is uncertain and at risk for failure and depletion. The state of the science regarding nurse leader sustainability is undeveloped and warrants critical examination and urgent restoration. Sustainability is the ability to persevere, lead, and achieve organizational goals while maintaining balance and stability in new and changing work environments (Kath et al., 2012; O'Connell et al., 2007). Sustainability is a significant measurement of success for nurse leaders. Nurse leader sustainability is essential to the organizational climate; organizational effectiveness; patient care delivery methods; and patient care outcomes (Shirey, 2006; Swearinger, 2009).

The depth of psychological strain associated with the all-consuming expectation of being *"always on"* may pose significant risks to the nurse leader's well-being (Frandsen, 2010). Depression and anxiety are common health concerns associated with prolonged and/or increased stressors noted among nurse leaders (Perry et al., 2015). Additionally, the nurse leader is often presented with the dilemma of performing under constant occupational stress as a result of competing priorities and relentless deadlines (Miyata, Arai & Suga, 2015).

The most evident contributing risk factors influencing nurse leader well-being are role fatigue, role strain, and role conflict (Kath et al., 2012). There is current knowledge and ample research examining the impact of occupational

stress among frontline nurses. However, there is insufficient research exploring, in an in-depth manner, the nature of and response(s) to occupational stress among nurse leaders.

The average nurse leader's tenure is seven to thirteen years and remains in jeopardy of a progressive decline (Parsons & Stonestreet, 2003). Projections forecast a proliferation of nurse leader vacancies due to involuntary/voluntary role departures, secondary to job stress/work demand and work-life imbalance (Titzer et al., 2013; U.S. Department of Health and Human Services, Health Resources and Service Administration, 2010, p.20). Titzer and colleagues (2013) predict a vacancy of nearly 70,000 nurse leaders by the year 2020. As a result, there is an urgent need to fully understand how occupational stress affects nurse leaders.

Occupational stress is described as the *magnitude* of job-related effort, labor, or exertion to perform that produces role strain, role fatigue, and/or role ambiguity (Motowidlo et al., 1986). As scopes of responsibility broaden for the nurse leader, there is a likelihood the role of the nurse leader will expand, resulting in intensifying magnitudes and sources of occupational stress. The purpose of this qualitative study is to explore occupational stressors in nurse leaders and their responses to this stress. The specific aim of this study is to:

Aim 1: To understand perceptions of occupational stress among nurse leaders.

The research questions of this study are:

Research Question 1: How do nurse leaders construct the issue of stress in the workplace?

Research Question 2: What are the perspectives of nurse leaders on their responses to this stress?

Background and Significance

The scope of the nurse leader's role is ever-changing, primarily based upon the emerging needs of today's healthcare (Aroian et al., 1997; Zastock & Holly, 2010). Nurse leaders are exposed to high [unrealistic] job demands; competing and compounding priorities; and exhaustive work hours (Frandsen, 2010). The nurse leader is confronted with daily challenges and multi-dimensional demands from various key stakeholders (Aroian et al.,1997).

As health care continues to evolve and become increasingly complex and competitive, the magnitude and intensity of occupational stressors may also increase significantly for the nurse leader (Zastock & Holly, 2010). The emotional well-being of the nurse leader directly impacts organizational climate, productivity, patient care delivery methods, and patient outcomes (Shirey, 2006; Swearinger, 2009). However, there is a lack of inquiry exploring occupational stress among nurse leaders.

The total percentage of nurse leaders in the United States is estimated at 12.5% (U.S. Department of Health and Human Services, Health Resources and Services Administration, p. 20, 2010). Titzer et al. (2013) posits a projected vacancy of nearly 70,000 nurse leaders by the year 2020. The most prominent contributing risk factors influencing nurse leader well-being and longevity are *role fatigue*, *role strain, role conflict* (O'Connor, 2002; Connaughton & Hassinger, 2007; Kath et al., 2013). There is a heightened concern regarding the perceived

inability of the nurse leader to sustain momentum and longevity under the constant demands of the work environment (Frandsen, 2010).

The perceived occupational stressors among nurse leaders include advancements in technology; persistent nursing shortage; and the broadening scopes of responsibility (O'Connor, 2002). There is a paradigm shift of the role of nurse leaders. Balancing clinical and financial expectations as a result of broadening scopes of responsibility is a significant catalyst of occupational stress among nurse leaders (O'Connor, 2002). Presumably, an unavoidable emphasis for the nurse leader is most likely a continued shifting predominantly to financial priorities, thereby intensifying job demands and expanding occupational stress (O'Connor, 2002).

In a qualitative study conducted by Shirey et al. (2010) common themes revealed in the study were perceived sources of stress; effective/ineffective coping strategies; and health-related consequences. Shirey et al. (2010) noted the principal source of occupational stress among the nurse leader is the perception of unrealistic organizational demands and the challenges with identifying effective coping strategies. The response to occupational stressors differs between novice and expert nurse leaders (Swearinger, 2009). Kath et al. (2012) examined nurse leaders' perception of job stress and the associated outcomes of high-level stress on organizational performance and organizational climate. Kath et al. (2012) found high-level stress unfavorably influences the nurse leader's mental and physical health, consequently impacting nurse leader retention; nurse leader recruitment; nurse leader turnover/ideation; and nurse

leader succession planning. However, research is scarce in understanding the origins of occupational stress and associated coping strategies at various levels of nursing leadership (Lee & Cummings, 2008; Shirey et al., 2008).

Nourry et al. (2014) conducted a descriptive correlational study that examined the psychological consequences [depressive symptoms] of occupational stress among nurse leaders. Role fatigue is noted among the leading risk factors or consequences of occupational stress among nurse leaders (Kath et al., 2012). Role fatigue results from an imbalance of effort-reward caused by unrelenting competing priorities and fluctuating healthcare demands (Kath et al., 2012).

An imbalance of effort-reward is identified as an early trigger of occupational stress and may predispose the nurse leader to an array of negative consequences, such as depressive symptoms (Nourry et al., 2014). Perry et al. (2015) used a cross-sectional survey design to describe the mental health status of nurses. Perry et al. (2015) found psychological conditions such as depression and anxiety are common mental well-being concerns associated with prolonged and/or increased occupational stressors experienced by nurses. Feelings of helplessness and inadequacy may arise due to an imbalance of effort-reward; competing priorities; and insufficient goal attainment (O'Connor, 2002; Zastock & Holly, 2010).

Psychosocial conditions among nurse leaders may present as a wide-spectrum continuum. Psychosocial conditions may emerge in the form of workplace violence; substance abuse; and increased truancy (Perry et al., 2015;

Shirey et al., 2010). Disengagement in the organization's vision and goals and feelings of distrust and suspicion may emerge in the form of disconnect from seniors, peers and subordinates (O'Connor, 2002; Zastock & Holly, 2010; O'Connor & Batcheller, 2015). The emotional well-being of nurse leaders directly impacts the emotional, financial, and responsive well-being of the organization and its key stakeholders (Shirey, 2006).

The extent of prolonged occupational stress experienced by nurse leaders may manifest in the form of poor decision-making; decreased alertness; and a lack of sustainable vigor (Shirey et al., 2010; Johansson et al., 2011). Negative physiological health conditions affecting nurse leaders may impact the cardiac, gastrointestinal, musculoskeletal, and immune systems (O'Connor & Batcheller, 2015). Symptoms of negative physiological health conditions may exhibit as fatigue, headache, visual disturbances, and sleep deprivation (Frandsen, 2010). In addition, Shirey et al., (2010) report the occurrence of increased workplace injuries among nurse leaders such as falls and back injuries, are frequently associated physiological risks linked to prolonged occupational stress. As a result of the aforementioned psychological and physiological conditions nurse leaders may decide to transition to less demanding roles or exit the profession entirely in an effort to preserve or regain mental and/or physical well-being (Shirey et al., 2010).

This study aims to narrow gaps in knowledge by a) exploring occupational stressors in nurse leaders and their responses to this stress and b) develop future interventions to decrease occupational stress in nurse leaders. Upon

successful completion of the proposed research, we expect our contribution to offer further insight and understanding of successful nurse leader retention and sustainability at all levels of nursing leadership. This contribution is expected to be significant because gaining such an understanding will significantly aid in promoting organizational effectiveness, thereby driving progressive patient care delivery methods, and potentiating favorable patient outcomes.

The preservation of nurse leaders is vital to the livelihood of high quality patient care delivery methods; favorable patient outcomes; and overall organizational effectiveness. Therefore, this study intends to increase the knowledge and understanding surrounding occupational stress and its associated consequences among nurse leaders. Furthermore, the study is essential in its effort to narrow the gap in knowledge and render explanations to counteract potential adverse consequences of occupational stress among nurse leaders.

The expected outcome from this study is an in-depth understanding of perceived occupational stress in nurse leaders. With this in-depth understanding, appropriate interventions can be developed to decrease stress in the workplace and increase nurse leader sustainability [and retention]. The long-term objective of this study is to develop future interventions to decrease occupational stress in nurse leaders.

Innovation

The study is innovative, in our opinion, because it shifts current research exploring occupational stress among staff nurses to exploring the perceptions of

occupational stress and the perceived responses specific to nurse leaders. There is limited exploration of the factors influencing occupational stress among the nurse leader. The most prominent contributing risk factors regulating nurse leader well-being are role fatigue, role strain, and role conflict (Kath et al., 2012). In addition, there is insufficient probing of the subsequent outcomes or consequences resulting from occupational stress (Shirey et al, 2010). Such consequences directly impact patient care delivery methods; organizational climate; and the future of nurse leader succession and progression plans (Shirey, 2006).

Leader agility is a significant element of the measurement of perceived success among leaders (Kath et al., 2012). The absence of agility potentially threatens the success of the nurse leader (Cummings et al, 2008). Emelogu's (2017) conceptual framework of agile leadership is the guiding framework for this study (Figure 1). The conceptual framework will be used to explore the perceived sources of occupational stress among nurse leaders and to further understand the effect on nurse leader well-being. Agile leadership is theoretically defined as *the ability to effectively respond to organizational expectations, while maintaining balance in new and changing environments.*

. The three core components of the conceptual framework are *environment* [organizational expectations]; *response* [nurse leader's affirmative response to the occupational stressors]; and *outcome* [sustained demonstration of agile leadership]. The conceptual framework provides a novel and redefining perspective of effective nurse leader retention in terms of the *quality* of nurse

leaders versus the *quantity* of nurse leaders. The framework places focus on the retention of nurse leaders who exhibits commitment, adaptability, resilience, and self-efficacy [quality], rather than the magnitude [quantity] of nurse leaders retained. The framework will be used in this study to serve as an underpinning for progressive research exploring the perceptions and responses of occupational stress among nurse leaders.

Preliminary Data

In the summer of 2018, I conducted a systematic review to examine and systematically synthesize the published research probing the impact of occupational stress among nurse leaders on healthcare organizations, patients, and staff. A systematic search was conducted using the CINAHL (n =20), EMBASE (n = 9), EBSCO (n = 10), PubMed (n = 28), PsycINFO (n = 2), and Medline (n = 23) electronic databases. Results from the review yielded seven records. Four qualitative studies and three quantitative studies examined the impact of occupational stress among the nurse leader on the organization, patient, and staff. Significant findings revealed occupational stress in nurse leaders influences the organization's ability to effectively recruit and retain nurse leaders and frontline nurses. The findings also revealed perceptions of occupational stress are largely based upon a heightened awareness of stress, as it exists in the work environment. The nurse leader will purposefully initiate [effective or ineffective] coping strategies used in past experiences to navigate through present stressful experiences. The coping strategy of choice will

determine [proactive or reactive] solutions for managing occupational stress and its subsequent impact on the key variables of interest.

The Role Stress Theory was used to examine the source(s) of role stress among the nurse leader and to further understand the associated predictor variable(s) of role stress. The theory underscores the origins of role stress as role conflict, role ambiguity, and role overload (Newton & Keenan, 1987). By examining the predictors of role stress among the nurse leader, the theory provided further knowledge and understanding of the effect of role stress on organizational, patient, and staff outcomes. Roy's Adaptation Theory was used to understand the coping mechanisms utilized to counteract occupational stress. The theory provided further insight and understanding into the selection process employed by the nurse leader to choose the best method to cope/adapt to the constant fluctuations in the internal and external environments. The theory's underpinning assumes the person is a bio-psycho-social entity in constant interaction with a shifting environment (Kaur & Mahal, 2013). The theory posits effective stress coping mechanisms are warranted to adapt to changing environments (Weiss et al., 1994). The theory further suggests responding favorably to environmental changes is the result of the individual's awareness of the changes as it occurs and willingness to adapt to such changes (Keil, 2004). The Leader Member Exchange Theory (LMX) was used to examine the impact of occupational stress on the interpersonal relationship between the nurse leader and employees. The LMX theory posits the vital importance of the *quality* of the interpersonal relationship between the leader and employees (Thomas &

Lankau, 2009). The theory implicates the quality of the interpersonal relationship directly impacts organizational climate; employee performance; and patient care outcomes (Laschinger, et al., 2011). The LMX theory described the relationship between the leader and employee in terms of level of quality. In that the higher level of organizational engagement exhibited among the employee is a direct result of the higher level of quality of relationship invested by the leader (Thomas & Lankau, 2009).

The nurse leaders may experience difficulty coping with perceived unrealistic organizational demands. Stress in nurse leaders affects the quality of patient care by diminishing the nurse-patient relationship and weakening patient care delivery systems. Occupational stress in nurse leaders disrupts the working relationship between the nurse leader and staff and poses risks to staff retention, satisfaction, and development. Increased awareness of the overt and covert elements that trigger occupational stress is a task the nurse leader must become astute to. It is imperative for the nurse leader to fully understand the response(s) to occupational stress directly impacts the organization, staff, and patient outcomes. In doing so, the nurse leader must be proactive in identifying and seeking out resources that will aid to effectively manage through stressful encounters and experiences.

Research Design and Methods

A generic qualitative descriptive approach, using thematic content analysis, will be used to explore the perceptions of occupational stress among nurse leaders (Crabtree & Miller, 1999; Kahlke, 2014). Data collection and data

analysis will be conducted over a four to six month timeframe. Sampling and informed consent will be obtained after CPHS approval. Recruitment strategies will include seeking permission from local professional nursing organizations geared to nurse leaders, such as the Texas Nurses Association (TNA) and the Texas Organization of Nurse Executives (TONE), to access member banks and post recruitment notices on their websites. In addition, the primary investigator will recruit within her professional network to obtain study participants, via email distribution and/or face-to-face discussions, explaining the nature of the study and to obtain study participants. The primary investigator's contact information (school email address) will be provided to potential participants address questions and obtain additional information, if any.

Sampling and Setting. Purposive sampling will be used to ensure participants meet four core inclusion criteria 1) administrative or clinical nurse leader with 24 hour accountability and responsibility for a direct care unit(s) or department(s), to include, but not limited to Nurse Manager, Nurse Director, Nurse Supervisor, Administrative Director, Chief Nursing Officer, Associate Chief Nursing Officer, or Vice President of Nursing 2) oversees fiscal and human resources and clinical performance 3) at least two years of nursing leadership experience and 4) currently employed in a community or academic teaching hospital in the greater Houston area. Exclusion criteria are 1) non-English-speaking 2) less than two years of nurse leader experience and 3) nurse leaders who do not reside in Houston, Texas or its surrounding areas. This study excludes nurse leaders with less than two years of nursing leadership [novice

nurse leader] to provide an opportunity for socialization into their new role. Furthermore, exclusion of novice nurse leaders to avoid a potential for skewed data due to early misperceptions and/or unclear expectations of the newly acquired role. Findings from this study may build upon new knowledge to guide future studies exploring novice nurse leaders.

An estimated sample size for this study is 20 - 30 participants and anticipated data saturation between 15 – 30 participants or until no new major concepts or phenomena is emerging from the data (Marshall et al., 2013; Moser & Korstjens, 2018; Onwuegbuzie & Leech, 2007; Trotter, 2012). In an effort to provide the most information-rich sources among a diverse representation of nurse leaders, maximum variation sampling via snowball sampling may be further employed. To avoid a breach in confidentiality and privacy, the primary investigator (PI) will ask current participants to share the information/recruitment flyers, which contain the PI's contact information, to potential interested participants. To further minimize risks and/or avoid a breach in privacy, the PI will inform current participants that incentives or compensation will not be provided for referrals. The aim of this sampling method is to recruit future subjects who may have differing viewpoints [heterogeneity] regarding perceived sources of occupational stress and their varied responses to stress. Semi-structured face-to-face interviews will be conducted at two designated hospitals in Houston, Texas.

Data Collection Procedures. Approval from the University of Texas Health Science Center's *Committee for the Protection of Human Subjects* (CPHS) will be obtained prior to the initiation of the study. After approval is granted, an information flyer detailing the study's premise and objectives will be sent electronically to the aforementioned professional nursing organizations' websites and posted on communication boards at the University of Texas Health Science Center (UT). The primary investigator will include her contact information (UT email address) on the flyer for prospective participants to contact her if interested in participating.

If the participant meets eligibility/inclusion criteria and desires to participate in the study, the primary investigator will provide a detailed explanation of the study; informed consent form; estimated length of time for the interview; and a demographic form. The informed consent process will include a comprehensive explanation of the study detailing information regarding risks and benefits. The informed consent process will also include/state the participant's right to [voluntarily] withdraw from the study at any time, without penalty or loss of benefits. During the interview scheduling process, the primary investigator will address questions regarding the informed consent form with each participant.

The primary investigator will partner with two hospitals in the greater Houston area to use their private conference/meeting rooms for conducting interviews. Participants will receive a $10 Starbucks gift card as an incentive for participating in the study. Participants will also receive complimentary parking vouchers if they select hospitals (study setting) where paid parking is expected.

Data collection via in-depth face-to-face interviews will be collected over a four to six-month timeframe. Interviews will range from 30 minutes to one hour. However, additional time will be provided to each nurse leader to allow sufficient time to fully express his or her thoughts, in a non-hurried manner. The aim is to provide a self-guided, relaxed, and non-threatening environment for each nurse leader. The emphasis is to evoke trust and comfort with the principle investigator, in an effort to produce information-rich responses. Participant's names will be de-identified to ensure confidentiality and integrity of the data collected. To ensure securement of data collection materials data will be stored using a double-lock filing system in the PI's office made accessible to CPHS.

Data Collection Method. All interviews will be audio-recorded and transcribed. An open-ended, semi-structured interview format will be used to capture unique and/or similar responses. This interview format is advantageous. It provides each participant an opportunity to fully express his or her thoughts and feelings, yet providing a guided and structured process for the researcher. Spradley's (1979) ethnographic descriptive questions via grand tour and mini tour questions will be used to guide the interview [data collection] process. Questions will be geared toward a) capturing experiences that highlight perceived triggers and/or sources of occupational stress b) understanding the nurse leader's response(s) to such triggers and/or sources c) and exploring the perceived consequences of such responses among nurse leaders. An interview guide consisting of 16 grand tour questions will be utilized (Appendix A). The investigator will use a reflexive journal to promote bracketing, in an effort to

reduce or prevent preconceived assumptions, opinions, or biases regarding occupational stress among nurse leaders. The interview guide may be modified based upon incoming data and new discoveries obtained from the reflexive journal.

Data Analysis. Data analysis will take place concurrently with data collection to capture any new discoveries and allow modification of the interview guide during the interview process. Data will be organized using computer-assisted qualitative data analysis software (CAQDAS) to capture similarities and unique themes. CAQDAS assists to analyze, organize, and manage large amounts of qualitative data in an efficient and streamlined method (Gibbs et al., 2002). Nurse leaders' perspectives of occupational stress constructs and their response to occupational stress will be coded using the CAQDAS, ATLAS.ti MAC.

Data organization will employ coding schemes to appropriately identify, label, and categorize concepts or themes. A codebook will be created to explain the precise definition of the categories or themes. The study will employ one coder [primary investigator] to ensure reliability and confirmability. Thematic content analysis will be used in this study to distinguish and/or categorize themes derived from the data (Fereday & Muir-Cochrane, 2006; Vaismoradi et al., 2013). Thematic content analysis will be conducted to identify distinct patterns originating from nurse leader demographics, such as patterns or themes apparent in male nurse leaders as compared to female nurse leaders or

perceptions of certain fears/stressors apparent in novice nurse leaders as compared to tenured nurse leaders.

External validation via peer debriefing will be used to enhance data quality and ensure accurate interpretations (Polit & Beck, 2017). Peer debriefing will include two experts in qualitative research who will confirm or rule out 1) researcher bias 2) evidence of sufficient reflexivity 3) achievement of data saturation 4) and cohesion of themes derived from the phenomenon of interest. In an effort to further increase method rigor, the primary investigator will conduct audit trails by reviewing process notes (trustworthiness of data); memos (raw data from written field notes); and personal response documentation (materials relating to viewpoints and attitudes).

Potential Limitations & Alternative Strategies

Interview setting/location may pose as a perceived problem. The designated hospitals may unexpectedly cancel room reservations as a result of priority/urgent scheduling needs for hospital business. As a result, the primary investigator would coordinate with the designated hospitals, well in advance, to reserve a primary and alternate location to conduct interviews. This may not be a significant challenge for the primary investigator, as most interviews are likely to be conducted after business hours to better accommodate the nurse leader's availability. The primary investigator would also reserve conference/meeting for evening and/or weekend use, to provide the nurse leader with sufficient scheduling options.

To further provide additional accommodating setting/location options, the primary investigator would provide video call options via Skype™ or WebEX™. A test environment will be conducted in advance to ensure all audio/video components are working effectively and to ensure the primary investigator is familiar with setup and functionality. The inability to recruit sufficient participants may pose a challenge, as well. Therefore, the primary investigator would counteract this potential challenge by posting announcements on professional networking forums such as LinkedIn™, to recruit for potential participants who meet the study's eligibility criteria.

Research Subject Risk and Protection

The Committee for the Protection of Human Subjects (CPHS) at the University of Texas Health Science Center will oversee all procedures in this application. Participants will be given the contact information of the primary investigator. Participants will be given the contact information of the CPHS chair to seek additional clarity about the study and/or ascertain additional information on human subject's rights.

Potential risks to participating in this study may include unauthorized disclosure of confidential information. Protections against potential risks to confidentiality will be 1) the assignment of unique identifiers for each participant 2) all hard copy and electronic data will be stored, using a double-lock system, in the primary investigator's office and 3) all electronic materials/media will be protected via encrypted USB flash drives and password-protected data upload capability via cloud. The company used for transcription services will sign and

comply with the confidentiality agreement form for use with transcription services and ensure protection and privacy of all data received. Due to the nature of this study, potential psychological risks to participating in this study may comprise of escalated emotions and/or thoughts. The primary investigator will pause the interview, to allow the participant time to recover and/or discontinue the interview. The primary investigator will encourage the participant to seek additional assistance and support from his/her employer's Employee Assistance Program (EAP).

Participants will be informed of the benefits of the study that include an opportunity to participate in research exploring the perceptions of occupational stress among nurse leaders. Results and discoveries obtained from this study will aid in developing stress management programs for nurse leaders. Benefits to others include improved patient satisfaction and employee satisfaction, as a result of effective stress management among nurse leaders.

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Karen S. Hill, DNP, RN, NEA-BC, FACHE, FAAN
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Dear Dr. Hill,

Please find enclosed a manuscript for consideration to the Journal of Nursing Administration, titled *Exploring Occupational Stress Among Nurse Leaders: Factors Influencing Nurse Leader Retention and Organizational Commitment.* This manuscript introduces new knowledge and understanding regarding perceptions of occupational stress among varying levels of nursing leadership. As it stands, there is an abundance of research exploring stress among frontline nurses. However, there is a lack of research exploring stress among nurse leaders and the impact on organizational effectiveness, success planning capacity, and patient care outcomes. Using a generic qualitative approach, we conducted 17 qualitative interviews with nurse leaders in the greater Houston area.

Through our analysis, we describe the nurse leader's perceptions of occupational stress and their responses to stress. We describe the sources and consequences of occupational stress among this cohort, in an effort to better understand potential stress coping interventions and redefine the *healthy work environment* specifically for the nurse leader. This manuscript would be most appropriate for the journal's audience and provide insight into the various aspects that influence nurse leader sustainability and effectiveness.

Thank you kindly for your consideration.

Best Regards,

Nnenna A. Emelogu

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Exploring Occupational Stress Among Nurse Leaders: Factors Influencing Nurse Leader Retention and Organizational Commitment

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Exploring Occupational Stress among Nurse Leaders: Factors Influencing Nurse Leader Retention and Organizational Commitment

Background: Nurse leader sustainability is essential to organizational climate and patient care outcomes. The state of science of nurse leader sustainability is fragmented and warrants critical examination. Current research exists examining the impact of occupational stress among frontline nurses. However, research is scarce exploring occupational stress among nurse leaders. *Purpose:* To narrow knowledge gaps by exploring perceptions of occupational stress among nurse leaders and their responses to stress. *Design/Sampling:* A generic qualitative descriptive approach was used to explore perceptions of occupational stress among nurse leaders. The final sample consisted of 17 participants via purposive sampling. *Analysis:* Thematic content analysis was used to categorize themes derived from the data. Data organization via coding schemes to identify, label, and categorize concepts or themes. *Findings:* Ten theme clusters subsumed under six emergent themes, *"Always under pressure"*; *"Lack of work/life balance"*; *"My senior leadership does not support me"*; *"Fear"; "My senior leadership does support me"; "Organizational commitment".* *Conclusion:* Establishing and sustaining healthy work environments for the nurse leader generates a cascading effect on the organization. A heightened awareness of the elements that trigger occupational stress is a task that the organization must become astute to. It is imperative nurse leaders understand their response(s)

to occupational stress directly impacts the organization, staff, and patient outcomes.

Keywords: *nurse leader, nurse manager, occupational stress, job stress, well-being*

Introduction

Nurse leader sustainability is essential to organizational climate, organizational effectiveness, patient care delivery methods, and patient care outcomes. The state of the science regarding nurse leader sustainability is fragmented and warrants critical examination and urgent restoration. There is current knowledge and research examining the impact of occupational stress among frontline nurses (Warshawsky & Havens, 2014). However, there is scarce research exploring the nature of and response(s) to perceived occupational stress among nurse leaders.

The depth of psychological strain associated with the all-consuming expectation of being *"always on"* may pose significant risks to the nurse leader's well-being (Frandsen, 2010). Depression and anxiety are common health concerns associated with prolonged and/or increased stressors noted among nurse leaders (Perry et al., 2015). Additionally, the nurse leader is often presented with the dilemma of performing under constant occupational stress as a result of competing priorities and relentless deadlines (Miyata, Arai & Suga, 2015).

The most evident contributing risk factors influencing nurse leader well-being are role fatigue, role strain, and role conflict (Kath et al., 2013). The average nurse leader's tenure is seven to thirteen years and remains in jeopardy of a progressive decline (Parsons & Stonestreet, 2003). Projections forecast a proliferation of nurse leader vacancies due to involuntary/voluntary role departures, secondary to occupational stress/work demand and work-life

imbalance (Titzer et al., 2013; U.S. Department of Health and Human Services, Health Resources and Service Administration, 2010, p.20). Titzer and colleagues (2013) predict a vacancy of nearly 70,000 nurse leaders by the year 2020. As a result, the purpose of this study is to narrow gaps in knowledge by exploring occupational stress among nurse leaders and to gain an enhanced understanding regarding nurse leaders' perceptions and responses to stress. The research questions for this study are 1) How do nurse leaders construct the issue of stress in the workplace? and 2) What are the perspectives of nurse leaders on their responses to this stress? The findings from this study may support development of interventions to decrease perceived occupational stress and promote job satisfaction.

Review of the Literature

The perceived occupational stressors among nurse leaders include advancements in technology; persistent nursing shortage; and the broadening scopes of responsibility (Shirey et al., 2010). There is a paradigm shift of the role of nurse leaders. Balancing clinical and financial expectations as a result of broadening scopes of responsibility is a significant catalyst of occupational stress among nurse leaders (O'Connor, 2002). Presumably, an unavoidable emphasis for the nurse leader is most likely a continued shifting predominantly to financial priorities, thereby intensifying job demands and expanding occupational stress (O'Connor, 2002).

A qualitative study by Shirey et al. (2010) reported these common themes: perceived sources of stress; effective/ineffective coping strategies;

and health-related consequences. Shirey et al. (2010) noted the principal source of occupational stress among the nurse leader is the perception of unrealistic organizational demands and the challenges with identifying effective coping strategies. The response to occupational stressors differs between novice and expert nurse leaders (Swearinger, 2009). Kath et al. (2013) examined nurse leaders' perceptions of job stress and the associated outcomes of high-level stress on organizational performance and organizational climate. Kath et al. (2013) found high-level stress unfavorably influences the nurse leader's mental and physical health, consequently impacting nurse leader retention; nurse leader recruitment; nurse leader turnover/ideation; and nurse leader succession planning. However, research is scarce in understanding the origins of occupational stress and associated coping strategies at various levels of nursing leadership (Lee & Cummings, 2008; Shirey et al., 2008).

Nourry et al. (2014) conducted a descriptive correlational study that examined the psychological consequences [depressive symptoms] of occupational stress among nurse leaders. Role fatigue is noted among the leading risk factors or consequences of occupational stress among nurse leaders (Kath et al., 2013). Role fatigue results from an imbalance of effort-reward caused by unrelenting competing priorities and fluctuating healthcare demands (Kath et al., 2013).

An imbalance of effort-reward is identified as an early trigger of occupational stress and may predispose the nurse leader to an array of

negative consequences, such as depressive symptoms (Nourry et al., 2014). Perry et al. (2015) used a cross-sectional survey design to describe the mental health status of nurses. Perry et al. (2015) found psychological conditions such as depression and anxiety are common mental well-being concerns associated with prolonged and/or increased occupational stressors experienced by nurses. Feelings of helplessness and inadequacy may arise due to an imbalance of effort-reward; competing priorities; and insufficient goal attainment (O'Connor, 2002; Zastock & Holly, 2010).

Psychosocial conditions among nurse leaders may present as a wide-spectrum continuum. Psychosocial conditions may emerge in the form of workplace violence; substance abuse; and increased truancy (Perry et al., 2015; Shirey et al., 2010). Disengagement in the organization's vision and goals and feelings of distrust and suspicion may emerge in the form of disconnect from seniors, peers and subordinates (O'Connor, 2002; Zastock & Holly, 2010; O'Connor & Batcheller, 2015). The emotional well-being of nurse leaders directly impacts the emotional, financial, and responsive well-being of the organization and its key stakeholders (Shirey, 2006).

The extent of prolonged occupational stress experienced by nurse leaders may manifest in the form of poor decision-making, decreased alertness, and a lack of sustainable vigor (Shirey et al., 2010; Johansson et al., 2011). Negative physiological health conditions affecting nurse leaders may impact the cardiac, gastrointestinal, musculoskeletal, and immune systems (O'Connor & Batcheller, 2015). Symptoms of negative physiological

health conditions may exhibit as fatigue, headache, visual disturbances, and sleep deprivation (Frandsen, 2010). In addition, Shirey et al., (2010) report the occurrence of increased workplace injuries among nurse leaders such as falls and back injuries, are frequently associated physiological risks linked to prolonged occupational stress. As a result of the aforementioned psychological and physiological conditions nurse leaders may decide to transition to less demanding roles or exit the profession entirely in an effort to preserve or regain mental and/or physical well-being (Shirey et al., 2010). The preservation of nurse leaders is vital to the livelihood of high quality patient care delivery methods; favorable patient outcomes; and overall organizational effectiveness. Therefore, this study intends to increase the knowledge and understanding surrounding occupational stress and its associated consequences among nurse leaders.

Conceptual Framework

Emelogu's (2017) conceptual framework of Agile Leadership is the guiding conceptual basis for this study (Figure 1). The conceptual framework was used to explore the perceived sources of occupational stress among nurse leaders and to further understand the effect on nurse leader well-being. Agile leadership is theoretically defined as *the ability to effectively respond to organizational expectations while maintaining balance in new and changing environments*.

The three core components of the conceptual framework are *environment* [organizational expectations]; *response* [nurse leader's

affirmative response to the occupational stressors]; and *outcome* [sustained demonstration of agile leadership]. The conceptual framework provides a novel and redefining perspective of effective nurse leader retention in terms of the *quality* of nurse leaders versus the *quantity* of nurse leaders. The framework places focus on the retention of nurse leaders who exhibits commitment, adaptability, resilience, and self-efficacy [quality], rather than the magnitude [quantity] of nurse leaders retained.

The Role Stress Theory was used to examine the source(s) of role stress among the nurse leader and to further understand the associated predictor variable(s) of role stress. The theory underscores the origins of role stress as role conflict, role ambiguity, and role overload (Newton & Keenan, 1987). By examining the predictors of role stress among the nurse leader, the theory provided further knowledge and understanding of the effect of role stress on organizational, patient, and staff outcomes.

Roy's Adaptation Theory was used to understand the coping mechanisms utilized to counteract occupational stress (Kaur & Mahal, 2013). The theory provided further insight and understanding into the selection process employed by the nurse leader to choose the best method to cope/adapt to the constant fluctuations in the internal and external environments. The theory's underpinning assumes the person is a bio-psycho-social entity in constant interaction with a shifting environment (Kaur & Mahal, 2013). The theory posits effective stress coping mechanisms are warranted to adapt to changing environments (Weiss et al., 1994). The

theory further suggests responding favorably to environmental changes is the result of the individual's awareness of the changes as it occurs and willingness to adapt to such changes (Keil, 2004).

Methods Design

A generic qualitative descriptive approach, with semi-structured interviews was used to explore the perceptions of occupational stress among nurse leaders (Crabtree & Miller, 1999).

Sample and Setting

Sampling and informed consent were obtained after approval from the University of Texas Health Science Center's *Committee for the Protection of Human Subjects* (CPHS).

Purposive sampling is a focused selection method based on the specific characteristics of a population to ensure information-rich data is obtained (Polit & Beck, 2017). Purposive sampling was used to ensure participants met four core inclusion criteria: 1) an administrative or clinical nurse leader with 24 hour accountability and responsibility for a direct care unit(s) or department(s), to include, but not limited to, Nurse Manager, Nurse Director, Nurse Supervisor, Administrative Director, Chief Nursing Officer, Associate Chief Nursing Officer, or Vice President of Nursing; 2) oversees fiscal and human resources and clinical performance; 3) at least two years of nursing leadership experience; and 4) currently employed in a community or academic teaching hospital in the greater Houston area. Nurse leaders were excluded if they: 1) did not speak English; 2) had less than two years of nurse

leader experience; or 3) were not currently employed in a community or academic teaching hospital in Houston, Texas or its surrounding areas. The study excluded nurse leaders with less than two years of nursing leadership experience [novice nurse leader] to provide sufficient opportunity to acclimate into their new role and to avoid the potential of skewed data due to early misperceptions and/or unclear expectations of the newly acquired role (Shirey et al., 2010; Havaei, Dahinten, & Macphee, 2015). In addition, maximum variation sampling via snowball sampling was used to provide the most information-rich sources among a diverse representation of nurse leaders. The aim of this sampling method was to recruit potential participants with heterogenous viewpoints and heterogenous responses to stress (Polit & Beck, 2017; Green & Thorogood, 2018).

Data Collection

In-depth face-to-face interviews were conducted from November 2018 to January 2019. An open-ended, semi-structured interview format was used to capture unique and/or similar responses (Kvale & Brinkmann, 2009). The semi-structured interview format provided each participant an opportunity to fully express his or her thoughts and feelings, while providing a guided and structured process for the researcher via an interview guide (Crabtree & Miller, 1999; Green & Thorogood, 2018).

The interview guide consisted of 16 grand tour questions and was modified based upon incoming data and new discoveries obtained from the reflexive journal (Appendix A). Questions were geared toward a) capturing

experiences that highlight perceived triggers and/or sources of occupational stress b) understanding the nurse leader's response(s) to such triggers and/or sources c) exploring the perceived consequences of such responses among nurse leaders and d) understanding how the nurse leader's perceptions of occupational stress influences retention and commitment. Interviews ranged from 30 minutes to one hour. All interviews were audio-recorded; downloaded to a secured password-protected icloud account; and transcribed by an external transcription service into a word document for subsequent coding and analysis.

Procedures

Recruitment strategies included seeking permission from local professional nursing organizations geared to nurse leaders, such as the Texas Nurses Association (TNA), whereby recruitment notices was posted on the professional organization's website and sent via member email distribution lists. The primary investigator's contact information (email address) was provided to potential participants to address questions and obtain additional information, if any. The primary investigator also recruited within her professional network to obtain study participants. Interested participants were screened for eligibility based on years of nursing leadership experience and who were currently employed in a community or academic teaching hospital in the greater Houston area. The settings for interviews were mutually arranged between the primary investigator and each participant. The majority of interviews took place in private offices. A few

participants requested to use the WebEx videoconferencing option, due to scheduling conflicts and/or accessibility.

To avoid a breach in privacy by not disclosing prospective participants' information, the primary investigator asked participants to share the recruitment flyers, which contained the primary investigator's contact information, to potentially interested participants. The primary investigator informed the participants that neither additional incentives nor compensation would be provided for referrals. Recruitment continued until data saturation was achieved. Each participant received a $10 Starbuck's gift card as an incentive for participating in the study.

Data Analysis

Participant interviews were transcribed in it its entirerty. Data analysis began during data collection to identify new discoveries and/or to monitor for data that warranted further clarity or understanding (Green & Thorogood, 2018). Data analysis involved familiarization with the data; coding the data set; identification of themes using deductive and inductive analysis; and organization of codes, coding schemes, and themes using thematic content analysis (Green & Thorogood, 2018). These steps of data analysis are presented in Figure 2.

Thematic content analysis was used to distinguish and/or categorize themes derived from the data (Green & Thorogood, 2018). Thematic content analysis was further used to capture similarities and differences within the data (Polit & Beck, 2017; Green & Thorogood, 2018). Thematic analysis

employed coding schemes to appropriately identify, label, and categorize concepts or themes (Saldana, 2016).

Each interview was transcribed and reviewed rigorously to gain in-depth insight and understanding of each participant's experience and perceptions. Eighty-seven significant statements pertaining to occupational stress, level of commitment, and coping strategies were extracted from seventeen transcripts. Table 1 provides examples from the significant statements that were identified and extracted from participants' transcripts. Each significant statement was examined and converted into formulated meanings.

Table 2 provides examples of how significant statements were converted into formulated meanings. The formulated meanings were then grouped into categories reflecting a distinct structure of clusters of themes. Ten theme clusters emerged which were grouped into six emergent themes. Table 3 provides an example of the process of constructing the first theme "Always under pressure" through integrating different clusters of themes and formulated meanings. A codebook was created to explain the precise definition of the categories or themes (Saldana, 2016). Figure 3 illustrates the themes and subthemes of perceptions occupational stress among nurse leaders.

Extensive peer debriefing at each point of the iterative and interpretive process was conducted with qualitative research experts to validate the accuracy of the formulated meanings and emergent themes (Polit & Beck,

2017). The primary investigator also used a reflexive journal to promote bracketing, in an effort to reduce or prevent preconceived assumptions, opinions, or biases regarding occupational stress among nurse leaders (Miles, Huberman & Saldana, 2014).

Findings

Sample Characteristics

The final sample consisted of 17 participants. Nurse leaders were defined as an administrative or clinical nurse leader with 24-hour accountability and responsibility for a direct care unit(s) or department(s) who oversees fiscal and human resources and clinical performance. Table 4 summarizes the demographics of nurse leader participants. The majority of participants worked at teaching hospitals (59%); Magnet designated hospitals (53%); and hospitals with union affiliations (18%). Participants were mostly female (82%), African American (59%), and ranged in age from 25 to 65 years, with the majority (71%) falling into the 36- to 50-year category. The years of nursing experience ranged from nine to 41 years (mean = 19 years). The years of nurse leader experience ranged from two to 30 years (mean = 9 years). The highest degree earned among the majority of participants was a Master's of Science in Nursing (65%). Doctoral-prepared nurse leaders represented 17% (n=3) of the participants. The majority of participants held roles as Nurse Managers (47%) and Directors (47%). Nurse leaders serving in senior leadership roles (Assistant Vice President of Nursing or higher) represented 6% of the participants (n=1).

Theme Clusters

The key findings of the study revealed ten theme clusters subsumed under six main themes (Figure 3). The main themes that emerged from the study were *"Always under pressure"*; *"Lack of work/life balance"*; *"My senior leadership does not support me"*; *"Fear"; "My senior leadership does support me"*; *and "Organizational commitment".* Together, these six themes capture the essence of the perceptions of occupational stress as experienced by nurse leaders and their corresponding responses to such stress. The findings provided in-depth insight into the various elements that described or defined occupational stress as experienced by the nurse leader.

Main Theme 1: Always Under Pressure

The overarching opinion expressed by the nurse leaders was the feeling of "always feeling under pressure to meet deadlines and expectations". There were two subthemes that subsumed under the main theme: *Episodic Stress* and *Self-Inflicted Stress.* Most participants felt like they were expected to outperform the previous task, in an effort to stay relevant in the eyes of their senior leadership. One nurse leader described work deadlines and expectations as:

> *"Unrealistic demands…often due to organizational priorities that are not true priorities, but priorities that are situational and most times due to knee-jerk reactions. Competing priorities are just really a result of situational and reactive priorities and can set us up for failure."* (#2)

Subtheme 1: Episodic Stress

Episodic stress refers to work pressure that may be seasonal and occurs intermittently. Participants described episodic stress as stress that comes expectedly during certain times of the year or during specific timeframes, such as Magnet designation/re-designation, Joint Commission accreditation, annual performance evaluations, and budget season. One participant described episodic stress as:

> *"I typically know the amount of stress to expect throughout different times of the year. I guess that's what you expect when you've been doing this for so long…I breathe through it and chant, "this too shall pass". Especially during budget season when I have to justify why I'm over-budget and still requesting additional funds for the next fiscal year. Every year I go through the same ritual and the amount of stress doesn't change. At the end…I typically get what I ask for, but the whole anticipation of it is literally torture."* (#1)

Subtheme 2: Self-Inflicted Stress

Self-inflicted stress is described as pressure that is placed on the nurse leader by one's own doing to ensure deadlines are met in the most expeditious manner. Self-inflicted stress is also described as the inability of the nurse leader to set boundaries regarding workload capacity and the ineffective or absent use of delegation to decrease workload pressures. One participant described self-inflicted stress as:

> *"Not using the power of no when compounding deadlines are surmounting. I struggle with limitations and place everything on my*

plate to appear as a team player. I put a great deal of pressure on myself to complete tasks in time and I don't usually trust others to delegate to…some say I micromanage myself. But I know my capacity and what I can deliver…so I consciously take on more than I should and don't delegate tasks as much as I should." (#5)

Some participants equated self-inflicted stress as a common syndrome among high-achievers to exhibit high-level functioning or performance. The nurse leader readily sought to assume more tasks and responsibilities to demonstrate worth and value to the organization. One participant explained:

"My stress is usually self-inflicted because I want to do well. I put a lot of pressure on myself. So making sure that whatever priorities, metrics, and outcomes that our organization sets for us, I'm able to meet. I'm able to meet them usually because I always want to do more. So I feel like I put the stress on myself." (#12)

The participants perceived self-inflicted stress as a necessary evil and a constant reminder that nurse leaders are perceived as dispensable if they do not meet the demands of the job nor produce favorable results or outcomes. One participant further described self-inflicted stress as:

"Pressure that I put on myself to be the best… we are no longer in "thrive" mode, we are in "survival" mode. Without it, I tend to become relaxed and passive and may take things for granted. Early in my career I've been burned too many times and learned my lesson hard the way… so I try to always keep a small fire burning under me to

remind me to stay five steps ahead and be the best at what I do at all costs. Sometimes I do see the consequences in my family life and my health, but I have to do what I have to do… to survive." (#7)

Many participants attributed nurse leader success as the outcome of exerting their maximum efforts at tasks in an effort to produce sustained optimal results. However, the definition of "success" may have derived from external forces as opposed to internal driving forces. One participant described self-inflicted stress as the consequence of trying to meet other people's standard of excellence, as opposed to one's own standard:

"I think my job stress comes from the pressure I put on myself to be the best manager I can be, but not using my own definition…using other people's definition. I care more about what they [staff] are seeing because I want them to also support it. I want to be a good manager for each of them. I think sometimes that's what my stress is… putting this pressure on myself by using other people's definition." (#16)

Some participants viewed the constant desire to produce optimal outcomes as a method to show their worth and value to senior leadership and the organization. However, doing so potentiated additional pressure on the nurse leader to keep up with endless demands and expectations. One participant explained:

"We were getting results. We were getting everything out…and I was asked to take on more. So I felt valued at that point. We're getting

results to feel valued…to take on more responsibility…to then take on more stress." (#10)

Main Theme 2: Lack of Work/Life Balance

All participants perceived a sense of sacrifice when it related to choosing between work life and personal life. There was one subtheme that subsumed under the main theme: *Never Off-Stage.* Most participants reported work life always prevailed over personal life. Mainly due to the organizational demands placed on the nurse leaders and the expectation to meet deadlines, by any means necessary. One participant described the constant pressure of organizational demands and meeting deadlines as:

"Something's always due and you're down to the wire… and all these competing priorities. It's working late, it's thinking about it [work] when you're not at work… or like after I'm done, I 'll be working again. It's working on your off hours and it's pressure. You're in the pressure to get things done." (#6)

The participants reported the pursuit to maintain a healthy work/life balance was a daily struggle and produced significant stress. The pressure of never finding an endpoint produced compounding frustrations for the nurse leaders. Many participants explained the constant feeling of "drowning in work" as evidenced by when one task is completed or nearly completed another set of tasks emerged. One participant described the challenge of maintaining balance as:

"From the minute I walk in, I'm already behind on what needs to be done. So I'm always working to catch up. So the stress of not ever able to be ahead of the work that needs to be done is a stressor. It's always there…it's on the weekends. Whenever I'm off, I'm always thinking about the stuff that I've got to get done that's still there." (#10)

The conflict of choosing between work life and personal life was reported as a common struggle for the participants. The participants realized the consequences and subsequent strain of choosing work over personal life. However, the intentional sacrifice to place priority focus on work rather than personal life was extremely dissatisfying, yet warranted. One participant described the constant challenge to balance work life and personal life as:

"They're very rough on middle managers. 24-hour accountability, which got really hard for me …either I committed myself to my job and I neglected my family…or if I tried to spend more time with my family, then my job fell behind. I mean there was just no downtime whatsoever and it really got tough." (#7)

Another participant explained the sacrifice associated with attempting to achieve a work/life balance as:

"I wake up early, I start early, and I end late. No I can't work seven days a week, but I may be able to squeeze in six every other week. Finding that 25th hour in the day…I do what I have to do. If you're going to lead the department well, you're going to spend sleepless nights

making sure that things get done properly…whether that's on your time or the company's time, you're going to make sure it's done." (#9)

One participant described the impact of a longstanding work/life imbalance on interpersonal relationships as:

"There's no work/life balance…and the person that I am…I become exhausted and overwhelmed. I have had a tremendous amount of job stress…and I felt like I was extremely out of character. I was angry constantly because it's a built up of just being overwhelmed, tired, not feeling supported. So I'm lashing out at my coworkers, I'm lashing out at my staff…I'm certainly lashing out at my family. I'm having so much stress I was called into the CEO's office because I didn't know how to communicate quietly with my coworkers…I couldn't have a conversation without yelling." (#9)

The lack of work/life balance was reported as a constant strain among nurse leaders. Several participants acknowledged this problem and viewed it as a normal-abnormal element of the role. Whereas, few participants believed the lack of work/life balance was the defining catalyst for departing the role of nurse leader or the nursing profession in general. One participant described the reason for departure as:

"Being a nurse manager is not pleasant at all. My organization is very rough on middle managers. They impeded on my work/life balance. I never got to go home and have days off. My department is the ED…it never closes. So I got calls all hours of the night. You got call-ins; you

got high censuses…you got to address the different patient complaints. You're addressing payroll, scheduling, evaluations, budgets. All that stuff goes into play. And then on top of that, at times when the patient volumes swells up, you've got to get out there and help…and it takes you away from the administrative function. So you do that too many times your administrative function starts to fall behind and you start getting these nasty emails about 'Hey you missed your deadline for this'." (#7)

Another participant described the plan for a potential departure as:

"Work/life balance is very important…what I'm not seeing right now is that. I'll get there about seven o'clock in the morning, but I'm not leaving until six or seven o'clock at night. Home life is really being hindered. I'm over so many different components of my service line. I have Labor and Delivery. I have the NICU. I have Childbirth Education. I have Lactation. I have Mother-Baby. Then they just added the GYN component…and then I have Maternal Fetal Medicine. I don't see myself in nursing in the next three to five years…I want to start my own boutique. I'm putting in all these hours and time. There's that piece of freedom that I'm yearning for. I'll put in the hours, but why not put in the hours for myself or for my brand?" (#17)

Subtheme 1: Never Off-Stage

All participants voiced concerns regarding rarely having time to fully recover from the pressures of work. The feeling of "always on and never off"

was reported as a substantial source of stress for the participants. Many participants felt they were always being called upon to address something of relevance or irrelevance in the workplace. Partly due to a significant gap in understanding the difference between urgent versus non-urgent.

The participants also understood their role entailed 24-hour accountability. However, there was a discernable disconnect from the understanding of being available versus being accessible. The expectation set forth by the organization and/or senior leadership in regards to 24-hour accountability of the nurse leader presented burdens for the nurse leader. One participant explained:

> *"The expectation of the organization to always be available…means you're there a lot longer than you plan to be. I don't know if I can call it realistic expectations or better timelines for things. We all have deadlines we have to meet, but I think that's when there's an issue. There's a knee-jerk reaction sometimes…they want results yesterday. So it's that pressure to perform and give results ASAP even if it means sacrificing your own personal time and attention outside of work."* (2)

Another participant explained:

> *"So you're puling yourself in so many different directions, and then you still go home and you're still being called. So that could easily take away from family time. It's hard to turn off, because duty always calls…and I always answer. And so before you know it, you don't have a work life balance, and you're stressed."* (#1)

All participants voiced an understanding of their accountability for ensuring their areas of responsibility remain fully operational and productive at all times and at all costs. However, such expectations directly impeded upon effective recovery time [off] for the nurse leaders. One participant described the outcome of 24-hour accountability and its associated consequences as:

> *"The hours that you work…because a lot of managers are just expected to go straight into staffing. If you don't have it [staff]…you're having to staff all the time and you're working a ton of hours. Even though you staffed these two days, you still have to come in for these other days. Then that starts messing with that work/life balance."* (#7)

Main Theme 3: My Senior Leadership Does Not Support Me

Many participants expressed the lack of senior leadership support contributed to heightened perceptions of occupational stress. There were two subthemes that subsumed under the main theme: *Lack of Resources* and *Lack of Professional Development Leads to Role Confusion*. The participants described senior leadership support as the allocation of sufficient resources, tools, and opportunities for professional growth and advancement, to efficiently perform and sustain as an effective leader. The lack of senior leadership support often precedes feelings of job insecurity; role confusion; distrust; and disengagement in organizational goals and priorities. The participants reported the challenge of working with limited resources while

trying to meet the various organizational demands. One participant described the direct impact on staff and patient engagement as:

> *"There's so many things that we have to do and it could done by somebody other than us…even one secretary I think would help with just the menial day to day operation. Even my manager gets tied up…when we should be out with patients, with staff, doing the leadership things they tell us to do. I don't have time to have one-on-ones with my staff. I don't have time to sit down and say "tell me about your goals". I don't have time to be a true leader, I think."* (#6)

Another participant explained:

> *"My job is 24 hour, seven days, so I think I need additional help. I find myself doing a lot of clinical things and don't have enough time to do the management side of things. I'm always busy auditing…don't have time to even further the staff and really look at what they need, talk to them and try to help them…spend half the day auditing different things."* (#1)

One participant reported the lack of senior leadership support may also be akin to the absence of verbal recognition or appreciation by senior leadership regarding constantly reliable performance. The participant labeled this behavior as *unconsciously competent* and described it as:

> *"Senior leadership…they're not very appreciative…I don't think it's intentional. You fall into a trap of unconsciously competent. It's almost like an expectation that you excel when you have an employee that*

does well all the time. So you forget to recognize because you're just so used to them at a high level…you tend to just forget because you're just used to their performance." (#7)

Subtheme 1: Lack of Resources

Many participants equated the lack of resources to high-demand and low-supply. Whereas, the [unrealistic] demands that are set forth by the organization via senior leadership did not align well with the insufficient supply or resources needed to achieve goals. One participant explained the perils of high-demand and low-supply as:

"I wish we had more staff. I think that has a lot to do with why we're so stressed and overwhelmed. We're given more work and less people to make it happen…but someone [me] has to make sure the T's are crossed and the I's are dotted. We have to meet goals using a lean method, but often times the goals are so unrealistic given the limited resources we are given." (#9)

The participants associated the lack of resources to a framework that predisposed the nurse leader to failure. The participants are often not provided with sufficient resources, such as adequate manpower; access to data; and consistent senior leadership support, to effectively and efficiently perform at high levels. Resulting in job stress, burnout, and overall job dissatisfaction. One participant explained:

"We have all these expectations that's been put on us, but still we don't have the tools to perform. We are looked down upon or viewed as

incompetent if we ask for help…if we even insinuate we need help. We are trying to work harder with less, yet still try to deliver results. So I think that's setting us up for failure." (#11)

Another participant explained:

"Nurse leaders are given so much that they have to manage and oversee…sometimes I think it's unrealistic. The ideal nurse leader ratio to employee is like one leader to 15 -17…where you've got leaders that are managing 50, 60, 70, hundreds of people. They don't feel like they have enough resources, such as leaders, partners, to help them manage." (#12)

Subtheme 2: Lack of Professional Development Leads to Role Confusion

Many participants identified a gap in transition of practice from bedside nursing to nursing leadership. The transitional gap is viewed as an effect of poor succession planning and frequently leads to role confusion and/or role ambiguities for the nurse leader. The participants reported that their early struggles in their leadership career was largely due to not understanding the full scope nor acclimating to their new roles.

Several participants expressed they were recruited to their first leadership positions based upon being an effective charge nurse or due to a longstanding tenure in the clinical setting. However, in hindsight, the participants recognized they were not effectively groomed to take on such a role. The participants acknowledged there was a significant lack of preparation as it related to balancing and understanding the financial aspects

of leadership; human resources aspects; and organizational priorities and metrics. One participant explained:

> *"We don't do a good job of transitioning the leader into that role. I think we set them up for failure…because you're going from bedside to now a business acumen. So now the business side of things it's a totally different world. Instead of preparing that leader for that business acumen, we expect them to fly and naturally set as a leader, unfortunately…it's go fly, go figure it out."* (#17)

The participants perceived the selection process of the nurse leader was another barrier to effective leader recruiting. One that is primarily based upon clinical tenure or clinical skills as opposed to identified leadership qualities. Often times, the dire need to "fill" a vacant leadership position far outweighed a well-thought out gradual strategy to properly implement an effective leadership succession plan. As a result, the selection process may be in haste in an effort to the reduce workload pressures and/or relinquish additional responsibilities assumed by the interim nurse leader. One participant explained:

> *"I was asked by my director… a position was opening up and if I would be interested. Most of my experience was as a clinical instructor for a community college. I've never had any leadership experience or training…after I took the position, there was just no time to take any leadership courses."* (#1)

Another participant described the recruiting process as:

"When I applied at the hospital, it was just a staff position. So when I went in…I guess through the interview and talking, then it was offered to me. "Hey, considering your experience and everything, your education, we have this available…would you be interested? I've never really been in a leadership position. I think that was my biggest challenge…learning as I go…made several mistakes too. I didn't realize how much emotional intelligence is needed for leaders to be successful in our roles." (#4)

Many participants reported that they did not participate in a structured leadership development program prior to assuming a leadership role or during their tenure as a nurse leader. Several participants voiced they were not provided with opportunities to participate in leadership development programs. Often resulting in uncertainty and vagueness regarding the expectations of the role. The participants expressed a dual frustration regarding the lack of opportunities to initially enter formal leadership programs as well as engage in programs specifically geared towards advancing in leadership. One participant described the dilemma as:

"I'll just say I'm not greatly satisfied in my job because of the lack of higher leadership support and communication. I don't feel like there's any fostering or coaching or growth opportunities from the immediate top leadership. There's no clear communication as to titles and roles and future advancement. I've never received any formal leader training and I do not want to be stagnant in my career. I'm now at the

point of having a conversation with top leadership about what I think the expectations of the role are and see how we can best remove the barriers regarding my growth." (#13)

Another participant reflected on the lack of professional development and its direct impact on work/life balance as:

"I see why people internalize some of the things that happen at home…I mean, in their jobs and they bring it to their home environment. So I think it's very important for us to understand that it's a real thing…but then also be given tools to deal with it. So now that I've been a leader for a while and I've had some training and I've gone through courses, but really knowing all that upfront, it would be more beneficial…and knowing that you're not crazy. We preach to our staff, you want them to have a work/life balance. I think as leaders, we need to understand that it's okay for us to have that work/life balance." (#12)

The participants further reported a constant struggle with balancing the needs of staff with the needs of senior leadership. Some participants termed this struggle as being "sandwiched". The participants attributed the inability to navigate through this conflict as a direct reflection of not having formal leadership development opportunities and/or senior leadership support. One participant explained:

"The biggest stress is just trying to do too many things at once. I truly don't think I was really prepared for this role. I find myself doing a lot of clinical things and don't have enough time to do the management

side of things. The job is a "clinical" manager role. So sometimes the clinical and the manager role is conflicting…because you're trying to be clinical, but you're trying to be management at the same time. You're sandwiched between your staff nurse and upper management. Sometimes trying to let the staff nurse understand what upper management wants and trying to let management understand can become very stressful." (#1)

Main Theme 4: Fear

Many participants described fear as the sense of anxiety, distress, worry, or concern brought about what is known and/or unknown. There were two subthemes that subsumed under the main theme: *Leader Bullying* and *Fear of Failure*. The participants denoted a distinct difference between fear versus worry. A prolonged sense of worry may eventually result in the emergence of fear. The participants viewed fear as a byproduct of the organization's culture and its behavior towards not meeting organizational expectations.

Many participants expressed either witnessing or experiencing the consequences of not adhering to organizational demands and/or not meeting organizational expectations. Consequences were described as verbal or non-verbal reprimand; cynicism or skepticism in nurse leader competence; and imminent feelings of job insecurity. As a result, the sense of fear influenced the participants' overall outlook about the magnitude of their roles. One participant explained:

"Fear is involuntary…worry is a choice. I would say that we mostly worry more about things…given the depth of our responsibilities. This is healthcare. We worry about patient satisfaction. We worry about quality, safety, staff engagement, staff satisfaction. I mean, that's leadership. The job is what the job is. A lot of us stress about minor things and make it bigger than what it needs to be…probably because we know what happens when we don't meet goals. I've seen leaders escorted off the premises without any prior notice. The constant threat of losing your job is very stressful. So I think we definitely internalize…which I think turns worry into fear." (#10)

The participants perceived fear was primarily ignited due to volatile workplace environments; the overwhelming magnitude of competing priorities; and wavering organizational demands. Several participants reported that they were cautioned and/or disciplined for not meeting expectations. One participant explained the sources of fear as:

"It's a constant what's next, the stress of fear is a problem in itself. Fear if I don't have enough staff. Fear of all the numbers…patient satisfaction. It's almost like you're waiting for your report card every week, or you're waiting for the next thing. You feel totally responsible and when you think of the responsibility and whether you are actually meeting all these expectations, it becomes too much." (#1)

Subtheme 1: Leader Bullying

Leader bullying is described as verbal or non-verbal aggression and/or intimidation exhibited towards the nurse leader. The participants explained the behavior displayed as staff-to-leader; leader-to-leader; or senior leader-to leader. The participants expressed the latter description was the most common form of leader bullying observed. Furthermore, the participants perceived the traditional labeling of *micromanaging* has evolved to a present-day labeling of *leader bullying*. The participants described four distinct recurring examples of leader bullying exhibited by senior leadership as the absence of autonomy; frequent criticism of nurse leader performance; failure or reluctance to promote or advance; and verbal and/or non-verbal admonishment. One participant described an example of intentional leader bullying by senior leadership to drive results as:

> *"I remember speaking with my boss about his decision to use a tactic that to me appeared bullying…and he said to me "sometimes you have to break a couple of eggs to make an omelette". He said "the end justifies the means"…meaning whatever you have to do to get results. He uses it as a scare tactic for his leaders to get results…to make himself look good. He is definitely known for making examples out of people… to scare the rest straight. He's extremely rigid…you just couldn't breathe. Breaking eggs to make an omelette…he'll do whatever he has to do to get up to the top. To say he's a micromanager is an understatement. It's outright sabotage and bullying at its worst."* (#10)

Subtheme 2: Fear of Failure

The fear of failure is a major pressure point for many participants. All the participants had specific presumptions regarding failure and expressed the definition of failure as subjective and relative to one's interpretations and experiences. Many participants attributed the fear of failure as primarily based upon perceptions of reprimand, insignificance, and incompetence in the eyes of staff, peers, and senior leadership. Most participants regarded themselves as high-achievers and perceived the fear of failure as a constant reminder to increase their efforts at consistently achieving goals, despite the magnitude of the task. *One participant explained fear of failure as:*

> *"What would create stress for me, because I'm very compulsive, is when I haven't been able to produce what I know I can produce. Someone else's standard was like my sub-standard. I'm always striving to beat the benchmark. My biggest challenge was that I micromanaged myself because I wanted things done perfectly…and now I guess everyone is so use to me delivering results. So there was always this pressure that I put on myself to make sure I deliver impeccable results…I know everyone's expecting it. Failure was not an option for me."* (#5)

One participant provided a distinct definition of the fear of failure and explained the perceived associated consequences (guilt) as:

> *"The fear of failure is the guilt of not being able to achieve everything. The fear that as soon as I leave, all hell is going to break lose…is*

absolutely on your mind. There's a real fear that the minute you walk out of the building or take a day off or something happens, which is inevitable, that you are going to be blamed or held accountable for it. But there's a lot of guilt…someone has to own it and it's always on your back…and we take it. In health care there's a whole lot of finger pointing. You feel like you're at fault for everything and unfortunately the hospital supports that."(#9)

The participant further explained the perceived associated consequences of failure (reprimand) as:

"Failing is something that I think it's in the back of all of our heads. This hospital, this healthcare system today…I think it's setting us up for failure. It wants us to be perfect…no CAUTIs, no re-admissions, no falls, no this, no that. Let's be realistic you're dealing with people, we're dealing with humans. Things happen. But please don't beat us up when we get one incident. And you're horrified when you get that one incident." (#9)

Main Theme 5: My Senior Leadership Does Support Me

Four participants expressed positive outlooks regarding senior leadership support and its direct influence on nurse leader retention and organizational commitment. There were two subthemes that subsumed under the main theme: *Mentoring* and *Succession Planning: Professional Advancement*. The main consensus was the continuous guidance and transparent intent to mentor and groom for professional advancement. The

participants expressed a mutual understanding existed with their senior leadership to implement an opportunity for professional advancement and/or succession planning. The participants equated the relationship with their senior leadership as "being lucky" to have such support. As they recognized most of their peers are not as fortunate to have such an authentic relationship with senior leadership. One participant described the successful relationship with senior leadership as:

> *"I have an amazing CNO who I report to. I'm lucky with my CNO and my CEO. I'm lucky that my CEO has the nursing background. There was a day that I was doing triage and she would help me with the vitals. I can see if you didn't have an understanding executive…you would be expected to go home after a twelve hour and then do ten hours of work at home. I would find that stressful because it wouldn't be the quality of work that I'd like to do."* (#5)

One participant explained the impact of senior leader support on job satisfaction:

> *"The components that help my job satisfaction is reporting to a leader that's invested in my development. Opportunities are being exposed to me…training or educational opportunities that help me develop as a leader. I'm always trying to grow, develop, learn. So somebody that's engaged and supports me…somebody that gives me opportunities to expose into other areas in my field…and is invested in what I'm interested in and they give you opportunities to further those*

opportunities. To make me more satisfied in my job was just for someone to give me the ability to do more." (#12)

One participant attributed senior leadership support through an organizational viewpoint and described the influence on nurse leader retention and organizational commitment. The participant further explained autonomy and the allocation of essential resources influenced positive perceptions of senior leadership support. Thereby, resulting in the ability to effectively perform and produce favorable results. The participant explained:

"I have a very good relationship with my boss who listens to me and supports me. I have autonomy and that is important to me, to lead in my area. We have a really diverse group of individuals in the clinical setting. We have pharmacists now here. We have the providers. We have mid-level providers. We have LVNs, clerks, social workers. So all of that brings satisfaction for me. I've accepted that the organization meets my needs and I feel that I'm an asset to the organization. I've already made up in my mind that this is the place where I want to retire." (#8)

Subtheme 1: Mentoring

The participants described mentoring as the continual support and guidance received from their senior leadership to help navigate through various aspects of nursing leadership more effectively and methodically. The participants acknowledged mentoring was a two-way approach. In which both parties must be willing to provide and receive constructive feedback and

then share the knowledge gained to encourage and influence others. The participants perceived the process of mentoring was life changing as it brought forth a deepening appreciation for the nurse leader role and its direct impact on staff, patient care, and the organization. One participant explained:

> *"I started out as a leader very young…and I have always had really good mentors. So I guess where I'm at now is a lot of paying it forward and trying to be that person that's going to inspire people. That's probably what I enjoy most, is helping build other people and sharing the knowledge and the experience that I gained over my career. That's why I went into the leadership track. My nurse manager at the time told me "you need to go into administration. You'd have a lot of stuff to contribute". So that's one of the things that keeps me grounded…and how can I make sure that I create a practice for nursing where they are engaged and where they want to thrive and succeed."* (#5)

Subtheme 2: Succession Planning: Professional Advancement

The participants explained succession planning was the trajectory and expectation among nurse leaders to progressively prepare for professional advancement. The participants did not equate succession planning to solely assuming the role of their immediate supervisor. Their ambition was to broaden their scopes of responsibility and complexity to add further value to the organization in whatever capacity. Few participants expressed a specific desire to assume a Chief Nursing Officer (CNO) role as their trajectory.

However, most participants expressed a definite open-mindedness in terms of the capacity or nature of opportunities that exists for professional advancement.

One participant explained:

> *"Early in my career my director pushed me into leadership and told me I could do it. She said that I had a gift for communicating to all levels. She felt my communication skills were strong. People saw something in me that they were able to push me to the next level. My current CNO supports me in my initiatives and provides me with opportunities to grow. He actually respects my perspective and listens to some of my ideas and will actually make changes based on my recommendations. I now find myself leading several projects, as a result. In the next three-five years I see myself not necessarily as a CNO, because I recognize the C-suite is always changing titles and roles. But I do see upward movement and so I remain open to whatever may be next."* (#3)

Main Theme 6: Organizational Commitment

Many participants described commitment as the dedication to oneself to remain loyal and steadfast to the goals set forth. There was one subtheme that subsumed under the main theme: *Mutual Relationship*. The participants further defined commitment as the purposeful perseverance to navigate through challenging situations by implementing solutions to ensure goals are

accomplished. One participant drew an analogy to commitment as being in a relationship and likened it to a marriage. The participant explained:

> *"Commitment…when someone puts their value to something or someone…are they reliable to an individual or a situation. If there are some challenges, they're not going to walk away from it. They're going to stay for the long haul. If there are problems, they're going to try to come up with some solutions and try as much as they can to improve the situation. If it doesn't improve, they're still going to stay there because they're determined to continue in the relationship, through the good times, the bad times. No matter what's going on, it should not affect your determination…it's like a marriage."* (#8)

One participant defined commitment as the amount of dedication exhibited towards achieving organizational goals based upon daily/present-day efforts, as opposed to years of service to an organization. The participant explained:

> *"Commitment is putting in 110%...making the choice to put in 110%. I don't necessarily think commitment means I'm going to give you ten years. It can be…I'll give you day-to-day. I will give you me at my best everyday. I will show up. I will be engaging and I will do what I am asked to do and I will even go above and beyond".* (#9)

Subtheme 1: Mutual Relationship

The participants described mutual relationship as a partnership between two or more parties or entities, based on the reciprocated respect

and understanding for one's ideas, thoughts, and efforts. Commitment is on a continuum and may fluctuate based upon the nurse leader's relationship with the organization. The participants explained organizational commitment was driven by the perception of a mutual relationship that exists between the nurse leader and the organization. However, the participants reported the relationship can reflect effective and ineffective partnerships.

Many participants reported their order of commitment was foremost to themselves, their role, their staff, and lastly to the organization. There were participants who reported their foremost commitment was to organization based on perceptions of a positive relationship with the organization. The participants explained their perceptions were largely due to intentional efforts of sustaining nurse leader job satisfaction through reward and recognition; professional development; and timely professional advancement. One participant explained the impact of effective partnerships on organizational commitment as:

> *"I've recently gained some new responsibility, so the challenge of the new responsibilities has kind of made my job satisfaction increase. I also have good leader support. I've climbed the career ladder pretty quick here…and hopefully at a higher executive level in the next two to three years. I would probably say I'm okay with staying within the same organization…just because I've had success in my current organization."* (#12)

There were participants who reported their foremost commitment was not to the organization. These participants expressed wavering levels of commitment were largely due to the frequent exposure to occupational stress; insufficient stress recovery time; and the perceived insensitivity by senior leadership to not render sufficient support. One participant explained the impact of ineffective partnerships on organizational commitment as:

> *"I'm committed to my role as a director, and I have a lot of experience. I'm committed to the patients, and what it means to be a nurse. I'm just not committed to the organization. And the reason for being is I just don't feel like the organization is committed to me either…It's a mutual relationship. I get very honest with senior leaders in meetings, but then they immediately get on the defense…so nothing gets accomplished and it's basically damaged relationships at that point. I think if I were to put in my resignation today, they would be like…okay. But I'm still here, three and half years later…not so much for the organization, but for my team and my patients."* (#10)

Discussion

This study found that occupational stress among nurse leaders is triggered by the perceived demands of the work environment; the perception of work/life imbalance; the various apprehensions and consequences of organizational expectations; and the presence or absence of senior leadership support. Occupational stress is described as the *magnitude* of job-related effort, labor, or exertion to perform and sustain work-related goals

(Motowidlo et al., 1986). The magnitude of occupational stress inherently affects the well being of the nurse leader (Tang et al., 2010). The nurse leader's well being directly influences the well being of the organization, employees, and patients (Swearinger, 2009; Tang et al., 2010). Findings from this study concur with prior research (Shirey, 2006; Zastock & Holly, 2010) explaining that prolonged exposure to occupational stress jeopardizes organizational effectiveness and patient care outcomes. The participants in the study reported their level of organizational commitment, engagement, and effectiveness are sensitive to the level of exposure to occupational stress. As a result, the nurse leader's capacity (or lack of) to perform under stress influences the organization's capacity to effectively withstand the various healthcare demands and achieve optimum patient care outcomes.

Findings from this study concur with prior research (Shirey et al., 2010; Kath et al., 2013) explaining that prolonged exposure to occupational stress jeopardizes employee engagement. The participants reported missed opportunities to effectively engage in professional development opportunities with frontline employees. This was primarily due to constant overlapping pressures to meet organizational expectations, lending insufficent time to adequately develop and nurture frontline employees.

The most prominent contributing risk factors of occupational stress influencing nurse leader well-being and sustainability are *role fatigue*, *role strain, and role conflict* (Connaughton & Hassinger, 2007; Kath et al., 2013). Nurse leaders are exposed to high job demands; competing and

compounding priorities; and exhaustive work hours (Frandsen, 2010; Karadzinska-Bislimovska et al, 2014). Findings from this study support prior studies describing the impact of such demands on the work/life balance of the nurse leader. The nurse leader's work hours are not the typical "banker's hours". The participants in this study expressed concerns of role fatigue. The participants reported their work hours routinely reached or exceeded sixty hours per week. The participants further reported the exhaustive work hours directly impeded on their ability to have sufficient downtime or personal time. Often resulting in insufficient time to engage in effective stress recovery efforts.

The broadening scopes of responsibility for the nurse leader have presented various challenges that require further scrutiny to identify effective stress coping measures (Kath et al., 2013). Findings from this study revealed that role strain was evident in the daily work life of the nurse leader, as a result of the broadening scopes of responsibility. The participants' perceptions of role strain were further exacerbated largely due to insufficient resources (support staff, leader development; leader support) to effectively perform and manage the wide range of tasks associated to the role.

The scope of the nurse leader's role is ever-changing, primarily based upon the emerging needs or demands of today's healthcare (Aroian et al., 1997; Zastock & Holly, 2010). Issues compounding the complexity and intensity of occupational stress for the nurse leader include pay-for-performance expectations and shifting organizational priorities (Aroian et al.,

1997; Connaughton & Hassey, 2007; Zastock & Holly, 2010; Kath et al., 2013). This study revealed organizational expectations for the nurse leader were based on competitive work environments that were relentlessly results-driven. This study concurs with prior research that there is a direct relationship between healthcare demands and the intensity of organizational expectations. Discoveries from this study found the struggle or exertion to balance those demands triggered perceptions of great occupational stress for the nurse leader. The participants reported the constant challenge of meeting deadlines and delivering results were often unrealistic and primarily based on the habitual reactiveness of the organization. The participants reported an understanding regarding the importance of delivering high quality care. However, the timeframe by which to meet organizational expectations and the lack of available resources were the main source of occupational stress reported by the nurse leaders.

A measurement of success for the nurse leader is the ability to achieve the organizational goals, while responding to organizational demands, in the most efficient and effective manner (Frederickson & Nickitas, 2011). However, this study does not fully concur with that definition of success. This study found that the nurse leader's perception of "success" is subjective. The participants in this study reported success is not solely based on the ability to achieve organizational goals. The participants reported the measurement of success is based on the extent of senior leadership support to proactively

assess, identify, allocate, and evaluate the essential resources needed for nurse leaders to efficiently and effectively perform their roles.

Limitations

The study did not capture a full representation of male participants. Only 18% of the participants (n = 3) accounted for the male population in this study. The assumptions are women are more likely than men to experience stress (Matud, 2004; Mayor, 2015; Faber & Schlarb, 2016). The largest representation of nurses (91%) is women (HHS, 2013; Barrett-Landau & Henle, 2014). However, the largest population of nurse leaders is comprised of men, who more specifically, assume senior leadership roles (Marshall, 1995; McMurry, 2011; Fielden & Burke, 2014). Therefore, a more substantial representation of male nurse leaders is warranted to better understand the full gamut of perceptions of occupational stress specifically among this population.

The study did not capture a full representation of participants who assume senior leadership roles. Only 6% of participants (n = 1) represented senior leadership in this study, of which was a female participant. Senior leadership's role as it relates to perceptions of leader support is among the main themes of the study. Therefore, it is essential and most advantageous to better understand senior leadership's perceptions of occupational stress. Doing so, will further advance efforts to gain insight into factors that influence organizational behavior.

The study excluded nurse leaders with less than two years of nursing leadership experience [novice nurse leader]. Therefore, the study did not capture the full scope of nurse leader perceptions of occupational stress from all nursing leadership levels (novice to expert). Findings from this study may build upon new knowledge to guide future studies exploring novice nurse leaders and their perceptions of- and responses to occupational stress.

Implications to Nursing Practice

The level of occupational stress experienced among the nurse leader may pose an undesirable impact on nurse leader retention and nurse leader succession planning. Letvak and Buck (2008) project a 40% RN vacancy rate by year 2025. According to the U.S. Department of Health and Human Services, Health Resources and Services Administration (2010, p. 20), the total percentage of employed nurse leaders is reported as 12.5%. A projection of more than 70,000 nurse leader vacancies is estimated by the year 2020 (Titzer et al., 2013). Thus, it is imperative to build a vigorous knowledge base to better understand the various components that influence nurse leader occupational stress. It is more so critical to align all efforts toward building a strong succession capacity. This study revealed several nurse leaders were recruited from the frontline without sufficient preparation or readiness to assume their first formal leadership role. Therefore, considerations for implementing effective bridging programs (succession planning) for frontline nurses to assume nurse leader roles are vital to building a strong succession capacity**.**

Nurse leader stress originates from the perceived lack of essential resources in the workplace and the perceived lack of consistent support by senior leaders (Mudallal et al., 2017). The ability or inability of the nurse leader to counteract occupational stress is contingent upon the level of awareness and support exhibited by senior leaders within healthcare organizations (Haggman-Laitila & Romppanen, 2018). Senior leadership is encouraged to engage in a thorough realistic re-examination of the role and scope of the nurse leader.

Consideration for implementing co-manager models for nursing leaders in middle management may prove beneficial in decreasing perceptions of occupational stress and increasing perceptions of work/life balance (Shirey et al., 2010). Implementation of co-manager models may potentially impact nurse leader retention and organizational commitment. The co-manager model, utilized as a division of labor strategy, may assist to alleviate burdens of role fatigue and role strain for the nurse leader. Healthcare organizations will benefit by promoting non-punitive, blame-free organizational cultures that empower the nurse leader to evaluate workload demands and advocate for more effective restructured workload models.

This study revealed nurse leader professional development is fragmented and inconsistent throughout the nurse leader's trajectory. Considerations for implementing ongoing formal *mentoring/coaching programs* for novice nurse leaders and *accountability partners* for seasoned nurse leaders may lend support to consistent nurse leader development

(American Journal of Critical Care, 2005). These opportunities may also assist with timely stress recovery efforts by peers and/or seniors who have experienced similar stress-induced experiences and have sustained the use of effective stress coping strategies in their own practices. Ongoing leader development through formal mentoring and coaching programs may inherently influence effective and sustained leader development; stress management coping strategies; and professional growth and advancement opportunities for the nurse leader.

Establishing and sustaining healthy work environments for the nurse leader generates a cascading effect on the organization, as a whole (Perry et al., 2015). Therefore, it is critical for senior leadership to proactively identify occupational stress among their nurse leaders. Understanding the significance of the considerations provided (*succession planning; co-manager workload models; and mentoring and coaching programs*) may proactively counteract the effects of occupational stress on the well being of the organization, its patients, and its staff.

Implications for Nursing Research

The detrimental consequences of prolonged occupational stress may manifest into role burnout and predispose the nurse leader to engage in poor decision-making; decreased alertness or reactivity; and susceptibility for work-related injuries (Shirey et al., 2010; Zastock & Holly, 2010). Therefore, future research is warranted to explore nurse leader occupational stress levels and effective stress management interventions. Healthcare

organizations are encouraged to heighten its awareness and redefine its understanding of *healthy work environments,* specifically for the nurse leader (Gurt et al., 2011). Approaches should be geared at early identification, management, and continuous evaluation of common occupational stressors. Future research is recommended to explore the definition/description of healthy work environments, as perceived among nurse leaders and senior leadership.

Inquiries regarding leadership mentoring and its impact on organizational behavior are warranted to identify if a connection exists. The assumption is the behavior of the nurse leader drives the behavior of the organization. This study revealed the positive effects of nurse leader mentoring on leader engagement, staff engagement, and organizational commitment. Therefore, implications for nursing research towards ruling out or confirming the assumption is significant to understand if there is an association between the two variables.

The study excluded nurse leaders with less than two years of nursing leadership experience [novice nurse leader]. Therefore, findings from this study may build upon new knowledge to guide future studies exploring the perceptions of occupational stress and their responses to stress, specifically among this cohort. Future research exploring novice nurse leader perceptions of occupational stress may further assist with re-examining succession planning efforts, aimed at building stronger succession capacity.

The perspectives of male nurse leaders' perceptions of occupational stress were not fully representative in the study (n = 3) and therefore unable to generalize findings. Male nurses account for a small percentage of representation in healthcare (HHS, 2013; Barrett-Landau & Henle, 2014). However, male nurses tend to assume nurse leader roles (Marshall, 1995; McMurry, 2011; Fielden & Burke, 2014). Therefore, it is most advantageous to gain insight into understanding their perceptions of occupational stress among male nurse leaders and compare findings among their female counterparts.

Conclusion

The nurse leader is instrumental in determining the outcomes of the ever-changing demands of healthcare and fundamentally responsible for ensuring favorable patient outcomes are achieved. The broadening scopes of responsibility delegated to the nurse leader may be viewed as a monumental accomplishment, denoting greater levels of authority and influence (Aroian et al., 1997; Shirey et al., 2008; Kath et al., 2013). However, with much responsibility invites greater risks of occupational stress [or distress].

As health care continues to evolve and become increasingly more complex and competitive, the magnitude and intensity of potential occupational stressors increases significantly for the nurse leader (Zastock & Holly, 2010). The nurse leader is expected to exhibit resilience as evidenced by timely recovery from the everyday rigors and challenges of the role

(O'Connor, 2002). However, the concern arises when the nurse leader is unable to recover timely, resulting in the presence of occupational stress and the use of ineffective coping strategies, resulting in potential role burnout and nurse leader turnover/ideation (Kath et al, 2013).

The importance of understanding the key elements that drive organizational culture/behavior is beneficial to organizational effectiveness. Largely in part, as these elements directly influences the perception of occupational stress; leadership support; organizational commitment; and overall job satisfaction for the nurse leader. An organization that exhibits high emotional intelligence understands the direct impact of nurse leader occupational stress on the organization, staff, and patient outcomes. Therefore, a heightened awareness of the overt and covert elements that trigger occupational stress among nurse leaders is a task that the healthcare organization must become astute to.

It is also imperative for the nurse leader to take full accountability of their role and understand their perceptions and response(s) to occupational stress directly impacts the organization, staff, and patient outcomes. The nurse leader must assume a proactive stance in identifying and seeking out resources that will provide optimal assistance and support to effectively manage through occupational stress. Doing so, the nurse leader may become successful in achieving a more effective balance between managing the current healthcare needs [demands], while strategically planning for the future needs of healthcare.

Appendix A

Interview Guide

1. How would you describe your overall job satisfaction?
2. What component(s) would you add to your job to increase job satisfaction? Probe: Why would you add this/these components?
3. What component(s) would you remove from your job to increase job satisfaction? Probe: Why would you remove this/these components?
4. How do you define job stress?
5. How do you respond to job stress?
6. Tell me about stress in your workplace?
7. Tell me about a time when you felt your contributions were valued at work?
8. Tell me about a time when you felt your contributions were not valued at work? Probe: How did you respond to that experience?
9. How do you define commitment? Probe: Where you do see yourself, professionally, in the next 3-5 years?
10. How did you come into leadership? Probe: What workplace factors influence turnover among nurse leaders?
11. How do you describe your leadership style?
12. Tell me about a time in which you had to adapt your leadership style? Probe: Why did that experience prompt you to adjust your style?
13. How do you maintain balance and stability during job stress?
14. How do you measure success as a nurse leader?
15. Tell me about a time in which you experienced failure as a nurse leader? Probe: How do you recover from failure?
16. What new discoveries have you identified during our conversation? Probe: What do you think is most important about understanding job stress as a nurse leader?

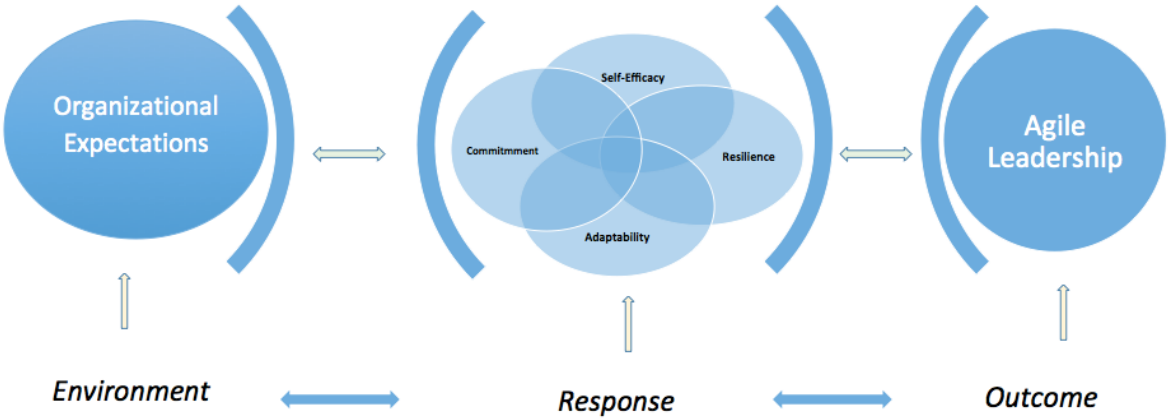

Figure 1. **Conceptual Framework: Agile Leadership**

The conceptual framework introduces the perceived sources of occupational stress among nurse leaders. The three core components of the conceptual framework that influence agile leadership are environment, response, and outcome (Emelogu, 2017).

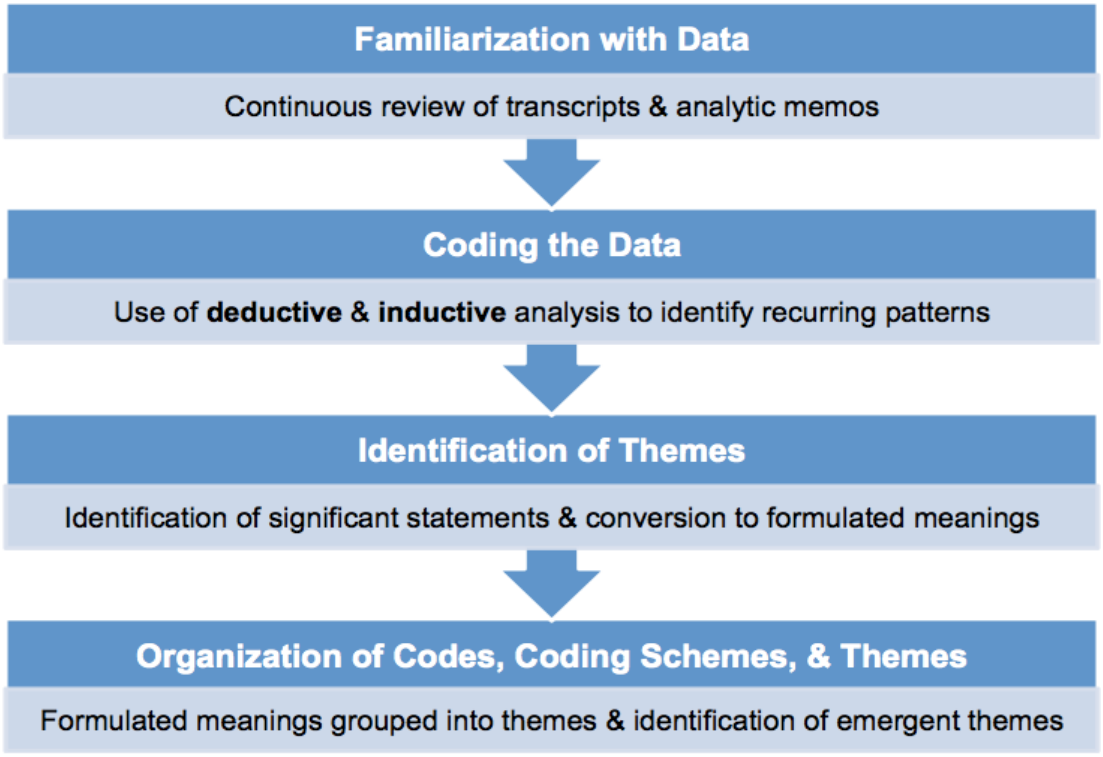

Figure 2. **Steps for Data Analysis Using Thematic Content Analysis**

Table 1

Examples of Significant Statements

Significant Statements	Transcript No.	Page No.
"Just trying to do too many things at once. The job is a clinical manager role, so sometimes the clinical and the manager role is conflicting because you're trying to be clinical, but you're trying to be management at the same time. You're sandwiched between your staff nurse…and upper management …sometimes trying to let staff nurse understand what upper management wants and trying to let management understand that this may not work, can become very stressful"	1	4
"From the minute I walk in, I'm already behind on what needs to be done…so I'm always working to catch up. So the stress of not ever able to be ahead of the work that needs to be done is a stressor…it's always there. It's on the weekends. Whenever I'm off, I'm always thinking about the stuff that I've got to get done that's still there"	3	4
"We all have deadlines we have to meet, but I think that when there's an issue, there's a knee-jerk reaction sometimes…they want results yesterday. So it's that pressure to perform and give results ASAP even if it means sacrificing your own personal time and attention outside of work. They want the "number" more so of quantity and not quality…so you get sucked into the "numbers vacuum"…and it takes away from the quality of the situation"	5	2

Table 2

Examples of the Process of Converting Significant Statements into Formulated Meanings

Significant Statements	Formulated Meanings
"I'm committed to my role as a director…I'm committed to the patients and what it means to be a nurse…I'm just not committed to the organization. I think if I were to put in my resignation today, they would be like "okay" (Transcript 3, page 5).	Nurse leader realizes commitment is relative to one's experiences and relationships within the organization.
"I think my job stress comes from the pressure that I put on myself to be the best manager I can be…but not using my own definition…using other people's definition. I think sometimes that's what my stress is…putting this pressure on myself by using other people's definitions" (Transcript 11, page 5).	Nurse leader realizes measure of leader success is based on external influencers rather than one's own definition of success, lending to misleading expectations of achievement.
"You're never off stage. You have to have some type of balance…stressful when you never have a chance to be off and really kind of re-group…take a breather and take care of yourself. I felt extremely out of character…I was angry constantly because of a built up of just being overwhelmed, tired, not feeling supported" (Transcript 14, page 3).	Nurse leader identifies ineffective stress-recovery efforts as a result of persistent work/life imbalances.

Table 3

Example of the Process of Constructing the First Theme "Always Under Pressure" From Different Clusters of Themes and Formulated Meanings

Examples of Formulated Meanings	Theme Clusters	Emergent Theme
Negative or positive definitions of stress are linked to one's perceptions of stress.	Self-inflicted stress	Always under pressure
Nurse leader equates resilience as an outcome of stress.		
Nurse leader believes stress is the result of not setting limitations and stress now becomes a normal-abnormal phenomenon.		
Nurse leader realizes the mental pressure that is applied to normal routines.		
Nurse leader describes stress and "real" and "expected".	Episodic stress	
Nurse leader realizes stress is cyclic and short-lived.		
Nurse leader describes stress as a shared bond experienced by peers.		
Nurse leader believes stress is situational and highly reactive.		

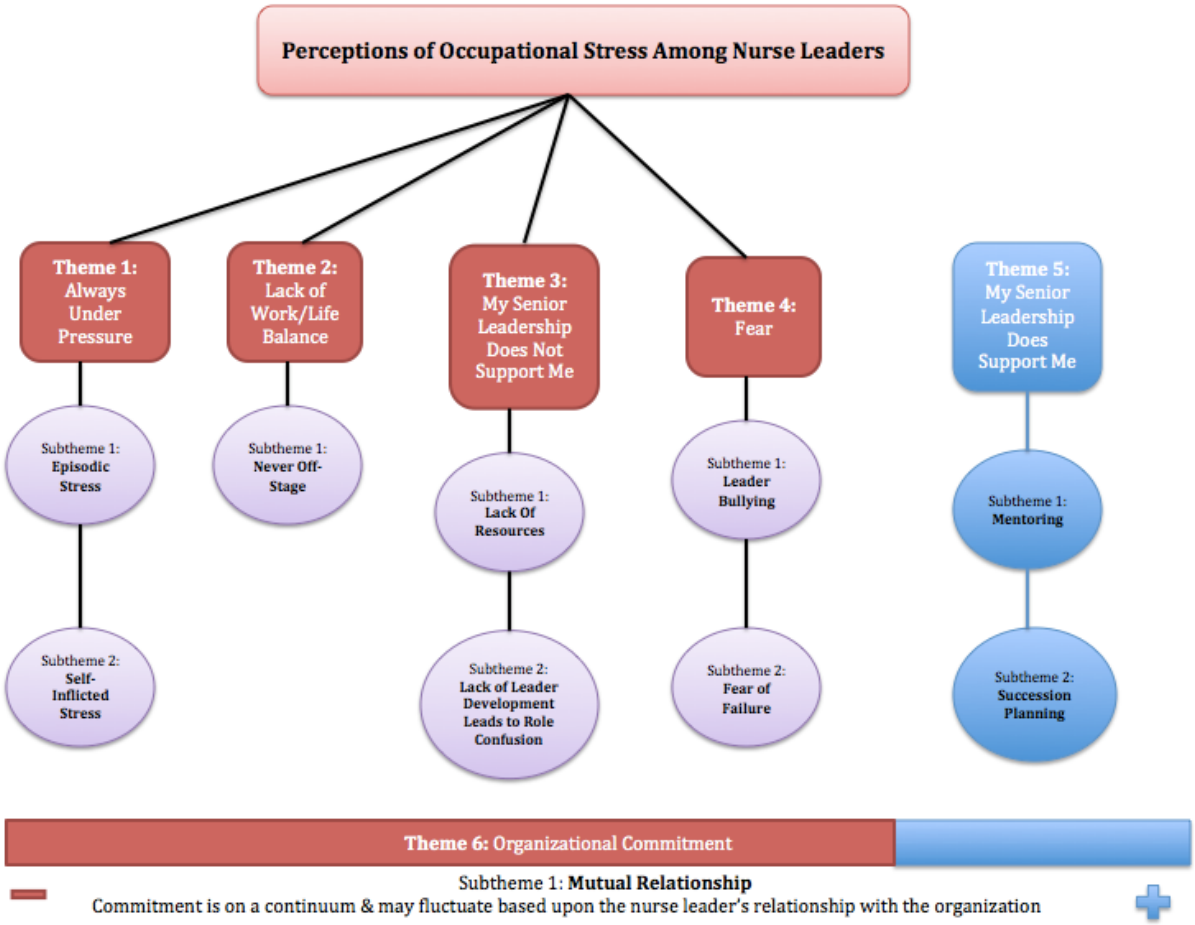

Figure 3. **Perceptions of Occupational Stress Among Nurse Leaders Themes**

Thematic display of major themes and subthemes or perceptions of occupational stress among nurse leaders.

Table 4

Demographics of Nurse Leader Participants

Category	n	% (n =17)
Gender		
Male	3	18%
Female	14	82%
Age Range	35-50 years old	71%
Race		
African American	10	59%
Hispanic	2	12%
Caucasian	4	24%
Asian/Islander	1	6%
Highest level of Education		
BSN	3	18%
Master's Degree	11	65%
DNP	2	12%
PhD	1	6%
Type of Organization		
Academic/Teaching hospital	10	59%
Community Hospital	7	41%
Magnet	9	53%
Non-Magnet	8	41%
Union	3	18%
Years of Nursing Experience	9 - 41 years	mean = 19 years
Years of Nurse Leader Experience	2 - 30	mean = 9 years
Role		
Nurse Manager	8	47%
Director	8	47%
Senior Leadership	1	6%

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Appendix A

University of Texas Health Science Center at Houston
Committee for the Protection of Human Subjects Approval

Appendix A
University of Texas Health Science Center at Houston
Committee for the Protection of Human Subjects Approval

Committee for the Protection of Human Subjects
6410 Fannin Street, Suite 1100
Houston, Texas 77030

Nnenna Emelogu School of Nursing

November 08, 2018 HSC-SN-18-0966 - *Exploring Occupational Stress Among Nurse Leaders: Factors Influencing*

Nurse Leader Retention and Organizational Commitment

The above named project is determined to qualify for exempt status according to 45 CFR 46.101(b)

***CATEGORY #2** : Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:*

a. information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND ,

b. any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

(NOTE: The exemption under Category 2 DOES NOT APPLY to research involving survey or interview procedures or observation of public behavior when individuals under the age of 18 are subjects of the activity except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.)

CHANGES: Should you choose to make any changes to the

protocol that would involve the inclusion of human subjects or identified data from humans, please submit the change via iRIS to the Committee for the Protection of Human Subjects for review.

INFORMED CONSENT DETERMINATION:

Signed Informed Consent Required

INFORMED CONSENT: When Informed consent is required, it must be obtained by the PI or designee(s), using the format and procedures approved by the CPHS. The PI is responsible to instruct the designee in the methods approved by the CPHS for the consent process. The individual obtaining informed consent must also sign the consent document. Please note that only copies of the stamped approved informed consent form can be used when obtaining consent.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA):

Exempt from HIPAA

STUDY CLOSURES: Upon completion of your project, submission of a study closure report is required. The study closure report should be submitted once all data has been collected and analyzed.

Should you have any questions, please contact the Office of Research Support Committees at 713-500-7943.

Appendix B

University of Texas Health Science Center at Houston
Research Participant Informed Consent Form

Appendix B
Research Participant Informed Consent Form

UTHealth
The University of Texas Health Science Center at Houston

INFORMED CONSENT TO TAKE PART IN RESEARCH
(Suggested Use: Minimal Risk Research Involving Focus Groups and Interviews)

Study Title:	Exploring Occupational Stress Among Nurse Leaders: Factors Influencing Nurse Leader Retention and Organizational Commitment
Study Sponsor:	N/A
Principal Investigator:	Nnenna A. Emelogu, PhD(c), RN, CVRN-BC, NE-BC, NEA-BC University of Texas Health Science Center-Houston Cizik School of Nursing
Study Contacts:	Nnenna A. Emelogu, Principal Investigator
Contacts:	Nnenna.A.Emelogu@uth.tmc.edu

We are inviting you to be in a research study by investigators at University of Texas Health Science Center - Houston, Cizik School of Nursing. We are studying the occupational stress among nurse leaders and its impact on nurse leader retention and organizational commitment.

If you agree to be in our study, we will talk with you for 30 minutes to one hour. If you agree, we will ask you to take part in one semi-structured face-to-face interview. You do not have to be in the study if you do not want to, your participation is completely voluntary. You may change your mind at any time and there will be no penalty.

You do not have to share any information that you are not comfortable sharing. You can stop the participating in conversation at any time.

We will be extremely careful to keep your information confidential. We understand there is always a small risk of unwanted or accidental disclosure. We plan to audio-record the conversations with your permission. Any notes, recordings, or transcriptions will be kept private by the primary investigator (Nnenna A. Emelogu). Any digital files will be encrypted and password protected. Your name will be de-identified and you will be provided with a unique identifier, only known to the primary investigator.

If you have questions or concerns at any time about the research, you can contact Nnenna A. Emelogu at Nnenna.A.Emelogu@uth.tmc.edu. If you have any questions about your participation in this research, you can call the Institutional Review Board (IRB) at (713) 500-7943. The IRB is a committee that has reviewed and approved this research study (HSC-XX-XX-XXXX).

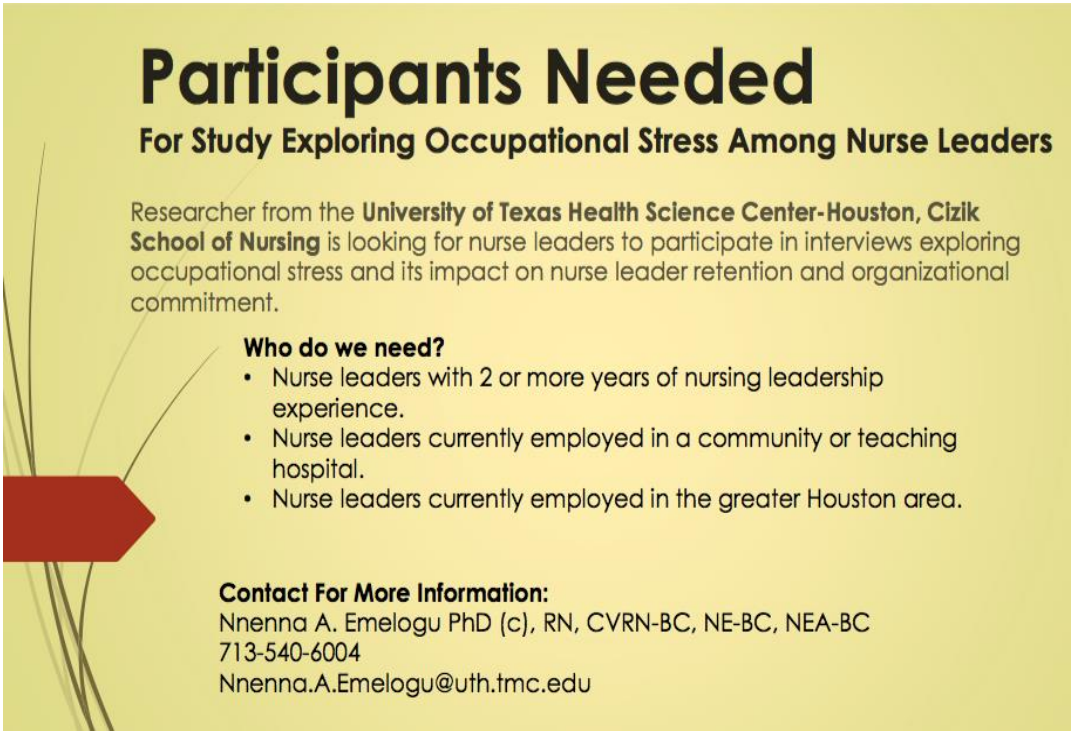
I agree to take part in interview: Yes/No
I give permission for my interview to be audio-recorded: Yes/No

Printed Name of Subject	Signature of Subject	Date
Printed Name of Person Obtaining Informed Consent	Signature of Person Obtaining Informed Consent	Date

Appendix C

Research Participant Recruitment Flyer

Appendix C
Research Participant Recruitment Flyer



Appendix D

Research Participant Demographic Form

Appendix D
Research Participant Demographic Form

Nurse Leader Occupational Stress Study
IRB # HSC-SN-18-0966

Study ID: _____
Interviewee's 2-digit birth month & initials (example: 06NE)

Interview Date: _____ **Interviewer Last Name:** Emelogu

1. Age (check one)
   - ☐ 20-24
   - ☐ 25-30
   - ☐ 31-35
   - ☐ 36-40
   - ☐ 41-45
   - ☐ 46-50
   - ☐ 51-55
   - ☐ 56-60
   - ☐ 61-65
   - ☐ 65-70
   - ☐ >71

2. Gender (check one)
   - ☐ Male
   - ☐ Female

3. Race (check one)
   - ☐ Black and/or African American
   - ☐ White
   - ☐ Indian/Pakistani
   - ☐ Asian
   - ☐ Hispanic
   - ☐ Native Hawaiian/Pacific Islander
   - ☐ Native American
   - ☐ Other please specify _____

4. What is your highest degree in nursing? (Check one)
   - ☐ BSN
   - ☐ MSN
   - ☐ PhD/ DSN
   - ☐ DNP

5. Total years of experience as a Nurse? _____

6. Total years of experience as a Nurse Leader? _____

7. a. What is your current practice setting? _____

   b. Total number of years in this setting? _____

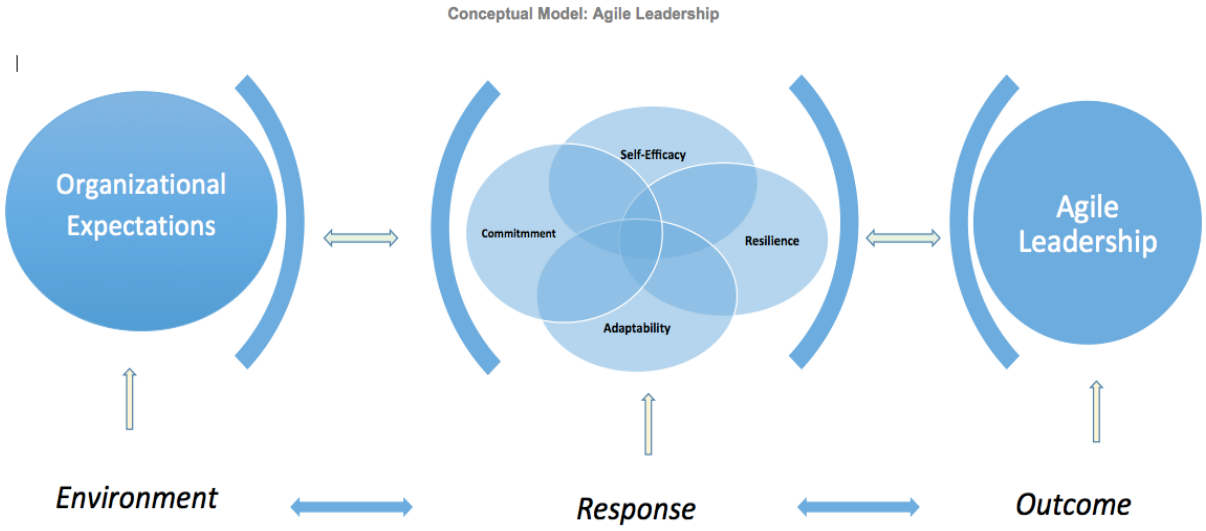
8. a. What is your current role? _____

   b. Total number of years in this role? _____

Appendix E

Conceptual Model

Appendix E
Conceptual Model



Appendix F

Interview Guide

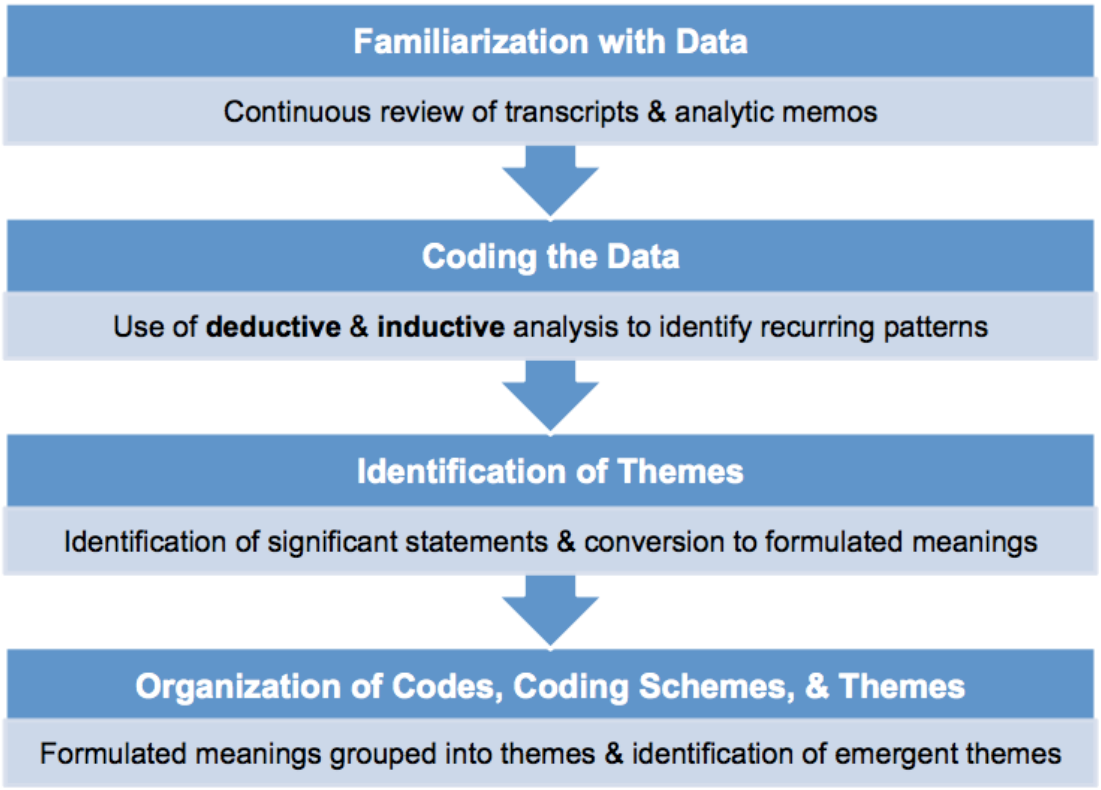
Appendix F
Interview Guide

1. How would you describe your overall job satisfaction?
2. What component(s) would you add to your job to increase job satisfaction? Probe: Why would you add this/these components?
3. What component(s) would you remove from your job to increase job satisfaction? Probe: Why would you remove this/these components?
4. How do you define job stress?
5. How do you respond to job stress?
6. Tell me about stress in your workplace?
7. Tell me about a time when you felt your contributions were valued at work?
8. Tell me about a time when you felt your contributions were not valued at work? Probe: How did you respond to that experience?
9. How do you define commitment? Probe: Where you do see yourself, professionally, in the next 3-5 years?
10. How did you come into leadership? Probe: What workplace factors influence turnover among nurse leaders?
11. How do you describe your leadership style?
12. Tell me about a time in which you had to adapt your leadership style? Probe: Why did that experience prompt you to adjust your style?
13. How do you maintain balance and stability during job stress?
14. How do you measure success as a nurse leader?
15. Tell me about a time in which you experienced failure as a nurse leader? Probe: How do you recover from failure?
16. What new discoveries have you identified during our conversation? Probe: What do you think is most important about understanding job stress as a nurse leader?

Appendix G

Data Analysis Steps

Appendix G
Data Analysis Steps: Thematic Content Analysis



Appendix H

Examples of Significant Statements

Appendix H
Example of Significant Statements

Significant Statements	Transcript No.	Page No.
"Just trying to do too many things at once. The job is a clinical manager role, so sometimes the clinical and the manager role is conflicting because you're trying to be clinical, but you're trying to be management at the same time. You're sandwiched between your staff nurse…and upper management …sometimes trying to let staff nurse understand what upper management wants and trying to let management understand that this may not work, can become very stressful"	1	4
"From the minute I walk in, I'm already behind on what needs to be done…so I'm always working to catch up. So the stress of not ever able to be ahead of the work that needs to be done is a stressor…it's always there. It's on the weekends. Whenever I'm off, I'm always thinking about the stuff that I've got to get done that's still there"	3	4
"We all have deadlines we have to meet, but I think that when there's an issue, there's a knee-jerk reaction sometimes…they want results yesterday. So it's that pressure to perform and give results ASAP even if it means sacrificing your own personal time and attention outside of work. They want the "number" more so of quantity and not quality…so you get sucked into the "numbers vacuum"…and it takes away from the quality of the situation"	5	2

Appendix I

Example of Conversion of Significant Statements to Formulated Meanings

Appendix I

Example of Conversion of Significant Statements to Formulated Meanings

Significant Statements	Formulated Meanings
"I'm committed to my role as a director…I'm committed to the patients and what it means to be a nurse…I'm just not committed to the organization. I think if I were to put in my resignation today, they would be like "okay" (Transcript 3, page 5).	Nurse leader realizes commitment is relative to one's experiences and relationships within the organization.
"I think my job stress comes from the pressure that I put on myself to be the best manager I can be…but not using my own definition…using other people's definition. I think sometimes that's what my stress is…putting this pressure on myself by using other people's definitions" (Transcript 11, page 5).	Nurse leader realizes measure of leader success is based on external influencers rather than one's own definition of success, lending to misleading expectations of achievement.
"You're never off stage. You have to have some type of balance…stressful when you never have a chance to be off and really kind of re-group…take a breather and take care of yourself. I felt extremely out of character…I was angry constantly because of a built up of just being overwhelmed, tired, not feeling supported" (Transcript 14, page 3).	Nurse leader identifies ineffective stress-recovery efforts as a result of persistent work/life imbalances.

Appendix J

Example of The Process of Constructing the First Theme “Always Under Pressure” From Different Clusters of Themes and Formulated Meanings

Appendix J

Example of The Process of Constructing the First Theme "Always Under Pressure" From Different Clusters of Themes and Formulated Meanings

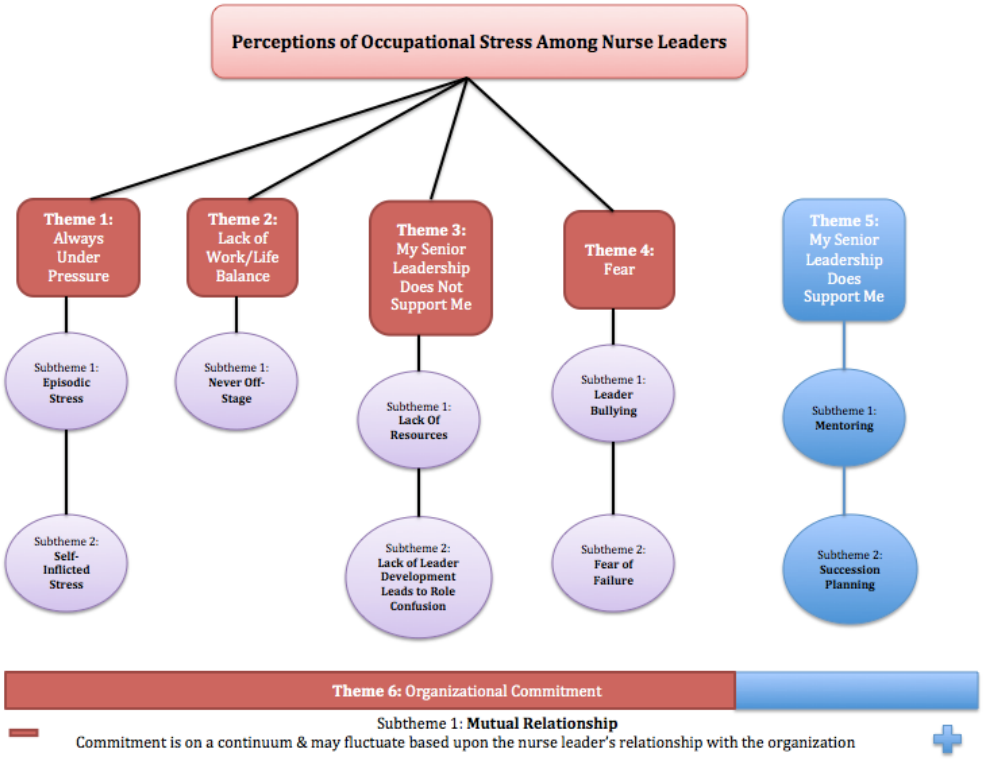
Examples of Formulated Meanings	Theme Clusters	Emergent Theme
Negative or positive definitions of stress are linked to one's perceptions of stress.	Self-inflicted stress	Always under pressure
Nurse leader equates resilience as an outcome of stress.		
Nurse leader believes stress is the result of not setting limitations and stress now becomes a normal-abnormal phenomenon.		
Nurse leader realizes the mental pressure that is applied to normal routines.		
Nurse leader describes stress and "real" and "expected".	Episodic stress	
Nurse leader realizes stress is cyclic and short-lived.		
Nurse leader describes stress as a shared bond experienced by peers.		
Nurse leader believes stress is situational and highly reactive.		

Appendix K

Thematic Display

Appendix K

Thematic Display: Perceptions of Occupational Stress Among Nurse Leaders



Appendix L

Demographics of Nurse Leader Participants

Appendix L
Demographics of Nurse Leader Participants

Category	n	% (n =17)
Gender		
Male	3	18%
Female	14	82%
Age Range	35-50 years old	71%
Race		
African American	10	59%
Hispanic	2	12%
Caucasian	4	24%
Asian/Islander	1	6%
Highest level of Education		
BSN	3	18%
Master's Degree	11	65%
DNP	2	12%
PhD	1	6%
Type of Organization		
Academic/Teaching hospital	10	59%
Community Hospital	7	41%
Magnet	9	53%
Non-Magnet	8	41%
Union	3	18%
Years of Nursing Experience	9 - 41 years	mean = 19 years
Years of Nurse Leader Experience	2 - 30	mean = 9 years
Role		
Nurse Manager	8	47%
Director	8	47%
Senior Leadership	1	6%

CURRICULUM VITAE

CURRICULUM VITAE
Nnenna A. Emelogu, PhD, RN, CVRN-BC, NE-BC, NEA-BC

Seasoned nurse leader with 19 years of clinical nursing experience, internal consulting, and nursing leadership. Areas of practice are wide-ranging from cardiology to neurosurgery and hospital operations.

EDUCATION

University of Texas Health Science Center- Houston 08/2015 – 05/2019
PhD in Nursing
Houston, Texas

University of Houston-Victoria 01/2010 - 12/2011
Masters of Science in Nursing – Nursing Administration
Sugar Land, Texas

Prairie View A & M University 08/2000 - 08/2001
Baccalaureate Degree in Nursing
Houston, Texas

Houston Community College Systems 08/1998 - 05/2000
Associate Degree in Nursing
Houston, Texas

EMPLOYMENT

Michael E. Debakey VA Hospital 05/2018 – Present
Nurse Manager
Houston, Texas

Areas of Practice: Medical ICU, Sepsis Team

- Responsible for managing a 9-bed Medical ICU
- Responsible for 35 direct reports.
- Patient population comprising of medicine, post-operative cardiovascular surgery, invasive cardiology, and neurology.

Houston Methodist Hospital –Texas Medical Center 10/2016 – 05/2018
Director of Nursing Practice
Houston, Texas

Areas of Practice: Hospital/System Education, Quality, and Patient Safety

- Responsible for 25 direct reports
- Facilitates and evaluates nursing education, quality, and patient safety across various service lines.
- Develops and evaluates professional practice models and policies/procedures in alignment with organizational priorities and ANCC Magnet priorities and identifies opportunities for continuous process improvement.
- Promotes and supports professional development among staff and leadership throughout all levels of nursing.
- Serves as a resource and liaison for the Chief Nursing Executive, Vice Presidents of Nursing Operations, and various senior leaders to assess and facilitate organizational priorities.

Houston Methodist Hospital –Texas Medical Center 03/2014 – 10/2016
Director of Nursing
Houston, Texas

Areas of Practice: Neurology/Neurosurgery Service Line

- Responsible for managing 51-bed acute care Neurosurgery/Neurology unit, inclusive of 6-bed Neurosurgery Transitional Care Unit (TCU).
- Responsible for 124 direct reports.
- Patient population comprising of post-operative neurosurgical patients, CVA, seizure disorders, cardiac/telemetry, CHF, Observation, and Acute and End-Stage Renal Disease.

Houston Methodist Hospital –Texas Medical Center 03/2013 – 03/2014
Clinical Nurse Manager
Houston, Texas

Areas of Practice: Cardiovascular Service Line

- Responsible for managing 60-bed acute care Cardiovascular surgical unit, inclusive of 15-bed Cardiovascular IMU.

- Responsible for 152 direct reports.
- Patient population comprising of post-operative cardiovascular surgical patients, cardiac/telemetry, CHF, Observation, and Acute and End-Stage Renal Disease.

Memorial Hermann Hospital – Northwest 04/2011-03/2013
Clinical Nurse Manager II
Houston, Texas

Areas of Practice: Progressive Care Unit, Neurology, Medical/Surgical, Telemetry, and Observation

- Responsible for managing 30-bed acute care unit.
- Responsible for 75 direct reports supporting two cost centers.
- Patient population comprising of CVA, cardiac/telemetry, CHF, Observation, and Acute and End-Stage Renal Disease.
- Responsible for managing unit and hospital throughput.
- In an effort to decrease patient wait times and increase patient satisfaction, developed and implemented unit-designated Admission and Discharge Nurse roles.
- Developed “Swoop Nurse” role, as it relates to decreasing Emergency Department wait times and patient throughput.

Memorial Hermann Hospital – Sugar Land 09/2008- 04/2011
Education Resource Specialist II
Sugar Land, Texas

Areas of Practice: Critical Care, Acute Care, Emergency Center, and Wound Care

- Responsible for providing and maintaining professional nurse staff development.
- Maintained active involvement in facility-based and system-based committees, comprising of the Critical Care System Council, Evidence-Based Practice & Quality Committee, Patient Safety Committee, Stroke Committee, and Education and Research Council.
- Collaborated with various members of senior leadership to establish and lead the development of the Clinical Career Ladder program.

- Collaborates with in-house attending Physicians, Hospitalists, and senior leadership to establish and/or revise policies and procedures and practice protocols.
- Collaborated with interprofessional team to create ICU Safe Practice Protocol, Ventilator Weaning Protocol, Cardiac Telemetry Policy, Wound Vac Management Policy, Rapid Response Protocols, Code STEMI Protocol, and Heparin Administration Protocol.

Memorial Hermann Hospital- The Texas Medical Center 02/2001- 08/2008
Staff RN - Critical Care
Houston, Texas

Areas of Practice: CVICU [primary unit], CCU, Surgical ICU, Surgical-Trauma ICU, Neuro-Trauma ICU, Burn Unit, Stroke Unit, CVIMU, Neuro IMU

- Responsible for providing and maintaining care for patients in the Acute Care and Critical Care patient care areas.
- Patient population consisted of pre and post-op cardiac, orthopedic, neuro, and GI health/disease states.
- Responsible for occupying the roles of Charge RN and Clinical Coach/Preceptor.
- Charge RN responsibilities comprised of coordination of care for a 24-bed CVICU unit and a 16-bed surgical IMU unit, which consisted of staffing, bed management, and team liaison duties.

Woman's Hospital of Texas 06/2000-01/2001
Staff RN- Critical Care
Houston, Texas

Area of Practice: Neonatal ICU

- Responsible for providing and maintaining care for Level I/Level II neonates.

ORGANIZATIONS

Sigma Theta Tau Nursing Honors Society – Eta Delta Chapter
American Nurses Association

Curriculum Vitae
NNENNA A. EMELOGU
Page 5

Texas Nurses Association – District 9
American Organization of Nurse Executives
American College of Healthcare Executives – Southeast Texas Chapter

CERTIFICATIONS

Nurse Executive Advanced – Board Certified (NEA-BC)
Nurse Executive – Board Certified (NE-BC)
Cardiovascular Registered Nurse – Board Certified (CVRN-BC)
ACLS
BLS

RECOGNITIONS

Invited Speaker, ABC Hospital
10/2015
Mexico City, Mexico
Presentation: *Nursing Research and Evidenced-Based Practice*

PROJECTS

- Involved in the development and implementation of the Discharge Nurse role at Houston Methodist Hospital *[Patient Throughput]*

- Involved in the development of the Clinical Patient Pathway at Houston Methodist Hospital *[Patient Throughput]*

- Involved in the implementation of the Rothman/PeraTrend patient acuity system in the Neurology/Neurosurgery patient care areas at Houston Methodist Hospital *[Early Warning System]*

- Involved in the development and implementation of the International Global Learner- Leader at the Bedside (Saudi) at Houston Methodist Global Health Care Services *[Clinical Leader at the Bedside]*

- Involved in the development and implementation of EPIC pre-conversion validations at Houston Methodist Hospital *[EPIC EMR Conversion]*

- Involved in the development and implementation of the TEAM-Based Educational Development Model *[Service Line-Based Quality, Safety, & Education Development]*