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An Exploration into the Perspective of Health Care Leaders Regarding Retention and Satisfaction

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ABSTRACT

The purpose of this qualitative inquiry project was to explore the perspectives of U.S. health care frontline health care leaders regarding their training strategies and their effects on retention and employee satisfaction. The study addressed the growing concern over nurse burnout, high turnover, and leadership gaps in clinical settings by examining whether current training strategies adequately support nurse leaders in real-world practice. The guiding project question was "What are the perspectives of U.S. health care frontline leaders on the and their effects on retention and employee satisfaction?" A generic qualitative inquiry methodology was employed to capture the lived experiences of nurse leaders. Semi-structured interviews were conducted via Zoom with a purposive sample of 12 registered nurses in leadership roles across various health care settings. The participant group included a diverse representation of gender, race, and experience. Thematic analysis was used to analyze interview transcripts, following Braun and Clarke's six-phase process. Key themes identified included the inadequacy of current training formats, the value of experiential learning and mentorship, the role of emotional intelligence in leadership, and the impact of leadership support on retention. Participants consistently emphasized the need for training programs that are relevant, emotionally intelligent, and tailored to the realities of nursing leadership. The study concluded that leadership development is most effective when it incorporates relational learning, mentorship, and context-specific support, rather than relying on generic computer-based modules. Practically, the project suggests health care organizations should restructure leadership training to include protected time for development, hands-on learning, and emotional skill-building. The deliverable for this capstone includes a set of recommendations for evidence-informed leadership development practices that align with frontline realities. This research contributes to the field by elevating the voices of nurse leaders and offering actionable insights for improving leadership development strategies in clinical practice.

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DEDICATION

This Capstone project is dedicated to all who have pushed me to strive for greatness and complete my educational journey with this Doctorate in Business Administration. I would like to first specifically thank my family. My husband has been my backbone through this entire experience, allowing me to take a step back from work and my social life to complete this program all while pursuing his own professional and personal goals. I would also like to thank my mother for pushing me outside my comfort zone and pushing me to be the first person in my family to graduate from college and pursue further education. I would also like to thank all my mentors throughout my life who have created a foundation for me to build upon and be able to grow and succeed in all the things that I set out to accomplish. Without their support and dedication throughout my educational journey, I would not have reached this milestone with my educational journey.

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I would like to acknowledge the many mentors that I have had the pleasure of working with throughout this educational journey. I appreciate every ounce of assistance and encouragement that was passed onto me throughout this program, and I know that with this degree, I am ready to take on the world!

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CHAPTER ONE
PROJECT DESCRIPTION

➢ *Overview of the Project*

Employee retention rates are a measure of team cohesion, morale, and work satisfaction in any industry. However, the need to retain nurses in the medical field is greater than ever. This is because the COVID-19 pandemic hastened the growing nursing shortage, which is predicted to reach a demand of over a million nurses by 2030 (American Nurses Association, 2023). Hiring and training expenses are another consideration. The salary range for a registered nurse (RN) might be between $28,400 to $51,700 (American Nurses Association, 2023). These costs quickly mounted up, with each institution spending between $3.6 and $6.5 million a year (American Nurses Association, 2023). An increasing number of business leaders, including health care organizational leaders, understand that maintaining engaged and satisfied staff largely depends on good leadership (Pappas, 2024). Hospitals faced significant issues due to nurse turnover on a global scale. Employees sought out leaders who cared for their needs and fostered a healthy work environment (Pappas, 2024). Being a great leader is a skill that needs to be constantly developed (Pappas, 2024). People with outstanding business performance are essential to every firm, especially health institutions, in order to thrive, adjust to shifting external circumstances, and keep a competitive edge (Farghaly-Abdelaliem & Abou Zeid, 2023). By establishing a pleasant work atmosphere and encouraging an optimistic organizational climate through policies that support optimism, leaders can attempt to increase their workforce's productivity (Farghaly-Abdelaliem & Abou Zeid, 2023) . Those with strong leadership qualities inspire and encourage their teammates (Pappas, 2024). A company may experience low morale and high turnover rates if its employees lack effective leaders. To keep top personnel, organizations should ensure to engage in leadership development (Pappas, 2024).

For executives within health care organizations, the key to the solution is to comprehend the essential elements around the significance of evaluating staff turnover, learning how it impacts the business, and grasping what is required to retain great personnel (Collins, S. K. & Collins K. S., 2004). A focus on acquiring human resources and a proactive approach to addressing and preventing high staff turnover or lower retention rates are characteristics of successful health care organizations (Collins, S. K. & Collins K. S., 2004). Employers must make a financial commitment to prioritize health care leadership education, but that investment has a high return on investment (Caduceus, 2023). Employee retention is likely to increase with the investment in providing effective health care leaders, education and skills training. Hospital leaders can save millions of dollars a year by increasing employee retention, yielding a financial return that far outweighs initial costs (Caduceus, 2023). According to Collins and Stockton (2022), the success of a health care department and the standard of care it provides are directly correlated with the measurement of employee turnover. According to certain research, the expense of employee turnover might amount to as much as 150% of their yearly pay (Collins, S. K. & Collins K. S., 2004). Moreover, when workers depart, their responsibilities are transferred to the remaining staff members, who feel compelled to take on the extra work (Collins, S. K. & Collins K. S., 2004). A small investment in professional growth and education yields significant returns, such as boosting self-assurance and competence, improving mental health, and creating a positive work environment to boost important employee retention, which may help stop the downward slope of health care frontline health care leader burnout (Caduceus, 2023).

Leadership should focus on teaching individuals within the organization how to innovate (Gibson, 2005) appropriately. Generating new and innovative ideas is only one part of the innovation process, and leadership should consider ways to evaluate fresh ideas so as not to sabotage the innovation flowing in from the workforce (Gibson, 2005). By understanding and identifying innovation within the current workforce, retention rates will climb, and satisfaction amongst the staff will increase as they feel heard and appreciated for their fresh and current ideas to improve important work functions that all employees rely on (Gibson, 2005).

➢ *Problem Statement and Purpose*

The general problem is that ineffective leadership development in U.S. health care organizations is leading to high turnover rates, increased employee dissatisfaction, and higher operational costs (Miller-Jones, 2020). To prepare their companies for the future, executives in the industry must be able to predict emerging trends to remain competitive within the market and attract new employees into the organization (Kupietzky, 2023).

The specific problem is that U.S. health care frontline leaders are not receiving effective and updated training, which results in a decrease in employee retention and satisfaction (Miller-Jones, 2020). Health care managers sometimes lack the specific expertise and training required to handle complicated and changing health care environments, particularly those in frontline positions (Miller-Jones, 2020). This encompasses leadership qualities, including emotional intelligence, conflict resolution, and change management, in addition to technical talents. Although many frontline health care leaders have no formal leadership training, they are in charge of managing teams in extremely demanding and dynamic environments. This shortcoming leads to subpar management techniques, which have a detrimental impact on team morale and output. The retention and job satisfaction of health care workers are directly impacted by underfunding of training for health care frontline leaders. When leadership is viewed as incompetent, unprepared, or unsupportive, frontline employees frequently express discontent (Aiken et al., 2011). Frontline health care leaders who receive inadequate, out-of-date leadership training suffer from things like lower employee satisfaction, lower retention rates, and higher organizational expenses. Enhancing staff stability, cutting operational inefficiencies, and improving care delivery all depend on investing in leadership development.

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The gap in practice is that despite the importance of leadership training for improving employee retention and satisfaction, U.S. health care organizations have not established comprehensive and up-to-date training programs for frontline leaders, contributing to a decline in retention and satisfaction (American Nurses Foundation, 2023). Frontline leaders are not being prepared to lead their teams effectively, which is causing a decline in employee and customer satisfaction (American Nurses Foundation, 2023). Competent frontline leaders in health care are essential for navigating the ever-changing landscape of health care (American Nurses Foundation, 2023). Health care frontline leaders track expenses and output, ensure staff overall satisfaction, and check that the needs of staff are met and exceeded (American Nurses Foundation, 2023). Health care frontline leaders have an impact on health care organizations at all levels and act as role models (American Nurses Foundation, 2023). Successful frontline leaders in health care should be able to inspire their peers and set the standard for a respectful, safe, high-morality, and retained workplace culture (American Nurses Foundation, 2023).

The purpose of this qualitative inquiry project was to explore the perspectives of U.S. health care frontline leaders regarding their training strategies and their effects on retention and employee satisfaction. This project can assist organizations in understanding where improvements should be made to encourage further education regarding leadership as it relates to employee retention rate and satisfaction. When individuals are placed into leadership roles who have pursued continuation courses meant to improve competencies related to leading a team successfully, employees may be more inclined to stay within the organization and assist in meeting the mission and goals set forth by the health care organization's executives.

- *Theoretical Framework*

An applied framework is a systemic method that categorizes and maps all qualitative data and is useful in determining critical flows or ideas in research (Joiner, 2019). The applied framework can best be described as a blueprint for a researcher in terms of the structure of the researcher as well as the rationale, problem statement, purpose, research questions, literature review, and applied statements for the research being performed (Joiner, 2019).

Chatzoudes, D., & Chatzoglou, P. (2022) conceptual framework can be utilized to examine factors affecting employee retention and satisfaction including leadership development, organizational culture, and clear mission and goals of an organization. Chatzoudes, D., & Chatzoglou, P. conceptual framework (see Figure 1) provides a comprehensive method to improve comprehension of the employee retention problem as well as the overall satisfaction of employees within the organization by combining the results of multiple earlier studies (Chatzoudes, D., & Chatzoglou, P., 2022). Chatzoudes, D., & Chatzoglou, P. (2022) framework has evolved from earlier studies on human resource practices and has been adapted to address modern organizational challenges, such as employee engagement and retention. This evolution highlights its relevance in understanding contemporary leadership dynamics. Chatzoudes, D., & Chatzoglou, P. (2022) framework has evolved from earlier studies on human resource practices and has been adapted to address modern organizational challenges, such as employee engagement and retention. This evolution highlights its relevance in understanding contemporary leadership dynamics.

Regarding the concept of human resource practices, human resources should be able to define and provide effective competencies needed by individuals who are selected for leadership positions and provide them with the necessary tools to lead effectively within the organization (Chatzoudes, D., & Chatzoglou, P., 2022). Prioritizing leadership development helps organizations become more operationally productive while also fostering a culture of trust and development. Employees are more likely to stay engaged, loyal, and dedicated to the company's mission when their leaders are capable and encouraging. Businesses that place a high priority on leadership development will be able to retain top people, lower turnover costs, and stay competitive in their respective industries as the labor market changes.

The concept of working conditions and the culture that surrounds the organization relates to the proposed project question as leaders must be able to recognize hostile or ineffective working conditions or culture so that they may be remedied before retention starts to fall and the satisfaction of employees suffers (Chatzoudes, D., & Chatzoglou, P., 2022). Employee retention is greatly influenced by organizational culture. A positive and encouraging work environment can greatly increase the likelihood that employees will stay with a company, whereas a toxic or negative culture can result in high turnover rates. In other words, employees are more likely to stick with a company where they feel appreciated, supported, and in line with its values and objectives. The human resource practices and organizational culture concepts directly relate to work attitudes and overall satisfaction, as an employee's attitude toward leadership and an organization as a whole can be altered based on the effectiveness of the leader they are assigned to (Chatzoudes, D., & Chatzoglou, P., 2022).

As for the mission and goals concept, leaders need to define the mission of an organization clearly for employees so that everyone can work towards a common goal, and cohesion with the mission can directly affect all of the concepts above and can positively or negatively affect retention rates and employee satisfaction based on the leader's capability (Chatzoudes, D., & Chatzoglou, P., 2022). Employee retention is directly impacted by a company's mission and goals because they foster a sense of purpose and alignment when workers believe their efforts contribute to a greater, meaningful goal. This increases employee satisfaction and loyalty and increases the likelihood that they will remain with the company; in other words, when workers believe in the company's mission, they are more likely to be engaged and committed to their roles, which lowers turnover rates.

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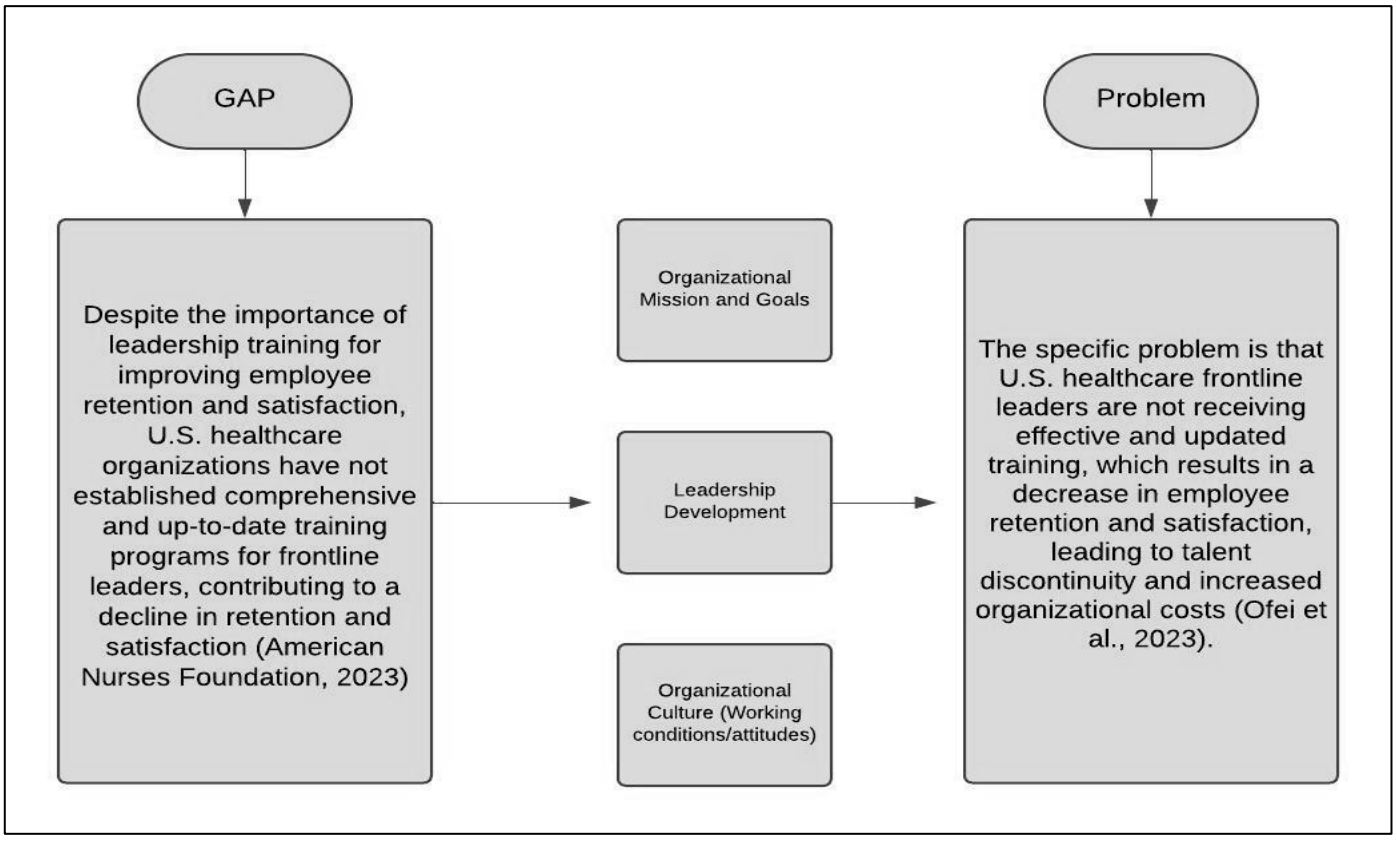

Fig 1 A Simplified Example of Chatzoudes, D., & Chatzoglou, P. (2022) Conceptual Framework

The theory that applied to this project is Maslow's (1954) hierarchy of needs as the primary theory utilized to support the business problem identified in this capstone study. Maslow's hierarchy of needs is a psychological theory of motivation that consists of a five-tier model of human needs that is frequently represented as levels within a pyramid (Maslow, 1954). Prior to addressing needs higher up in the hierarchy, people must attend to needs lower down. The needs include physiological, safety, love and belonging, esteem, and self-actualization, going up the hierarchy from the bottom (Maslow, 1954). Researchers can better determine the needs of the frontline leadership in health care regarding skills and competencies and the employees that fall under them, as well as the best ways to increase satisfaction and retention within the organizations by using key constructs of Maslow's hierarchy of needs (McLeod, 2025). Interview questions will be crafted based on Maslow's Hierarchy of Needs, such as asking leaders how they ensure their employees' safety and belonging. This will help analyze whether leadership practices align with the motivational needs outlined by Maslow and whether the organization's culture is aligned with the overall goal of the organization. All the concepts of Chatzoudes, D., & Chatzoglou, P. (2022) conceptual framework and Maslow's (1954) hierarchy of needs theory correlate to the ability to maintain satisfaction within the organization and promote higher retention. Leaders can assist in identifying the training needed by leadership within a health care organization that would promote positive change, including increasing satisfaction and retention rates by focusing on creating a clear mission and goals, implementing strong leadership development, and promoting a positive organizational culture.

- *Project Context*

Because toxic leadership has a major impact on health care outcomes, organizational performance, and the sustainability of the system as a whole, a research study on employee retention and satisfaction in the US health care system is desperately needed. In health care management, toxic leadership, which is typified by traits like authoritarianism, poor communication, a lack of empathy, and unethical decision-making, has grown to be a major concern (Farghaly-Abdelaliem & Abou Zeid, 2023). Addressing more general structural issues in the health care industry requires an understanding of its role in employee discontent and attrition. One of the main causes of employee discontent, burnout, and, eventually, high turnover in health care organizations is toxic leadership. Health care professionals who experience toxic leadership are less likely to trust others, experience more stress, and have lower morale. These circumstances have the potential to cause health care employees, especially those working on the front lines, to quit, which would increase the already high turnover rates in the sector (Farghaly-Abdelaliem & Abou Zeid, 2023). Health care managers may have negative effects on patient care, organizational performance and morale, and the accomplishment of organizational goals if they are not aware of the several options available for lowering turnover (Farghaly-Abdelaliem & Abou Zeid, 2023).

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- *Nature of the Project*

Toxic leadership research is essential for creating evidence-based strategies to enhance leadership behaviors and lessen their detrimental impacts. Designing solutions that successfully address these difficulties requires an understanding of the particular actions and attitudes that make up toxic leadership, as well as how these interact with other elements, including organizational culture and individual employee attributes. Evidence-based research, for example, can assist in developing focused leadership development initiatives, enhancing organizational regulations, and cultivating positive work environments. Without this kind of study, health care institutions might still be dealing with poor leadership and the ensuing harm to staff morale and patient care. Toxic leadership is a negative style of leadership that may be harmful to individuals as well as organizations (Farghaly-Abdelaliem & Abou Zeid, 2023). Lower-level employees inside the company may be affected by the negative actions of leaders in the workplace (Farghaly-Abdelaliem & Abou Zeid, 2023).

In addition, workers showed signs of emotional exhaustion and quiet as a result of the leadership's aggressive behavior. Employees' self-confidence and individual performance will decline when their sense of self-worth is undermined (Farghaly-Abdelaliem & Abou Zeid, 2023). This research project hopes to confirm that the three sub-dimensions of toxic leadership, unappreciativeness, self-esteem, and self-seeking, negatively affect job satisfaction and worker performance.

- *Scope*

The scope of this project is frontline leaders within the health care industry who have had more than 3 years of experience leading a team within a health care organization. These frontline leaders could be administrators or nurses who have held a frontline leadership position within a health care organization. The health care organization can include primary care practices, larger hospitals, health care organizations, and dental clinics.

- *Significance of the Project*

This proposed project is significant to business leaders in the U.S. health care industry as they might gain valuable insight into innovative strategies to improve the current skillsets of frontline leaders and increase the overall satisfaction of their employees as well as ensure retention of employees remains high. Over the years, many employees have been faced with leadership that fails to provide a comfortable and nourishing environment that allows them to feel appreciated and welcome within their respective organizations. This has led to staff shortages within many health care organizations as they tend to flock to organizations that show a promising history of compassion for their patients and their staff. Many employees have seen discrimination throughout the last few decades surrounding their age, gender, race, or even their sexual orientation. Oftentimes, leadership failed to receive the appropriate training needed to be able to adjust their behaviors in a way that was productive for the organization and allowed satisfaction to remain high among the employees who followed them.

This project will hopefully shed some light on the lack of skills current and previous frontline leaders in the health care industry possess. It also aims to potentially allow organizations to understand the necessary steps to ensure staff satisfaction and retention, which can increase productivity and save the organization funds. Research on the organizational elements that can incite retaliation is desperately needed, as toxic leadership is becoming more and more prevalent in health care organizations. Nor has the role that psychological well-being plays in protecting against toxicity been sufficiently investigated.

- *Historical Background and Current Trends*

Toxic leadership has been present in society for decades, especially in the health care industry. Employees have faced toxic leadership in many forms, including discrimination against race, gender, and sexual orientation. Although many organizations have fought off the effects of these toxic leaders, there have been events in history that have allowed the face of toxic leadership to show its' face within many organizations. Health care is an industry that was already presented with turnover rates that were higher than one would expect, however, one specific event in recent history was able to truly show the negative effect that toxic leadership can have, and that was COVID-19.

- *Historical Background*

Toxic leadership is a new idea within health care organizations despite having emerged across a variety of industries or domains, such as the military, politics, and business (Williams, 2005). Health facilities provide ideal settings for toxic relationships, and as this theory gains traction, so will the number of scholarly studies on the topic (Williams, 2005). According to research done on 400 executives, 39% of whom are employed by health care facilities, 94.7% of the participants had to cope with a toxic coworker (Kusy, M. & Holloway, E., 2009).

Although there are not many significant events in history that can support the correlation of toxic leadership to employee dissatisfaction and lower retention rates for health care organizations, COVID-19 can be utilized as one significant event that sheds light on how toxic leadership can lead to negative effects on staff and a health care organization as a whole. One crucial factor that greatly affects an organization's capacity to successfully manage problems is the relationship between toxic leadership and organizational response during crises like the COVID-19 epidemic (Wolor et al., 2022). Examining how toxic leadership behaviors can obstruct and interfere with different aspects of the organizational response is necessary to comprehend this connection (Wolor

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et al., 2022). Because toxic work cultures are becoming commonplace, nursing practitioners are growing more worried about the phenomenon of abusive leadership in health care organizations (Ofei et al., 2023). Leadership styles of frontline leaders in high-income countries (HICs) negatively affect the quality of patient care. Nurses who worked in toxic environments were more likely to exhibit unproductive work practices and a stronger desire to leave their positions (Ofei et al., 2023).

One of the ways that toxic leadership can affect an organization is ineffective communication and lack of transparency, especially in a crisis. Open communication is often impeded by toxic leaders, who frequently cultivate an atmosphere of mistrust and terror (Wolor et al., 2022). This may hinder the exchange of vital information required for a successful crisis management strategy (Wolor et al., 2022). In order to further their personal agendas, toxic leaders may omit crucial information or control communication, thus eroding confidence and fostering an atmosphere of distrust (Wolor et al., 2022). Many organizations were met with ineffective communication during the pandemic, and it led to mistrust and increased stress among the staff (Wolor et al., 2022). With this, many employees within the health care industry began to feel increased stress and frustration as it was not easy to balance work and personal life during this time (Wolor et al., 2022). The stress and frustration felt by the staff due to the ineffective work-life balance due to short staffing and ineffective communication can directly affect the satisfaction and retention rate of the employee(s). When employees' efforts yield noteworthy outcomes, they feel satisfied, which boosts their job satisfaction (Ofei et al., 2023). Short staffing and unclear expectations led to an exodus of employees who sought employment that gave them security and comfort from home or even within other organizations that were able to identify issues and react appropriately, offering positive solutions that promoted positive morale amongst the employees as well as the frontline leaders (Wolor et al., 2022).

- *Current Trends*

Given the anticipated scarcity of health care workers in the industry, nurse retention is a major concern in delivering safe and high-quality treatment. A study written by Einarsen et al. (2007) titled “Destructive leadership behavior: A definition and conceptual model.” demonstrated that the degree of organizational trust and the intention to leave an organization is significantly impacted by the toxic leadership opinions of nurses. As a result, nurses who thought their supervisors exhibited less toxic leadership behavior had higher levels of trust in their companies and fewer intentions to leave. Even though there is prior knowledge and research of how toxic leadership affects the organization and the worker, particularly in nursing, more research is necessary to give information on how toxic leadership arises and what kinds of treatments could help managers. Toxic leadership actions that potentially compromise the quality and safety of patient treatment and overall employee satisfaction must be stopped by organizational action. Health organizations can evaluate the current situation by examining the leadership ideologies of both existing and prospective nurse managers. To help nurse managers become more aware of their leadership styles, self-evaluation can also be done regularly. It is also possible to create an organizational culture in health organizations that prohibit risky behavior. To enhance the leadership behaviors of nurse managers, and human resource personnel, nurse administrators should place a high priority on leadership development that stresses the development of positive leadership behaviors, effective communication, and the creation of supportive work environments. Leadership development can assist in identifying the skill sets that need to be developed in current and future leaders within an organization. When an employee of an organization is introduced to a leadership role, the organization should initiate training that can help those new leaders identify their strengths and weaknesses and offer tools and resources to build on those skills and become successful leaders within their field.

- *Synthesis of the Scholarly Literature*

Toxic leadership in the U.S. health care industry has been the subject of increasing scholarly attention, particularly because of its profound impact on employee well-being, organizational outcomes, and patient care (Skibinska & Karaszewski's, 2024). Toxic leadership is typically characterized by behaviors such as narcissism, authoritarianism, bullying, micromanagement, and a lack of empathy, which can create a dysfunctional work environment. Literature provides a wealth of information about the detrimental impacts of toxic leadership in various organizational contexts, emphasizing establishing and preserving a healthy work atmosphere, guaranteeing the provision of high-quality health care, and advancing the best possible patient safety all depend on effective leadership. Effective leadership is essential for guaranteeing the best possible patient care and employee welfare in the high-stakes health care industry (Skibinska & Karaszewski's, 2024). The literature that is described throughout this section describes the traits that contribute to toxic leadership as well as the negative effects that toxic leadership may have on a health care organization as well as the employees that are affiliated with said organization(s). With these effects that toxic leadership has on those within a health care organization, the literature also discusses how organizations should combat this behavior and the negative effects that tend to follow toxicity such as decreased employee satisfaction and retention.

Bullying, harassment, and general animosity in the health care setting are frequently linked to toxic leadership. Leaders who ignore bullying or engage in bullying themselves foster a poisonous workplace culture that lowers employee morale, increases stress, and ultimately results in burnout. Research indicates that bullying at work has a negative impact on staff dedication and job performance, in addition to harming interpersonal connections (Johnson, 2019). Interviews were conducted with thirteen staff nurses who worked in various settings around the United States. "Biased behavior manifested as workplace bullying, workplace bullying disguised as a performance review, and workplace bullying as entrenched behavior in nursing" are the three interconnected discursive strands that were found (Johnson, 2019). Reactions to bullying differed depending on whether a discursive strand was used. Bullying in the workplace is a tactic used to expel nurses who are different, according to the main subject at the intersection

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of the discursive threads (Johnson, 2019). Training on proper performance assessment procedures, workshops on how to work with different coworkers, and an analysis of how nursing education processes support bullying in clinical settings all necessary components of any effort are to combat workplace bullying among nurses (Johnson, 2019).

Skibinska and Karaszewski's (2024) study elaborated on the need for increasing retention and employee satisfaction, which requires an approach from leadership that would support rather than undermine the team or employees. In the management literature, the topic of toxic leadership is becoming more common, and in the last few years, it has attracted the attention of many academics. Based on the literature that is represented throughout this study, toxic leadership has become more of a leadership style rather than being defined as an absence of effective leadership abilities. The characteristic of toxic has become more of a trend within many industries and the health care industry and based on the research from Skibinska and Karaszewskis the is a direct correlation that can be observed between toxic leadership and the overall retention and satisfaction of the workforce.

Stress at work, frustration with effort, and unfavorable working circumstances are some of the primary causes of early retirement among health professionals. Furthermore, high levels of stress at work are linked to increased absenteeism, job dissatisfaction, and a higher intention to leave the health profession early. A pattern of responses that arises when employees are faced with demands or pressures (stressors) that are out of proportion to their knowledge, skills, and talents and that test their capacity for coping is known as work-related stress (Peter et al., 2024).

The study described above by Skibinska and Karaszewski's (2024) investigates the widespread problem of toxic leadership in health care institutions, which is typified by unethical and destructive activities. Both qualitative and quantitative methodologies were used in the analysis to find recurring themes and trends in leadership practices. Finding evidence of toxic leadership practices in the chosen health care facilities was the main goal of this study's findings. It could aid in comprehending the indirect effects that leadership has on patient treatment, staff retention, and satisfaction.

Health care settings are becoming more complicated as management strives to provide high-quality care, frequently with limited funding, while dealing with escalating problems, including staffing shortages (Mackoff & Triolo, 2008). Health care managers have shorter tenures and are more likely to leave their jobs due to high levels of stress and burnout, which reduces organizational leadership capacity. This is a result of both a lack of mentoring and an inability to manage stress (Mackoff & Triolo, 2008) effectively.

Businesses without plans for accountability, transparency, and professional and personal growth foster toxic leadership and provide the conditions for its spread, which is bad for the business (Hughes, 2022). In a study with 14 managers in a top-down hierarchical organizational structure, Hughes found that all the managers felt that organizational accountability betrays employee trust and creates an atmosphere ripe for developing and maintaining toxic leadership within the company.

The literature agrees that toxic leadership can cause serious problems for the company. Loss of training and development within an organization, high turnover costs, diminished brand equity, low productivity, and the possibility of deviant employment behavior are a few examples. Hughes (2022) confirmed the negative correlation between toxic leadership and organizational citizenship behaviors, as well as the correlation between followers' general workplace deviance and very damaging leadership levels. Research indicates that there is a strong correlation between unethical behavior by subordinates and the presence of strong relationships between immoral leaders and their followers (Hughes, 2022). Organizational culture, defined as effective culture, job satisfaction, observed integrity and trust, along with communication and recognition, and environment, may have a greater impact on retention than compensation and other conventional factors, according to research examining the relationships between toxic leadership and associate retention. However, associate retention is not the only sign of toxic leadership. A person who works for a toxic leader is more likely to feel that their ideal workplace and the one that the toxic leader promotes are not compatible. With subordinates having less job mobility or in a stifled employment market, retention may not be adversely impacted, even in the face of toxic leadership. Hughes (2022).

- *Synthesis of the Practitioner Literature*

Leadership theories were formed in the business world and then applied to the health care unit; they were not developed in the health care settings. Therefore, the theories are dynamic and will change as time goes on. Complex interfaces between various specialists in a variety of jobs make up health care organizations. Effective collaboration is a crucial deficiency in many areas of health care. Therefore, strong leadership is essential to implementing the adjustments required to raise the caliber of the organizations. The practitioner literature that is described throughout this section describes information on how effective leadership is essential for ensuring the delivery of high-quality health care, promoting the highest level of patient safety, highlighting, creating, and maintaining a healthy work environment, and learning about the negative effects of toxic leadership in diverse organizational contexts. Bill George (2016) wrote in Fortune 500 Magazine that the author discussed the risk that comes with the behaviors associated with toxic leadership.

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George (2016) stated that toxic leaders create environments that alter the behaviors of those surrounding them. For example, morale starts to decrease, and employees start moving on to organizations with histories of increased employee satisfaction, growth, and retention. However, the rise of toxic leadership, characterized by abusive behaviors, a lack of support, and the abuse of authority by leaders, is causing the nursing profession to become more and more concerned. This issue is particularly relevant in high-acuity settings, such as emergency departments, where nurses usually operate in a demanding and stressful environment. This information can be identified with the organization researching and searching for the information needed to make a positive change.

An easy way for an organization to identify these negative traits and highlight positive traits in their leadership staff is by conducting climate surveys that are aimed at identifying the specific needs for changes within the organization. Based on the work written by Semedo (2022), there are ways for an organization or individual to identify and avoid toxic leadership by building oneself up and growing in resilience. Semedo (2022) states that it is crucial for organizations to recognize when an employee is not the primary culprit as it pertains to toxic work environments and that it is quite often the leadership that is affiliated with that employee that is creating an environment that causes stress and aggression. Again, this is where the climate surveys or annual questionnaires can identify issues within leadership and allow the organization to correct those issues before these toxic leaders can harm the organization. Toxic leaders can harm the organization in many ways, including employee dissatisfaction, leading to employees seeking work elsewhere or even leaving the organization altogether (Semedo, 2022).

Climate surveys in health care organizations are invaluable tools for assessing the organizational environment, especially in relation to leadership development (Cummings et al., 2018). These surveys offer direct insights into how employees perceive the leadership culture, communication practices, work conditions, and overall job satisfaction within the organization (Semedo, 2022). Understanding these factors is critical for identifying areas where leadership development programs can be most effective. Without such feedback, it would be difficult for health care organizations to gauge the true needs of their staff, or to tailor leadership training to address specific challenges and opportunities within the team (Semedo, 2022).

One of the primary benefits of conducting climate surveys is that they provide a platform for staff to voice their experiences and concerns in an anonymous and structured way (Cummings et al., 2018). When it comes to leadership development, this feedback can highlight gaps in leadership practices, such as insufficient communication, lack of support for staff, or ineffective decision-making processes. By analyzing these survey results, health care organizations can better understand how their leaders are perceived, whether they are seen as approachable and supportive, and if they are fostering a culture of trust and accountability (Cummings et al., 2018). This insight is crucial for shaping leadership development initiatives that target real-world issues and equip leaders with the tools to foster a positive and productive work environment.

Furthermore, climate surveys can help measure the effectiveness of existing leadership programs by tracking changes in staff attitudes and perceptions over time. If an organization has recently implemented leadership development initiatives, the results of climate surveys can reveal whether those efforts have led to improvements in team morale, communication, and job satisfaction. This allows health care organizations to assess the return on investment (ROI) of leadership development programs and make data-driven decisions about refining or expanding these initiatives (Semedo, 2022). Leaders who are attuned to the needs of their teams and who actively respond to the insights gained from climate surveys are more likely to foster a supportive, engaged, and high-performing workforce (Cummings et al., 2018).

Another key importance of climate surveys is their role in promoting organizational transparency and accountability. When leaders actively solicit feedback through surveys, it signals to staff that their opinions are valued, and that leadership is committed to continuous improvement. This helps build trust between staff and management, which is essential for creating a positive work culture. In health care settings, where stress levels can be high and burnout is common, transparent leadership that listens to and acts upon staff feedback is crucial for retaining talent and maintaining high standards of patient care.

George (2016) also describes the need for positive leadership and the positive effects that could stem from leaders in the workforce promoting positive behaviors. Genuine leaders aim to bring out the best in others. Their goals are to help people see the potential in others, to give them the confidence to own up to their mistakes and to collaborate to improve the lives of everyone. Today's leaders in industry, health care, nonprofits, academia, and, yes, politics must do this in order to unite society and improve everyone's quality of life while also addressing our problems (George, 2016). The idea of leadership has changed significantly with the advent of transformational leadership, moving from signifying an authoritative connection (transactional) to a process of influencing people (transformational) (Van Diggele et al., 2020). Transformational leadership is the process of guiding people or "followers" to strive for a shared organizational objective. The foundation of this modern leadership style is motivating people and building teams to accomplish objectives (Van Diggele et al., 2020). Organizations are defined by transformational leaders who articulate a distinct vision and principles (Van Diggele et al., 2020).

Vorwerk (2024) argued that relationships are more important than series in determining the effects of leadership, whether toxic or positive. Vorwerk (2024) also stated that by agreeing to study harmful leadership qualities, researchers can identify the qualities to avoid when leading an organization, just as researching positive leadership styles can guide an organization in improving interactions and building relationships with employees. Organizations oftentimes have annual climate surveys that are sent out, and

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by performing an appropriate analysis of these surveys, the organization can get a better understanding of the current abilities of the leadership. This will also allow the organization to understand what training and development needs to be created and implemented to promote positive changes within the organization. Wong and Briggs, in their 2024 article, described the need for leadership training and the necessity for those seeking leadership roles to expand on their current skills and seek out new skills that will allow them to lead individuals positively.

Wong and Briggs (2024) also described within the article a few key steps that organizations or individuals can utilize to expand on those skills, and one of the most important steps for an organization is to implement programs or events to identify the need for growth. Once an employee has been selected for a leadership role, the organization should place them into a leadership development program that will assist them in identifying their strengths and weaknesses to promote healthy development and become successful within their new role (Wong & Briggs, 2024). These programs will leave those new or expected leaders with the tools and resources to expand on their current skill sets and understand how to navigate the world of leadership. A complicated and highly valued aspect of health care education, effective leadership is becoming more widely acknowledged as being crucial to the provision of high standards in clinical practice, research, and education (Van Diggele et al., 2020). All health professions will need more capable leaders to handle the demands of health care in the twenty-first century. Therefore, all curricula for health professionals should include leadership development and training. A new kind of leader is developing, one that prioritizes teamwork and sets an example of striking a balance between accountability and autonomy. Leaders in health care education must be able to collaborate and work well across organizational and discipline barriers. This essay examines leadership duties and competencies in the context of health care education while also providing a brief analysis of contemporary leadership philosophies (Van Diggele et al., 2020).

Iannarino (2023) wrote an article that describes five indicators that show how a job or organization is a trap for negative leadership. Iannarino (2023) discusses five indicators that a job is a negativity trap and offers suggestions for getting out of one.

High turnover rates are the first indication since people tend to leave unsatisfied in unfavorable cultures (Iannarino, 2023). Negative leadership in health care organizations is a significant driver of high turnover, a pervasive issue that can have far-reaching consequences for both the staff and the quality of patient care. When leadership is characterized by poor communication, lack of support, micromanagement, or an inability to inspire and motivate staff, it creates a toxic work environment that directly impacts employee satisfaction and retention (Cummings et al., 2018). Nurses, physicians, and other health care professionals who feel unsupported or undervalued by their leaders are more likely to experience burnout and job dissatisfaction and, ultimately, leave their positions in search of better working conditions. This not only results in a loss of skilled staff but also incurs substantial costs for health care organizations in terms of recruitment, training, and lost productivity.

The second indicator is a lack of transparency, which fosters a hostile environment in a culture that is secretive (Iannarino, 2023). Negative leadership combined with a lack of transparency can have a profoundly damaging impact on health care organizations, affecting both employee morale and the overall effectiveness of the organization (Kempster et al., 2019). Transparency is a cornerstone of good leadership, particularly in health care settings where trust, collaboration, and open communication are essential for delivering high-quality patient care. When leaders fail to be transparent, whether in their decision-making, organizational goals, or day-to-day interactions with staff, employees are left feeling confused, disengaged, and uncertain about their roles and the future of the organization (Kempster et al., 2019). This can create a toxic work environment where rumors and misunderstandings thrive, further eroding trust and morale.

The third indicator is unhealthy interpersonal dynamics, like gossip and bullying (Iannarino, 2023). Toxic leadership is commonly associated with bullying, harassment, and general hostility in the health care setting. Leaders who either tolerate bullying or bully others themselves create a toxic work environment that depresses staff morale, raises stress levels, and eventually leads to burnout. According to research, bullying at work damages interpersonal relationships and has a detrimental effect on employees' commitment and job performance (Johnson, 2019). Thirteen staff nurses who worked in different settings around the United States were interviewed. Three interrelated discursive threads were identified: "Biased behavior manifested as workplace bullying, workplace bullying disguised as a performance review, and workplace bullying as entrenched behavior in nursing" (Johnson, 2019).

The fourth indicator, as seen by the team's low morale and lack of excitement, is a negative trap (Iannarino, 2023). Negative leadership in health care organizations is a significant contributor to low morale among staff, and the impact of this on employee well-being, productivity, and patient care can be profound. In environments where leadership is ineffective, unsupportive, or characterized by poor communication and micromanagement, staff members can quickly become disengaged, stressed, and demotivated (Humphries et al., 2014). This erosion of morale doesn’t just affect individual employees but can permeate entire teams, leading to a toxic work culture that negatively influences both staff retention and the quality of care provided to patients.

The fifth indicator is stress and burnout, which is why work-life balance is so crucial. The article outlines the importance of looking for a supportive workplace and acting quickly on these indicators (Iannarino, 2023). Negative leadership in health care organizations is a major contributor to stress and burnout among staff, and its effects can ripple through the entire organization, impacting both employees and patient care (Humphries et al., 2014). In high-pressure environments like health care, where employees are already working under physically and emotionally demanding conditions, negative leadership can significantly

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exacerbate stress levels, leading to exhaustion, disengagement, and, ultimately, burnout. When leaders fail to provide adequate support, fail to recognize the challenges their staff face, or exhibit poor management practices, they create an environment that drains the energy and well-being of their teams (Humphries et al., 2014).

Leadership development in nursing is crucial for ensuring high-quality patient care, fostering professional growth, and enhancing the overall effectiveness of health care systems. In a field as dynamic and demanding as nursing, leaders must possess not only clinical expertise but also the ability to inspire, guide, and support teams in delivering compassionate care. Strong nursing leadership ensures that teams are cohesive, motivated, and able to respond effectively to the rapidly changing health care environment, from technological advancements to evolving patient needs. Effective leadership helps create an organizational culture that values collaboration, innovation, and continuous improvement, all of which are essential for meeting the challenges of modern health care.

The development of nursing leaders also plays a key role in improving patient outcomes. Research shows that when nurse leaders are well-trained and skilled in communication, decision-making, and conflict resolution, they can better manage their teams, improve workflow, and address patient concerns with greater efficiency. Leaders in nursing settings act as role models, influencing the behavior and attitudes of the staff they lead. By fostering an environment of trust, respect, and professional growth, nurse leaders can reduce staff turnover, enhance job satisfaction, and improve patient care. Additionally, leadership development helps nurses navigate complex ethical dilemmas, manage stress, and advocate for both patients and staff, which are all essential components of the nursing profession.

Furthermore, leadership development is vital for promoting innovation within health care settings. As the health care landscape continues to evolve with new technologies, treatment protocols, and patient care models, nursing leaders must be equipped to lead their teams through change and adapt to new challenges. Through leadership development programs, nurses are trained in strategic thinking, problem-solving, and change management, enabling them to contribute to advancements in patient care and operational efficiency. Nursing leaders who are empowered with the right tools and knowledge can drive improvements in practice, policy, and health care delivery systems, thereby enhancing both patient and organizational outcomes.

- *Alignment of the Project with the Literature and Discipline*

Based on the literature that has been synthesized above, toxicity in the workforce is present throughout organizations, no matter what the industry. It is important for the executive leadership within an organization to recognize toxic behaviors and work towards eliminating these behaviors to promote positive employee satisfaction and morale as well as ensure retention rates. By ensuring that toxic behaviors in leadership are thwarted, and employees remain happy within the organization, the respective organization can then allocate funds to improving the organization and client outreach rather than spend funds on replacing employees who leave due to toxicity. Organizations need to understand the need to identify these behaviors and work to correct them prior to the negative behaviors pushing employees out the doors and into other organizations. The goal of this research project is to identify these behaviors within the health care field and possible ways that by health care organizations being able to identify the negative behaviors, they may be able to decrease the effects of the current nursing crisis. In summary, leadership development in nursing is essential for cultivating effective, compassionate, and forward-thinking leaders who can meet the demands of an ever-evolving health care system. By investing in the growth of nurse leaders, health care organizations can improve patient care, enhance workforce satisfaction, and promote innovation, all of which contribute to the overall success of the organization and the well-being of the communities it serves.

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CHAPTER TWO
PROCESS

- *Project Questions*

PQ1: What are the perspectives of U.S. health care frontline leaders regarding their training strategies to improve retention and employee satisfaction?

- *Project Design/Method*

For this capstone project, utilized semi-structured interviews with frontline leaders within U.S. health care organizations to understand better the current training and development expectations and the skills and techniques one can benefit from to be a good leader. One of the most popular research techniques in the social sciences is the semi-structured interview. Interviewing is a universal method of inquiry in the social sciences, according to Hyman et al. (1954). The semi-structured interview is an exploratory interview, according to Magaldi and Berler (2020). They go on to say that the semi-structured interview is usually centered on the primary subject, offers a broad framework and is usually based on a guide. Furthermore, Magaldi and Berler (2020) contend that a semi-structured interview allows a researcher to delve deeply for discovery, even though topical paths are pre-provided. Utilizing a semi-structured interview technique will allow the participants to be more forthcoming with the information they provide so that potential resolutions can be identified and discussed within the conclusion of this study (DeJonckheere & Vaughn, 2019). This approach usually entails a conversation between the participant and the researcher, aided by a flexible interview process and enhanced by comments, follow-up questions, and probes. The approach enables the researcher to gather unstructured data, investigate participant ideas, opinions, and sentiments regarding a specific subject, and deeply investigate private and occasionally delicate matters (DeJonckheere & Vaughn, 2019). Conceptually and symbolically, qualitative findings are helpful because they help individuals better understand their experiences, which enables them to provide more individualized solutions and anticipate potential issues in a given situation (Miller, 2010). By exploring the depth and diversity of experiences, perceptions, and meanings that people ascribe to their interactions with the world around them, qualitative research investigates complexity. The foundation of this study methodology is the conviction that comprehending complex social phenomena, such as organizational culture, requires both individual interpretation and context (Ford, 2024).

The population for these interviews would be to reach out and enter discussions with 12-15 U.S. health care frontline leaders, including but not limited to charge nurses, nurse managers, and practice managers with at least three years of experience in the field; however, I will only require at least 10-12 participants to reach full data saturation so that I may be able to gather substantial evidence supporting the lack of training and development as a contributing factor to low retention rates and customer or employee satisfaction. Each of these semi-structured interviews will last 45-60 minutes.

I shall utilize Braun and Clarke. (2006) thematic analysis to analyze the data. The six steps of Braun and Clarke's iterative thematic analysis method are as follows: getting to know the data, creating codes, specifying categories, coming up with themes, going over themes, defining and labeling themes, and finding exemplars (Braun & Clarke, 2006). Gaining familiarity with data involves reading in recurrent cycles and immersing oneself in it, with each round producing new insights (Braun & Clarke, 2006). Finding a pattern may involve noting frequency, but the main goal is to emphasize significance rather than number (Braun & Clarke, 2006). According to Braun and Clarke (2006), there is no hard-and-fast answer to the question of what proportion of a researcher's data set needs to display evidence of the theme for it to be considered a theme.

The limitation to be expected throughout this capstone project is the availability of participants for the study. Based on the information received throughout this program, I have found a service that can assist in locating participants for my study. This service is called FindParticipants, and this service offers the ability to connect a researcher with valid participants to speed up the research process and identify individuals who are best suited to offer expertise on the subject that is being researched. I input the study's needs into the website, and the service will attempt to connect myself with qualified individuals who will assist in offering essential experience and expertise that will ultimately lead to a resolution to the proposed project question(s). In the case that this participant location service fails, I had a fail-safe program or service to utilize in order to locate participants. This secondary service is called Respondent and has a great history of assisting researchers in locating and matching participants that best match the criteria of the referenced study. With the assistance of these services, I will then take the developed interview questions and perform Zoom interviews that will last 45 minutes to 1 hour to allow time to take notes and allow the participant to elaborate on any vague answers given to the interview questions. Allowing extra time within these interviews will ensure increased validity and reliability of the study as the information given will be elaborate and allow myself to break down the answers into clear, concise information that can allow for positive change within the respective health care organizations (Jamshed, 2014).

The timeline for this project is as follows: preliminary topic revisions were completed at the end of March 2024. The literature review was completed June 2024. The project proposal was completed in August 2024. This project will start with the Capella University Institutional Review Board (IRB) approval process. The completion date for results, analysis, and reflection was September 2024, avoiding any potential issues that arose due to unforeseeable bias identified during the interview process. No issues

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were identified, thus eliminating the need for alternate participants that were identified before the beginning of the interview process to avoid any potential delays in the completion of the study.

- *Stakeholders, Participants, and Target Audience*

The research topic and the study's goal must be taken into account while choosing participants for a qualitative research study. Additionally, while choosing participants, I specified the precise traits or standards that were seen as important to the sample (Abbas, 2024). The population for these interviews would be to reach out and enter discussions with 12-15 U.S. health care frontline leaders with five or more years of experience in the field; however, I only required between 10-12 participants to reach full data saturation so that I was able to successfully gather substantial evidence supporting the lack of training and development as a contributing factor to low retention rates and customer or employee satisfaction. The selection of participants was based on their experience leading large teams in the health care industry and their length of time in leadership positions. Selecting leaders with a minimum of five years of experience ensures participants have the depth of understanding necessary to discuss

People or organizations that are interested in a research study or who influence or are impacted by its results are considered stakeholders. People who support a study, as well as others who might not support it or even be critical of it, are considered stakeholders (Vitae, 2015). Regarding this study and its results, the stakeholders who apply are the executives and staff members associated with the facilities and organizations identified within the study. Senior health care leaders will provide insights into the real-world implications of leadership styles, shaping the study's practical applications. Hospital management teams will facilitate data collection by granting access to relevant organizational data, ensuring the research findings are grounded in everyday challenges. Notifying the stakeholders of the results is important as it could shed light on the negative aspects of leadership within the organization(s) and allow them to take necessary actions to correct or modify the development and training that is offered to new and existing leadership within the given organizations (Vitae, 2015). By identifying the negative aspects of health care leadership education and training, executives can then adjust the training offered to boost morale and increase retention within the organization. This can then save the organization money by retaining the employees rather than allocating funding to hiring and recruiting events. The results can be applied by frontline leaders to enhance their daily leadership tactics, or by executive leadership to restructure leadership development programs.

A particular subset or sector of the general population that is the main focus of a study, intervention, or marketing campaign is referred to as the target population. It stands for a more limited set of people who fit particular requirements or have particular traits. The research topic or the goals of a certain program serve as the basis for identifying the target group (Willie, 2023). The target audience for this study is members of the health care community, whether existing or upcoming leaders with at least five years of experience. When referencing nurse leaders, I am referencing entry-level to mid-level nurse leadership to include charge nurses, practice managers, and nurse managers, who want to ensure that the training and development of leadership are up to a specific standard. This study will also allow new and current leaders to identify specific trends or characteristics present within the health care community that can be seen negatively and understand how to implement changes to promote positive leadership within their respective organizations. Health care policymakers will use the study's findings to inform new policies that promote effective leadership practices, ultimately enhancing patient care outcomes. Leadership development professionals can tailor training programs based on the identified leadership gaps, improving organizational culture and employee satisfaction. The target audience could also incorporate stakeholders, as the positive changes that could arise from the study would be from executives and stakeholders within the organization(s) identified within the study. I believe that the outcome(s) of this study will assist the target audience in speaking with their leadership and executives within the organization and identifying ways to improve the education and training of current and upcoming nurse leaders within the organization.

- *Role of the Researcher*

In my role as the researcher, I was the primary data collection instrument for the information gathered from frontline health care leadership. I had access to an approved interview guide. However, I was the sole individual responsible for collecting the information needed to complete the requirements of this study. I utilized my role as a researcher to interview multiple frontline leaders within the health care industry to identify common issues with leadership training and development and perspective ideas on how to increase the positive outcomes of a proper leadership training and development program. Before conducting this study, I held the preconception that inadequate leadership training directly leads to high employee turnover. To minimize the influence of this bias, I made a conscious effort to approach data collection with an open mind, allowing participant responses to guide my understanding rather than preconceived notions. I kept a reflexive journal throughout the research process to continuously Llorente et al., 2021).

My current background is as an employee of the federal government as a contract administrator for multi-million-dollar aviation contracts that service our warfighters and a few foreign military affiliates that require material from the United States government. I am a 29-year-old Caucasian Male who has no current ties to leadership and development programs within the health care industry. I have held leadership positions while in the military; however, once I transitioned into the civilian sector for work, I have not held a leadership position that has required me to attend any leadership and development training. Based on prior experience in the field of health care as a Health Information Manager for a national hospital corporation and a Practice Manager with a national corporate dental practice chain, I believed that I could identify common themes within this study and positively identify common

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issues and resolution tactics amongst the study participants. Based on my prior leadership experience, I had a specific idea of how leadership should be trained to promote retention and positive attitudes toward the work that is being performed. I have struggled throughout my career with inadequate leadership, and my goal is to ensure that those who work with me from now and into the future are never put in a situation where they are uncomfortable in the workplace. Also, with my spouse currently working in the field of nursing, I wanted to assist him as he progresses in his career to ensure he can be the best leader that he can be. Now, this assistance will not be directly affecting him, but with the results of this study, I hope to promote positive change within the health care field and the leadership that dwells within. My training in qualitative research methods, combined with experience in organizational leadership, equipped me to conduct and analyze interviews effectively. This background ensures a rigorous and credible research process.

The intrinsic subjectivity that researchers bring to the investigative process is embodied in researcher bias in qualitative research, which affects data collection, interpretation, and analysis (QDAcity, n.d.). This bias, which arises from individual convictions, life experiences, and cultural backgrounds, may unintentionally influence how information is interpreted, and conclusions are made. It may be difficult to completely eradicate researcher bias, but by recognizing it and using techniques like reflexivity, peer debriefing, and triangulation, its effects can be lessened, and research findings can continue to be as objective and accurate as possible in reflecting participant viewpoints (QDAcity, n.d.). As a former health care manager, my experience in leadership roles has provided me with insights into the dynamics of leadership training. However, I recognize that my previous experience may bias my interpretation of data, particularly in evaluating current leadership training practices. My academic background in business administration, focusing on leadership, may also shape the way I approach this research. To avoid any personal bias, I have decided to research leadership and development within the health care industry, as this will allow me to research and obtain information and data without a conflict of interest by collecting data within my current field of occupation. I will ensure that the pool of participants I am pulling from has no relation to myself or my spouse and ensure that the facilities the participants are employed by are not facilities or organizations that my spouse or family members have ever been affiliated with. By having no current affiliation with the field of health care, I have successfully eliminated the risk of conflict of interest according to the Resources for Research Ethics Education (n.d.). By taking extensive notes during the interviews, I will leave little room for error and personal bias by utilizing the experiences that my participants face rather than putting their experiences into my own words (Suttie, 2023). With this information, I am prepared to proceed with the study as outlined in the sections presented above. I plan to work towards a resolution while remaining objective to the information that is being collected.

My cultural background as a white male may lead to unconscious biases regarding leadership dynamics. For example, I might prioritize hierarchical leadership structures. Acknowledging this, I will critically assess how these biases might shape my interview questions and data interpretation. To ensure that I remain objective throughout this, I will maintain a reflexive journal to document any potential bias so that I can take action appropriately and adjust my study to ensure the results can promote positive change within the field of leadership in nursing and health care. To address preconceptions, I will implement bracketing by documenting all assumptions before data collection and revisiting them throughout the study. Peer debriefing sessions will also be scheduled to ensure that my analysis remains grounded in the data. To mitigate bias, I engaged in peer debriefing with colleagues who were not involved in the research process. This allowed me to gain an external perspective on my findings and identify areas where my interpretations may have been influenced by personal experiences. Additionally, I employed member checking, sharing interview summaries with participants to ensure that my interpretations accurately reflected their views. Member checking will involve participants reviewing their interview summaries to confirm accuracy. practices, I balanced my subjectivity with a commitment to allowing the data to speak for itself, resulting in a more authentic and nuanced interpretation of the findings. While my professional background allowed me to connect with participants on the topic of leadership development, I remained mindful of the need for objectivity. By engaging in reflexive to address potential bias, I will use reflexive journaling to self-assess and minimize the influence on data interpretation.

➢ *Project Study Protocol*

In the following sections, the sampling strategy will be discussed, and a brief discussion of the sampling criteria will be given to select the participants for the referenced study. One of the other items to be discussed is the justification of the size of the sampling as the method of identifying those who will be participating in the study. In the following sections, readers will be provided with a step-by-step recipe card style with the overall proposal, leading to the final step of completing the data collection. Readers will also have a section that describes and discusses any ethical considerations that apply to the study. Finally, readers will see a step-by-step recipe card style on how data analysis will take place.

- *Sample*

When discussing the topic of sampling, a researcher must be prepared to identify the necessary individuals who will provide the study with the best information to reach a resolution that could show positive change within the environment that is being evaluated. First, we will start with sampling framing. The sample frame is the group of individuals that can be selected from the target population, given the sampling process used in the study (Martinez-Mesa et al., 2016). The researcher must carefully consider if the sample frame chosen meets the study aims or hypotheses, especially if there are ways to get around the sample frame limits since the sample may only reflect a subset of the target population. In qualitative research, the sample size should be sufficiently

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large to yield nearly all the information required to reveal a deep and novel understanding of the phenomenon being studied, but it should also be sufficiently modest to allow for a thorough examination of the qualitative data. Large data collection and analysis can be resource-wasting and frequently just unfeasible, while small sample sizes degrade study quality (Sharma et al., 2024). In qualitative research, it is the usual procedure to attain saturation with 12–13 responses, meaning that the number of themes or insights obtained from a survey of 13 or 130 respondents is the same (Sharma et al., 2024). Based on Creswell and Poth's (2018) guidelines for qualitative research, a sample size of 12-15 participants is sufficient to reach data saturation, where no new themes emerge. This sample size aligns with previous research on health care leadership, which found that saturation was achieved with 12 interviews in similar studies.

For this study, I utilized a recommended website that assists in connecting researchers with study participants. Academic researchers can quickly contact thousands of willing research volunteers through FindParticipants.com, which provides a global platform for research participants to participate in studies. As a backup, the service Respondent had been identified to assist in locating participants for the study. Once the participants had been identified and selected, they received an email. These emails went out to each of the participants individually and were provided with a link to a calendar to which they scheduled the interview for a later date. Once they successfully scheduled the interview, they received a confirmation email confirming the time and date of the interview via zoom and were provided with the required link and information to prepare them for the interview. This confirmation email will contain specific instructions on how to download and access Zoom, as well as specific setup details that will eliminate any technical errors that may arise. The interviews were scheduled for 1-hour blocks that allowed for the resolution of any technical difficulties. In the instance of a no-show, I had already identified a backup participant to contact and schedule an interview as quickly as possible which would have eliminated the potential for delay in data collection and results reporting. Interviews were conducted over a period of 4 weeks, with each interview lasting approximately 60 minutes. If recruitment targets were not met within 2 weeks, the pool was to be expanded to include health care leaders from adjacent regions.

This study utilized purposive sampling, selecting health care frontline leaders who met specific inclusion criteria. Purposive sampling is appropriate for qualitative research because it allows for the intentional selection of participants who can provide in-depth insights on leadership training and its impact on retention (Patton, 2002). By selecting participants with at least five years of experience in health care leadership, I was able to gather data from those with firsthand knowledge of leadership practices. In qualitative research, purposeful sampling is a commonly employed strategy that facilitates the identification and selection of instances with abundant information, hence optimizing the utilization of few resources (Patton, 2002). This entails locating and picking people, or groups of people, who have particular expertise or experience with a topic of interest. Bernard, H. R. (2001) and Spradley, J. P. (1979) emphasize the significance of availability and willingness to participate in addition to knowledge and experience, as well as the capacity to articulately, expressively, and reflectively share experiences and viewpoints. By reducing the possibility of selection bias and accounting for the possible impact of known and unknown confounders, probabilistic or random sampling, on the other hand, ensures the generalizability of results. I utilized purposive sampling in order to recruit participants into this study who offered positive expertise that led to a positive resolution in identifying the need for leadership training in health care facilities across the nation. The participants that were targeted for this study were able to identify the need for leadership training in a way that individuals not currently working in this capacity were able to offer, eliminating the chances of reaching a negative resolution.

Inclusion criteria for this study include, (a) participants must have at least five years of experience in frontline health care leadership roles, this can include positions that are directly related to the field of nursing or health care without possessing the title of nurse, this is due to the ability for individuals with this amount of experience would be able to provide more robust information that could assist in leading to the appropriate resolution or conclusion in this study (b) they must currently work in the U.S. health care sector and have experience with overcoming the identified GAP in practice, as this experience is more adequate for the information required to be collected by the study outlined in this paper, this is to ensure that the information that is provided by participants is current and relevant to the study (c) they must be willing to participate in a 45-60 minute interview that will be audio recorded, as this amount of time will be needed to gather all information that is necessary to ensure saturation of data and (d) must be willing to be contacted after the interview has been concluded in case some follow-up questioning needs to be performed, this is to ensure that any clarify information is obtained in order to reach the appropriate resolution or conclusion to this study. I will keep participants informed about the study's progress and show gratitude for their efforts in order to lower participant attrition. Building rapport and providing flexible schedule alternatives are excellent ways to keep participants committed.

Exclusion criteria include those who have not held a leadership position for more than five years, as they may not have sufficient experience with the creation of leadership development programs as well as the implementation of those programs to overcome the identified GAP in practice, which is the lack of leadership development having a direct correlation to the overall retention and satisfaction of the employees within a health care organization. Other exclusion criteria can include those individuals who are not currently employed as a nurse or health care leader, as their lack of expertise could draw away from the study and the need for appropriate resolution. Also, participants who are not able to sign off on all inclusion paperwork or do not fully comprehend the purpose of the research study may cause the information collected to skew the data unfavorably. The final exclusion criteria that have been identified is that the participants may not be affiliated with the researcher in any way so as not to have bias within the research study.

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The individuals identified as participating in the study were provided complete anonymity. All participants were assigned a unique ID code to maintain anonymity, and no identifying information (e.g., names, specific locations) was included in the final reporting of data. Relevant demographic information, such as years of leadership experience were included to provide context, but these details will be generalized. If any participants were to have dropped out, I would have reached out to other qualified candidates from the recruitment pool to maintain the required sample size.

Depending on the demographics introduced into the participant pool, there is potential for identifying biases that need to be discussed. With these potential biases, the researcher must be prepared to identify and eliminate the bias to not skew the data collected in a negative direction and allow the study to obtain or find a positive resolution (Call et al., 2023). With the researcher paying attention to the demographic characteristics within the study, the researcher will also be able to identify any potential equitable issues that are present within leadership training protocols in the respective facility (Call et al., 2023).

- *Data Collection*

Qualitative research approaches give us a deeper understanding of the experiences of patients and caregivers, as well as a detailed understanding of how interventions may change care (Busetto et al., 2020). They also enable us to investigate the decision-making process. Qualitative research necessitates comprehensive, rich, and nuanced data to produce such insights, enabling themes and conclusions to surface through meticulous analysis. An overview of the main methods for gathering data in qualitative research is given in this article, along with an analysis of their advantages, disadvantages, and difficulties. Focus groups, observation, and interviews are the three main methods used in qualitative research to gather data. These methods give researchers rich and in-depth insights. Every method generates a significant amount of raw data and calls for expertise from the researcher. Nonetheless, the data obtained using these techniques will enable researchers to build a thorough understanding of patient experiences and nursing practice through methodical and meticulous analysis (Naeem et al., 2023).

The process of selecting people for market and user research is known as participant screening. Screener questionnaires help researchers identify the appropriate subjects. Screener questions are a valuable tool for user researchers to gather pertinent information and decide who should be included in a study. Choosing the appropriate participants is crucial to obtaining precise and practical findings. Participants should be representative of the intended user base and possess the necessary expertise and experience (Interaction Design Foundation, 2017). Participants will be recruited through health care professional networks and an online research participant platform (e.g., FindParticipants.com). An initial email will be sent to 50 potential participants outlining the study's purpose and inviting them to participate. Follow-up emails will be sent two weeks later if no response is received. Participants will be recruited over four weeks, with initial emails sent in week one and follow-up reminders in week two. If response rates are low, a third email will be sent in week three, and snowball sampling will be considered.

The first step that was utilized for participant screening was defining the criteria needed for the study. By defining specific criteria, I filtered out those who inquired about participating and may not meet the needs of the study (Freeman & Greenberg, 2024). The specific criteria that have been identified will assist in selecting participants that match the needs of the study. After further research, the website that was utilized to find the participants for the study screens the participants to ensure credibility and validity. Potential participants were screened by answering screening questions to ensure they met the inclusion criteria that had been outlined within this research project. Informed consent was obtained through an online form, which participants signed digitally, acknowledging their understanding of the study's risks and benefits and their right to withdraw at any time.

A semi-structured interview guide, such as the one located in Appendix B, is a schematic presentation of questions or subjects that the interviewer must cover, which serves as the foundation for semi-structured interviews. To accomplish optimum use of interview time, interview guidelines serve the useful function of studying many responders more methodically and fully as well as keeping the interview focused on the desired line of action. The interview guide's questions consist of a central question and numerous related questions that are related to it (Jamshed, 2014). This interview guide will assist in identifying whether a participant who has made it past the initial screening process is indeed credible. To ensure credibility, I will employ member checking by sharing a summary of the findings with participants and asking for their feedback. Data saturation will be reached once no new themes emerge from the interviews. I will maintain a reflexive journal throughout the research process to document my thoughts and potential biases, ensuring dependability. Triangulation will be achieved by comparing participant interview data with field notes. If at any point a participant has been identified as not credible or invalid, I would have utilized a substitute or backup participant to ensure full saturation of the study. A potential threat to trustworthiness is participant withdrawal mid-study, which could result in incomplete data. To mitigate this, I will over-recruit participants to ensure sufficient data even if some participants withdraw. I also utilized peer debriefing to identify any researcher bias that might influence data interpretation. To ensure credibility, I conducted member checking by sending participants a summary of their responses for validation. Triangulation will involve comparing interview data with field notes and any relevant organizational reports. Reflexive journaling will be done after each interview to reflect on potential biases and maintain transparency.

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The second step was identifying the pool of participants to be utilized within the study. Researchers want to ensure that the study participants can offer specific expertise to the research and find a resolution to the question being posed. The third step for participant screening was describing the study itself. This helped those seeking out study and research opportunities to identify if they are the right fit. Researchers should be clear and concise in the description of their study to promote a clean and experienced participant pool (Freeman & Greenberg, 2024). The fourth step was to write and order the interview questions so that the interview flow was straightforward and led to a positive back-and-forth between the researcher and the participant. The questions should be short, simple, and to the point so that the resolution of the overall research question can be identified. Open-ended questions are also great to include throughout the interview so that the information gathered can be considered saturated and the information can be evaluated to reach an appropriate resolution. Once all these steps were achieved, it was essential to have a third party review the screening questions to ensure that the interview questions meet the needs of the research topic (Freeman & Greenberg, 2024). The interview guide was reviewed by two experts in qualitative health care research. Feedback included refining the wording of several questions to improve clarity and relevance. A pilot interview was also conducted with one participant, and minor adjustments were made to the sequence of questions based on the participant's feedback.

The primary data collection method for this research study was detailed semi-structured interviews. Each session was recorded (with participant consent) and transcribed verbatim. Field notes were taken during the interview to capture non-verbal cues and immediate reflections. I was able to collect more detailed and saturated information with these open-ended questions, leading to a more productive resolution. Credibility is attained through prolonged participation, persistent observation, and triangulation; transferability is achieved through thorough and detailed explanations; dependability is attained through meticulous documentation and the establishment of an audit trail; and confirmability is attained through peer debriefing, member checking, and reflexive journaling, are the main requirements for guaranteeing the quality of qualitative research (Ahmed, 2024). In qualitative research, establishing reliability is essential for shaping future directions and increasing the body of knowledge.

A semi-structured interview has multiple pivotal inquiries that aid in delineating the domains to be scrutinized while simultaneously permitting the interviewer or interviewee to deviate to delve further into a notion or response (Gill et al., 2008). The health care industry uses this interview format the most because it gives participants some ideas about topics to discuss, which many find helpful. The flexibility of this method, especially when contrasted with organized interviews, also makes it possible to find or elaborate on material that participants find significant but that the research team may not have previously considered relevant.

A set of open-ended questions that serve as a framework for an interview (e.g., semi-structured interview) is called an interview guide. Since gathering as much data as a researcher can is the aim, the interview questions should motivate interviewees to be candid about their experiences. Whether an interview is structured or semi-structured, the three main question types that can be utilized are general research questions (Tell me what it's like...), follow-up questions (Can you elaborate on...), and targeted questions (Have you ever experienced....) (DeJonckheere & Vaughn, 2019).

The procedure generated a lot of data, regardless of the researcher's philosophical stance and the method used to collect it (focus groups, one-on-one interviews, etc.) (Sutton & Austin, 2015). Before beginning data analysis, whether the researcher is collecting data by audio or video, the recordings must be transcribed verbatim. One 45-minute video and audio-recorded interview can, on average, take an experienced researcher/transcriber 8 hours to complete, which results in 20–30 pages of written dialogue.

For this research study, I recorded the interviews (audio) and took extensive notes throughout the interview. Informed consent was obtained via an email prior to the start of the interview. The recording was utilized after the interview to refer back to for clarification and elaboration of the notes that were taken and assisted in providing a resolution to the research study with a detailed explanation of answers and dialogue. By recording the interviews, the information that was gathered was deemed to be accurate and was deemed trustworthy since the participants were screened for trustworthiness and expertise within the field that is being evaluated prior to the start of each interview. This led to information that offered a favorable resolution.

- Ethical Considerations

Scientific integrity, respect for human rights and dignity, and cooperation between science and society all depend on research ethics. These guidelines guarantee the informed, safe, and voluntary engagement of research subjects in investigations (Bhandari, 2024). The researcher must strike a balance between following morally righteous research processes and essential research goals. Whether intended or not, it is always vital to protect participants against long-term or severe harm. Research credibility will also be damaged by breaking research ethics because it will be difficult for others to believe the data if the procedures are unethical (Bhandari, 2024). The value of a research idea to society does not excuse abusing study participants' human rights or dignity. To ensure that the information that the participant relays to me remains confidential, I gave each participant a numerical code to identify them, and all information that is specific to an organization that could lead readers to identify a partic

Taking part in any research study voluntarily is essential. No one should feel coerced into taking part in activities they don't want to or that they are under pressure to do so. Respect for persons will be upheld by providing detailed, easy-to-understand consent forms and offering participants the right to withdraw at any time without consequences. Justice will be ensured by selecting a diverse sample that fairly represents different leadership experiences in health care settings. This entails granting individuals the freedom

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to refuse participation in the study at any point, even if they have already consented to it (Denison, 2025). Not only is informed consent morally right, but it's also legally required. The participants must understand all the terms and advantages of the agreement. Before beginning interviews, each participant was provided with an informed consent form that clearly outlines the purpose of the study, the potential risks and benefits, and their right to withdraw at any time without penalty. Participants signed a digital consent form to indicate their understanding and agreement. This e-signed consent form was signed via Adobe PDF as this program had the capabilities to allow for the participant(s) to e-sign all relevant documents utilized within this study, they were also be described their rights within the study in detail, including the right to terminate or pause the interview in case of emotional or psychological distress caused by the reliving of leadership interactions. I confirmed that they understood and agreed to the terms of the study and also confirmed that the information they provided was accurate and they would continue to refrain from any personal bias they have with specific individuals or an organization in general and focus on the problem that is being discussed within the study. The consent form was then digitally signed by the participants prior to beginning the interview and returned before beginning. This ensured that the participants were aware of their rights and allowed them to answer any questions that they may have had regarding their rights. The interview then was able to be scheduled once the participant signed and returned the informed consent form.

It is common for research participants to get paid for their involvement. The sort of study, the amount of time spent conducting research activities, and the methods involved in the research all affect how much is paid (Resnik, 2015). Participation in this study was incentivized; however, I understood that the incentives that were being offered were not to exceed an acceptable amount and could not in any way be seen as coercion or bribing in order to obtain the information needed to perform and complete the study. To avoid undue influence, participants were offered a nominal incentive of $25 via electronic gift card to either Amazon or Starbucks in order to reflect fair compensation for their time. This amount did not serve as a coercive factor and ensured voluntary participation.

Data from the research must be anonymized so that individual participants cannot be identified. This entailed giving each participant a unique digital ID that would not be connected to their real identity through the use of numeric codes. Study-related data needs to be kept private and confidential (Denison, 2025). Participants in the study benefited from confidentiality and privacy protections. All interview recordings and transcripts were stored on a secure, encrypted drive, accessible only to me. Participant names and organizational affiliations were anonymized to prevent identification. Once data analysis is complete, raw data will be deleted or destroyed after the required retention period. Also, when we discuss the ethical considerations for research, I must ensure that I adhered to the standards and principles within the *Belmont Report*. This report discusses three basic ethical principles that should be adhered to throughout the course of the study. The first is “respect for persons”. Respect for humans encompasses at least two moral beliefs: people should be considered independent agents, and people who have less autonomy should be given assistance. Thus, the moral precept of respect for persons can be split into two distinct requirements: the obligation to recognize autonomy and the obligation to defend those whose agency is limited (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Given the potential vulnerability of health care frontline leaders, the consent form will clearly explain that participation is voluntary and that withdrawing from the study at any time will not affect their professional standing. This ensures respect for participants' autonomy.

The second principle that is discussed within the *Belmont Report* is “beneficence.” In order to treat someone ethically, one must endeavor to ensure their well-being in addition to honoring their choices and keeping them safe. Such care is covered by the beneficence principle. The word "beneficence" is frequently used to refer to deeds of generosity or kindness that go above and beyond legal requirements. In this declaration, beneficence is interpreted as a duty in a more comprehensive sense (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). As parallel definitions of beneficent behaviors in this sense, two general criteria have been developed, (a) cause no harm and (b) maximize potential benefits and minimize potential downsides (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

The third and final principle that was utilized throughout this research study is “justice.” An injustice happens when someone is unfairly denied a benefit to which they are entitled or when they are unfairly burdened (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). An alternative interpretation of the justice principle is that those who are equal should be treated equally. But this claim has to be clarified. Who has equal rights, and who does not? For what reasons is a deviation from equal distribution acceptable? Almost all observers accept that there are situations where factors like experience, age, deprivation, skill, merit, or status can justify treating someone differently for specific reasons (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Therefore, it is imperative to clarify the areas in which individuals ought to get equal treatment. Obtaining justice in a research study involves ensuring fairness, equity, and respect for the participants, as well as promoting the ethical integrity of the study design, data collection, analysis, and reporting processes. It is about safeguarding the rights of participants, ensuring their treatment is just, and making sure that the research results benefit everyone equitably, especially those who are marginalized or vulnerable. The principles that are important in order to ensure justice is obtained in a study such as this are respect for a participant’s autonomy, ensuring equitable selection of participants, protecting a participant’s right to privacy, distributive justice, fair treatment in data collection and analysis, justice in research outcomes and benefits, and finally ethical oversight (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). By incorporating these principles into this research study, I was able to ensure that the process and outcomes of the study are just, ethical, and respectful of all involved, thus promoting a fair and responsible approach to scientific inquiry.

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A conflict of interest arises when a secondary goal, such as money gain or career development, could unfairly affect professional decisions or actions involving a primary interest, such as the duties of a medical researcher (Romain, 2015). The resulting bias could be conscious or unconscious, and the secondary interest could be financial or non-financial. The trust that the public, patients, and professionals have in research and the research sector is threatened by the existence of conflicts of interest. A key component of effectively accomplishing the objectives of research is having efficient methods for recognizing and handling disagreements. These tactics usually center on the investigator and are dependent on disclosure, which has many drawbacks. Process-oriented procedures and outcomes-oriented tactics are examples of additional management techniques (Romain, 2015). As a former health care administrator, I recognize my potential biases in interpreting leadership behaviors and employee satisfaction. To mitigate these biases, I maintained a reflexive journal throughout the data collection process, regularly reflecting on how my position may affect my interpretation of the data. Additionally, I have no direct connections to the health care organizations involved in the study, minimizing conflicts of interest.

An individual who has interests in the research results that could result in personal gain and could, therefore, actually or appear to jeopardize the integrity of the research is said to have a conflict of interest in research (Andorno, 2022). The fact that the same person is interested in two conflicting objectives, one of which may taint the other's motivation and inject bias into their professional judgment, is a crucial aspect of this scenario. Stressing that a conflict of interest is a circumstance rather than an instance of misbehavior in and of itself is crucial. Recognizing a conflict of interest does not mean that a researcher has to accept responsibility for their actions. Being in such circumstance does not equate to unethical behavior. In relation to specific individuals or organizations, we are all in (or may find ourselves in) situations like these. What we do in that case is a pertinent ethical matter because, if mishandled, it could raise questions about our research's objectivity or our impartial participation in a specific decision-making process (Andorno, 2022).

- *Data Analysis*

The process of data analysis involves dividing the notes collected throughout the study, also known as results, into smaller, more manageable chunks. These fragments of text or other material found throughout a study are often called "snippets". Analysis involves closely studying these data snippets to determine their relevance, context, and constituent parts. It is also more straightforward to understand the extracted portions than the entire dataset while looking at them (Ronsen, 2024).

The essence of synthesis is combining these bits and pieces to create something new, like a theme. It's the skill of combining disparate parts to create a cohesive whole. Synthesis is essentially the opposite of analysis; it is the process of assembling the constituent pieces to obtain a comprehensive understanding. When categorized, these topics offer a more comprehensive or complete depiction of the excerpts (Ronsen, 2024).

A crucial component of qualitative analysis and synthesis is taking notes effectively and utilizing inductive coding techniques. To ensure that they record all the essential information from observations, interviews, and other encounters, researchers employ a variety of note-taking techniques. The latter phases of analysis and synthesis are intimately related to these tactics (Baylé, 2018). Making notes is about allowing ideas to develop from the data, not about solving problems right now. Frameworks give researchers direction and structure as they organize their data and, eventually, produce insights that can be put to use (Baylé, 2018).

Discourse analysis and other qualitative techniques share similarities with the thematic analysis technique's guiding principles, which include data coding, theme discovery, theme refinement, and findings reporting (Naeem et al., 2023). One technique for analyzing qualitative data is thematic analysis. Thematic analysis as described by Braun and Clarke (2006) was chosen due to its flexibility in identifying, analyzing, and reporting patterns (themes) within data. This method is particularly suitable for exploring complex phenomena such as leadership behaviors in health care (Creswell & Poth, 2018). It entails finding and reporting patterns in a data set that are subsequently analyzed for their underlying significance (Braun & Clarke, 2006; Liebenberg et al., 2020). Thematic analysis involves six steps: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing a final report (Braun & Clarke, 2006). For instance, recurring phrases like 'lack of support' were coded under the theme 'ineffective leadership,' revealing patterns linked to staff dissatisfaction. A thematic map was created to show the relationship between 'HR practices,' working conditions,' and 'employee satisfaction,' visually linking the emergence of these themes across multiple interviews (see Figure 1). NVivo will be used to create thematic maps that visually display the connections between leadership behaviors and employee outcomes. For instance, a thematic map will illustrate how communication strategies impact team performance and job satisfaction, providing a clearer understanding of these relationships.

The first step that is described in the thematic analysis is familiarizing oneself with the data that is collected. A researcher should immerse themselves in the data that is collected and, in most cases, should read through the data before taking any notes. I, as the researcher, was able to highlight any parts that they may see as important for future usage and elaboration (Braun & Clarke, 2006). Descriptive statistics were used to summarize the demographic characteristics of the participants (e.g., degree level to better understand the participant's level of education and expertise in the field, as well as years in leadership roles to understand their expertise based on experience). Care was taken to ensure that no identifiers could compromise participant confidentiality. Then, moving onto coding within a research study, coding helps a researcher find specialized content that is pertinent to the area of study.

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The data is being divided into more manageable and significant segments by the researcher. This entails taking a detailed look at it and effectively labeling specific sections of the text. Those labels are then considered codes. Researchers can use them to assist in organizing and categorizing the data, as each code and label reflect a distinct component of the information. Next in this process is generating themes within the research (Braun & Clarke, 2006). Using hand coding to capture participant language in the interview transcripts, initial codes will be created. In qualitative research, hand coding is the process of manually going through qualitative data, such as field notes or interview transcripts, and allocating codes to pertinent textual passages without the use of specialized software. This enables researchers to conduct in-depth analyses and personally interpret the data to find themes and patterns. These codes will then be categorized into more general themes. The codebook was developed iteratively by initially coding a subset of interviews, refining the codes through peer debriefing, and finally arriving at a robust set of codes that represented key themes such as 'leadership development' and 'toxic workplace behaviors. The codebook was developed through an iterative process, starting with initial codes derived from a subset of transcripts. Themes aren't things researchers have to search far and wide within the collected data to find. Themes are not hidden in the study; rather, they are being created by the researcher. Furthermore, the research process used by Braun & Clark (2006) is reflective, meaning that the researcher is constantly conscious of their prejudices, their stance, and the contributions they are making. Researchers may approach the data with certain assumptions and certain preconceptions, and that impacts how the researcher generates themes. Thus, the researcher must tell stories about the concepts they come up with. Researchers need to consider the relation of that to theoretical, social, cultural, and political contexts. Build and develop the arguments based on these topics and the reasons behind their creation. Once the themes are generated, they should be reviewed and refined before proceeding with the data analysis process of the research study (Braun & Clarke, 2006). Themes will be validated by member verification, in which participants examine and attest to the correctness of the themes found in order to guarantee the reliability of the data. Step five is the defining and naming of the themes that have been generated within the research study. Each theme should be clearly defined, labeled, and provided with a brief description to correlate them to the research study. Finally, writing up the results of the data analysis is the focus of step six. Here, the researcher discusses the findings' wider implications while providing a thorough explanation of each theme and a few examples from the data. The researcher must be cognizant of any restrictions that are specific to the institution or discipline when composing their topic analysis (Braun & Clarke, 2006). Researchers must make sure they are aware of any particular requirements their discipline may have for how they should write this up.

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CHAPTER THREE
FINDINGS AND APPLICATION

➢ *Relevant Outcomes and Findings*

- *Introduction*

Within this study, the researcher explored the perspectives of current U.S. frontline leaders regarding their training strategies and their effects on the improvement of retention and employee satisfaction. The finding of this study creates a preliminary view of the effects that leadership development programs can have on current and rising frontline leaders and their drive to continue on within the described career path. The interviews revealed that frontline leadership development significantly impacts both job satisfaction and retention. Participants advocated for hands-on, relevant training supported by adequate time and resources. They emphasized the need for soft skill development and inclusion in the design of leadership initiatives. When leadership development aligns with practice realities and is supported institutionally, it fosters loyalty, reduces turnover, and builds organizational trust.

- *Data Collection Results*

The data collection process was carried out through semi-structured interviews designed to elicit in-depth responses regarding frontline leadership development and its relationship to job satisfaction and retention. During the selection process for participants, 15 individuals applied to participate in the interviews. Out of the 15 applicants, 12 were selected and interviewed via Zoom meeting. Upon selection, the applicants were sent the informed consent form via email and were given adequate time to review and reach out for any questions regarding their rights as it pertained to this study. The participants then returned the signed informed consent form for me to review and sign. Once signed by myself, the participants were given my schedule and signed up for interviews via digital calendar. All interviews were conducted virtually via Zoom, providing a secure and accessible platform for participants across different shifts and locations. Each interview lasted between 35 minutes and one hour, depending on the depth of the participant's responses and availability.

During the interviews, responses were recorded using Zoom's built-in audio recording function with participants' permission. The participants were receptive to the questions that were posed. Although some may have been caught off guard by the complexity of the questions, they were able to reflect and answer the questions in a way that was able to lead to the identification of codes, categories, and themes. The participants took advantage of the time within the interview to ask clarifying questions regarding the questions I asked, as well as clarifying questions regarding the basis behind the study itself. During the interviews, I took detailed notes and began hand coding the raw data in real time to catch codes as they emerged. Immediately following each session, recordings were downloaded and securely stored in an encrypted, password-protected file. Audio files were then transcribed verbatim using Zoom's built-in transcription service. Transcripts were manually reviewed to ensure accuracy, and all identifiable data was omitted within this study analysis in order to maintain participant confidentiality.

- *Location, Participants, and Duration*

Interviews were conducted with a purposive sample of 12 United States health care frontline leaders currently employed in full-time, direct frontline leadership roles at hospitals within the United States. The data collection period lasted four weeks, during which interviews were scheduled based on participant availability, including weekday and weekend options to accommodate varying shifts. All interviews were conducted remotely using personal Zoom accounts.

- *Variations From the Proposed Data Collection Plan*

The original data collection plan was largely implemented as designed; however, a few minor variations and unusual conditions occurred. Several participants initially expressed interest in the interviews but were unable to commit due to changing shift demands or staffing shortages. To accommodate these scheduling conflicts, the interview schedule was extended by an additional few hours in the evening and included weekend time slots to provide greater flexibility for the participants. In addition to the variation described above, two interviews experienced temporary audio disruptions caused by poor internet connectivity or background disturbances. To ensure data quality and completeness, the interview momentarily paused in order to clear the audio issues. The interviews were able to resume without further issue. Also, there was one participant who experienced a temporary power issue, which was alleviated by this participant switching devices and the interview was able to continue as planned with only a momentary lapse in the interview process. These variations had a minimal impact on the overall quality of the project but required flexibility in scheduling and communication. No interviews were lost or compromised.

- *Demographic Characteristics of the Sample*

The final sample consisted of 12 deidentified participants, that met the criteria set out for participation in this study. The criteria included frontline leaders who have held a frontline leadership position for no less than five years. Also, they were required to be located within the United States in order to collect relevant data for the researcher's area.

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- *Implications for Interpretation*

This sample offered broad insight into leadership perceptions and professional experiences across diverse roles and tenure levels. The variety in unit types allowed for comparison of leadership effectiveness in different clinical settings, which is particularly important given the variable demands and team structures across units. However, since the sample was limited to nurses within the United States, findings should be interpreted cautiously when generalizing to different geographic or organizational contexts.

- *Data Analysis Results*

This research employed Braun and Clarke's (2006) six-phase framework for thematic analysis to systematically examine qualitative interview data from frontline nurse leaders regarding their perceptions of leadership development, satisfaction, and retention. The thematic analysis was executed with careful attention to methodological rigor, ensuring each step was thorough, transparent, and replicable.

The first phase of thematic analysis involved an immersive process of becoming deeply familiar with the data. This began immediately after each interview was conducted via Zoom. I took handwritten notes during each session, capturing key points, emerging ideas, and nonverbal cues. Each interview was audio-recorded and later transcribed verbatim. I reviewed each audio file and compared it to its transcript to ensure accuracy, correcting any discrepancies and annotating places where emphasis or tone added meaning to the dialogue.

Next, I read through all 12 transcripts multiple times. In the first reading, the goal was to understand the overall narrative and tone of each participant's experience. During the second and third readings, I highlighted and underlined segments that appeared especially rich, repeated, or relevant to the project question: How do frontline nurse leaders perceive the effectiveness of leadership development training in improving satisfaction and retention? I also took margin notes to record early analytical impressions, patterns, and initial thoughts, which later guided the formal coding process.

This next phase involved the systematic development of initial codes based on a detailed review of each transcript. I opened the transcripts into Microsoft Word and used the comments and color coding to identify the initial codes and highlighted corresponding quotes, then worked through each transcript line by line, manually identifying and labeling relevant segments of text. These codes captured both descriptive and interpretive elements, specific participant statements as well as underlying meanings relevant to leadership development and training effectiveness.

I applied an inductive, data-driven coding approach. Initially, 41 initial codes were identified. For each relevant segment of data, I assigned a short phrase or label that summarized its meaning. For instance, when a participant mentioned the ineffectiveness of computer-based training, I coded that segment as "Quality Training." When another discussed the value of role-modeling, I used the code "Mentorship." I tracked similar codes across interviews and started grouping quotes under recurring labels. Throughout this step, I frequently revisited earlier transcripts to ensure consistency in code application and to merge similar or overlapping codes.

Additionally, I considered frequency, salience, and alignment with the research question. Some codes were applied across multiple participants (e.g., "Lack of Time," "Need for Hands-On Training," and "Mentorship Value") and were flagged as high-frequency codes with strong thematic potential. Codes that were rare but offered unique insight (e.g., "Leadership Pressure from Retention Metrics") were also retained for further review.

In the next phase, I reviewed the full set of initial codes and began organizing them into broader patterns. I printed out all codes and arranged them into conceptual clusters using color-coded sticky notes on a physical workspace. Similar codes were grouped under tentative theme labels, such as "Instructional Quality," "Leadership Interaction," and "Access to Training."

This process yielded 5 thematic categories that represented high-level concepts in the data: instruction, communication, peer interaction, leadership, and resource availability. Each theme served as a container for multiple codes that shared a conceptual focus. For example, the theme "Instruction" included codes like "Effective Training Strategies," "Confidence in Role," and "Quality of Materials." This iterative sorting process included cross-checking participant quotes to ensure that grouped codes reflected not only conceptual alignment but also consistency across cases.

During the next phase, I revisited both the coded data and the candidate themes to evaluate coherence, distinctiveness, and representativeness. I re-read all excerpts associated with each theme to ensure internal consistency. Any themes that were too broad or too narrow were refined or split.

For example, initial themes "instruction" and "training quality" were combined after reviewing that both were referring to the same construct, participant perceptions of how training was delivered and its applicability. Conversely, the category "Supportive Environment" was eliminated because its sub-codes were already captured within "Leadership" and "Peer Interaction." The review led to the refinement of the themes into final categories that better reflected the data's depth and diversity.

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This stage finalized the themes and resulted in 20 refined codes, reduced from the 41 initially generated. The final categories and aligned codes were summarized in a comprehensive codebook and presented in Table 2 of the study.

With the refined themes in place, I conducted a deeper analysis to define each theme's unique focus and explain how it related to the research question. I wrote detailed theme definitions and supported them with illustrative quotes from participants.

For example, the theme "Perceived Effectiveness of Training Programs" was defined as "quality instruction for required or sought-out training that promotes increased satisfaction and retention in an organization." Supporting quotes described hands-on learning, structured leadership classes, and frustration with CBT modules. The "Leadership Perspectives and Priorities" theme focused on the behaviors and strategies of leaders that influenced trust, loyalty, and morale.

Each theme was clearly differentiated to ensure that overlap was minimized. Quotes were carefully selected to represent the variation within each theme while maintaining conceptual clarity. These theme descriptions formed the basis for the thematic findings.

The final phase involved synthesizing the analytic findings into a coherent, compelling narrative that addressed the research question. I structured the results around the six key themes, using participant quotes to bring authenticity and depth to the discussion. Each theme was introduced with a summary, followed by supporting evidence, sub-patterns, and interpretations tied back to the purpose of the study.

In addition, I created a final visual summary of the thematic structure in the form of Figure 2, which displayed how codes were organized and refined. The report includes reflective commentary, identifies implications for practice and policy, and contributes new knowledge to the existing literature on health care leadership development.

Overall, this rigorous thematic analysis followed Braun and Clarke's (2006) methodology to ensure credibility, transferability, and depth. Through repeated engagement with the data, careful documentation of codes and themes, and methodical refinement, the findings accurately reflect the experiences of frontline health care leaders. The process not only answered the guiding project question but also illuminated specific, actionable areas where leadership training can be enhanced to promote satisfaction and retention in nursing practice.

Table 1 presents the final codebook developed through the analysis of qualitative interview data collected from frontline leaders. This codebook reflects the structured progression of coding used to identify meaningful patterns, concepts, and themes directly aligned with the study's research question: What are the perspectives of U.S. health care frontline leaders on the effectiveness of their training strategies in improving employee retention and satisfaction?

Table 1 Final Codebook

Code	Code Definition	Quote
Access to training	The ability of nurse leaders to obtain and participate in relevant leadership development opportunities, supported by organizational resources, scheduling flexibility, and equitable availability.	"I think over the last year [the training has] gotten better. They're refocusing on leadership. The trainings are really good. I think they're really beneficial." (P02)
Accountability	The expectation that frontline health care leaders take ownership of their actions, development, and team outcomes, reflecting a commitment to growth, responsibility, and transparent leadership practices.	"And it's a constant learning endeavor that I've learned that you have to do. It's not a once and done." (P01)
Active listening	The intentional practice by frontline health care leaders of fully hearing, understanding, and responding to staff concerns and feedback, fostering trust, inclusion, and collaborative problem-solving.	"I think like, especially like higher leadership, like active listening like, hey, like for our unit. This is what we're struggling with for this unit. That's what they're struggling with like, how are you? Going to give us the tools to help improve that. So, I think that's also a huge thing. Because if you're constantly saying like, we need help, we need help. We need help. And then a blind eye is just being turned. Then it doesn't. Satisfaction goes down. Retention goes down." (P04)

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Adequate time	Sufficient, protected time allocated within the work schedule for nurse leaders to fully engage in training and development activities without compromising clinical responsibilities.	"The time is absolutely lacking to be able to step away from job duties, especially within my spectrum of home health and hospice." (P03)
Communication	The exchange of clear, honest, and timely information between staff and leadership, allowing for the expression of needs, feedback, and expectations that support trust, collaboration, and shared understanding within the team.	"We're definitely taught to meet people where they're at, not to act on emotion, to kind of self-reflect, hearing both sides, so that you're not being accusatory." (P12)
Confidence	A frontline health care leader's sense of self-assurance and competence in their role, strengthened through meaningful training, support, and successful real-world application of leadership skills.	"If you are comfortable in being able to supervise and communicate with your staff, schedule appropriately and everything that comes along with meeting the expectations of your job role and the company, and being able to, you know, kind of stand out and impress, you are going to want to stay within that position because you feel respected and trusted." (P03)
Continuous training	Ongoing leadership development opportunities that extend beyond initial onboarding, allowing nurse leaders to refine skills, adapt to evolving roles, and stay current with best practices.	"If you continue your leadership development, you continue to develop those around you." (P10)
Effective training strategies	Instructional methods that are interactive, relevant, and tailored to real-world leadership challenges, enabling nurse leaders to build confidence, retain knowledge, and apply skills meaningfully in practice.	"I have went out on my own and I've taken a lot of courses like on Coursera just to expand my own knowledge base. Just to be more effective as a leader, because when I 1st took on a supervisory position, I was inept." (P01)
Engagement	The active involvement, interest, and emotional investment of frontline health care leaders in training, team dynamics, and organizational goals, which enhances learning, performance, and retention.	"They're engaged because they know that they're cared about so, and I believe that that is not always the way that my company goes. They would go for that shiny politician most times, and a lot of times it it's very short lived so at the turnover is very quick and the leadership due to that." (P05)
Hands-on learning	Practical, experience-based training that allows nurse leaders to apply skills in real-world scenarios, enhancing engagement, confidence, and the ability to respond effectively in clinical situations.	"The training programs that we have given you scenarios. You actually like work as a group to work through things together, and how to appropriately address things. I think that that makes people way more satisfied in their job." (P02)
Identifying needs	The process by which nurse leaders and organizations recognize gaps in skills, resources, or support, allowing for targeted training and responsive leadership development.	"When you see a weakness, be able to say, Okay, you know this. I've noticed this. This is not what I see on a normal basis with you. What's going on being able to identify when your employee is struggling and what you can do to help pick them up and get them back to where they need to be. So, they're more effective as an employee." (P05)
Improving work attitude	The enhancement of staff morale, motivation, and outlook through supportive leadership practices, effective training, and a positive work environment.	"I think training programs should include talking about the mindset and how to build the environment of the staff member. So, building that trust between leadership and staff." (P07)
Loyalty	A sense of commitment and dedication nurse leaders and staff feel toward their team or organization, often strengthened by supportive leadership, trust, and personal connection.	"If your leaders are not bought in, then your staff's not going to be bought in." (P02)
Mission and goals	The guiding values and objectives of the organization that shape leadership expectations, influence training content, and align staff efforts toward a shared purpose and vision.	"We call them our spirit values, because the biggest thing with the company that I'm with and the education and training is, you know, the diversity of the population that we're taking care of and being able to socialize with them and be proactive and protect and inspire." (P03)

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Positive work environment	A supportive, respectful, and collaborative workplace culture fostered by effective leadership, where staff feel valued, motivated, and empowered to perform at their best.	"If we're able to resolve conflicts effectively or communicate with emotional intelligence, then staff is going to be a lot more likely to stay because of a healthy work environment." (P12)
Quality training	Well-designed, relevant, and engaging leadership development that equips nurse leaders with practical skills, fosters confidence, and directly applies to real-world clinical and management challenges.	"We do a lot of education for our new hires so that they feel they have the right equipment and skills to do their job efficiently." (P02)
Resources	The tools, materials, and organizational support necessary to participate in and benefit from leadership training, including technology, staffing coverage, time, and educational materials.	"You are what you have, and the resources are very limited, and you have higher quotas to meet. " (P01)
Respect	The mutual recognition of value and professionalism among staff and leaders, demonstrated through inclusive communication, acknowledgment of contributions, and supportive team interactions.	"If you're always trying to grow them, and you're always trying to take them to the next level. I think that they can build faith in you, knowing that okay, this person is out to see me succeed in whatever, on whatever level, that I choose to go to." (P05)
Team inclusion	The intentional involvement of all team members in decision-making, problem-solving, and training processes, fostering a sense of belonging, collaboration, and shared purpose.	"Gain knowledge that they can bring back and then and teach to everybody else. So, I think that that's a huge one is just being able to have that knowledge." (P06)

Each code in the table was derived through an iterative process of inductive thematic analysis. The codes represent key dimensions of leadership development, training quality, organizational support, and interpersonal dynamics, as described by participants. Definitions were crafted to reflect the practical meaning of each code as it appeared in the data, and participant quotes are provided as evidence of how these concepts were articulated in the interviews.

During the data analysis phase of this qualitative study, thematic coding was used to identify patterns in participant responses. These codes were then grouped into broader conceptual categories based on shared meanings and relevance to the research question. Table 2 presents a breakdown of the five primary categories that emerged: *Instruction*, *Communication*, *Peer Interaction*, *Leadership*, and *Resource Availability*. Each category is defined and aligned with a set of related codes that reflect specific participant sentiments, experiences, and terminology found in the data.

Table 2 Development of Categories from Codes

Categories	**Categories Definition**	**Codes Aligned**
Communication	A way to capture quality, clarity and responsiveness within teams.	Communication, identifying needs
Instruction	Offer effectiveness of training strategies, the structure and clarity of instructional content.	Quality training, adequate time, effective training strategies, engagement
Leadership	Characteristics of leadership that align to the overall values of the organizations.	Mission and goals, positive work environment, improving work attitude, active listening, loyalty, respect, confidence
Peer Interaction	Relationships, collaboration, and shared responsibility among team members.	teamwork, team inclusion, accountability
Resource Availability	Tools, time, and opportunities provided by health care organizations to support leadership development.	Access to training, hands-on learning, continuous training, resources

This section presents the findings of the research study exploring frontline leadership development and its impact on job satisfaction and retention. Using thematic analysis based on semi-structured Zoom interviews, seven primary themes were identified, (a) Reputation and Integrity, (b) Conformity versus Individuality, (c) Emotional Intelligence, (d) Mentoring and Professional Networking, (e) Perceived Effectiveness of Training Programs, and (f) Leadership Perspectives and Priorities. These themes are supported by participant quotes and analysis below.

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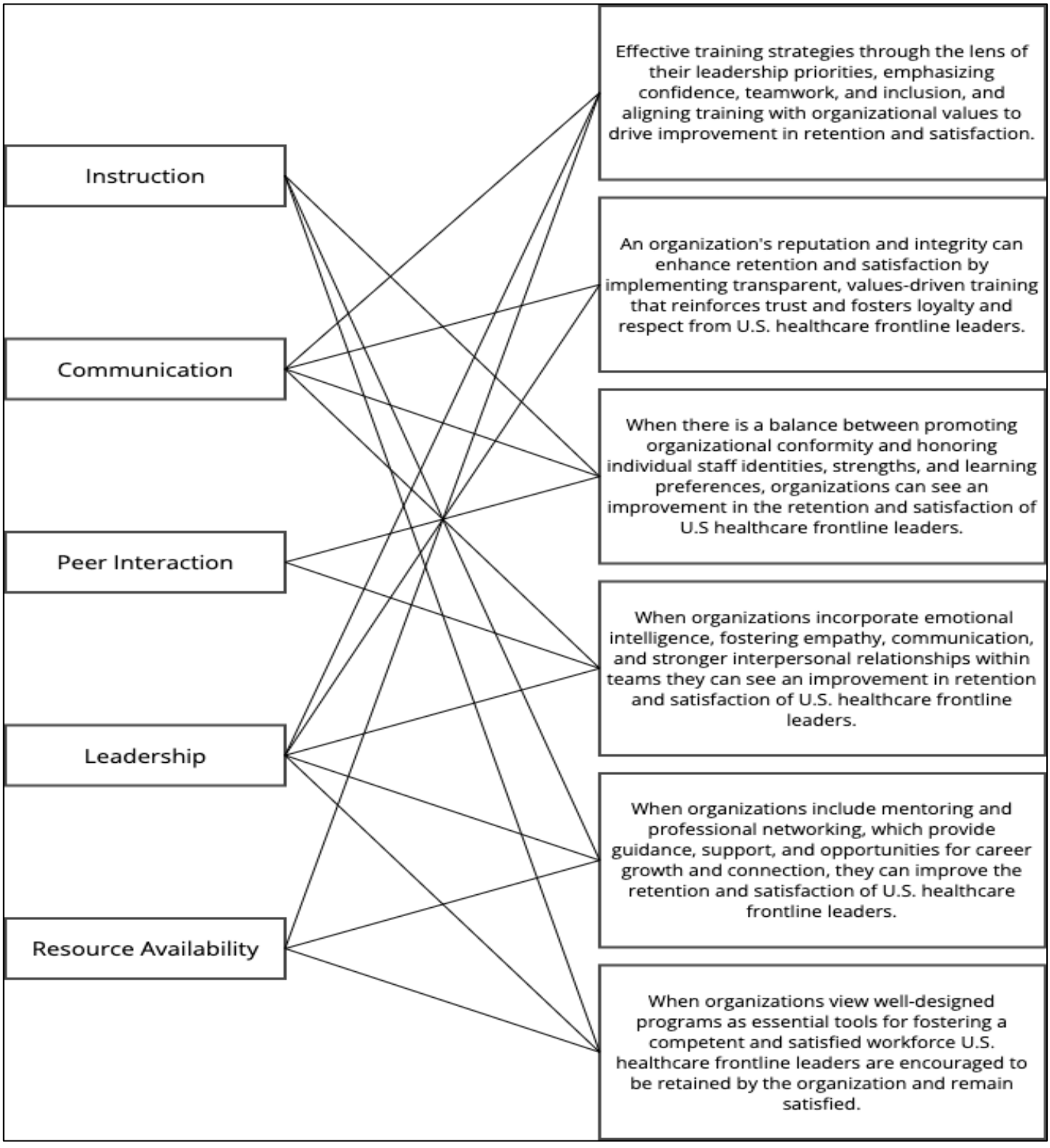

Fig 2 Thematic Map Identifying Themes and Aligned Categories

- *Theme 1: Reputation and Integrity*

The theme of Reputation and Integrity was a recurring, though sometimes subtle, thread across participant interviews that directly related to the identified mission and goals of the participants' organizations. It emerged most strongly in discussions about leadership visibility, honesty, consistency, and ethical decision-making, especially in relation to how leaders manage their teams and communicate under pressure. Participants consistently tied leadership integrity to organizational trust and professional loyalty, emphasizing that when leaders clearly align their actions with the stated mission and goals, they foster a culture of transparency and reliability. This connection between words and actions was often cited as essential to earning respect and encouraging staff engagement.

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The Communication category amplified this theme, particularly through the codes of Active Listening and Identifying Needs. Participants highlighted that leaders who genuinely listened to staff concerns and responded meaningfully were perceived as more trustworthy and credible. Effective communication was not only about conveying expectations but also about creating space for dialogue, ensuring that employees felt heard, valued, and understood. In doing so, leaders demonstrated integrity by aligning their behavior with both individual and organizational values.

Similarly, the Leadership category played a vital role in reinforcing reputation and integrity. Leaders who cultivated a Positive Work Environment and took deliberate steps toward Improving Work Attitudes were often described as role models, earning Respect and Loyalty from their teams. Confidence in leadership was tied closely to consistency in behavior and the leader's willingness to advocate for staff, even in challenging organizational climates. Participants reported that when leaders were approachable, emotionally intelligent, and acted in alignment with the institution's mission, they fostered long-term professional commitment.

Table 3 Theme Reputation and Integrity and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
An organization's reputation and integrity can enhance retention and satisfaction by implementing transparent, values-driven training that reinforces trust and fosters loyalty and respect from U.S. health care frontline leaders.	"Integrity is doing the right thing, and then respect comes in with communicate timely with empathy and transparency." (P03)	"I think just leveling the playing field would lead to higher retention, because everyone wants to be seen a little bit... everyone has different ideas." (P04)	"You have to believe in what you're teaching and kind of do those things. They have to believe that you understand these things and that you do these things." (P07)	"When you sign on as those particular leaders, you already have an audience. There's a level of expectation for nurses, and you just have to lead by example. That's the expectation when you take those roles." (P10)

- *Leadership and Respect and Loyalty with Effective Communication*

Participants highlighted that staff members are highly perceptive of whether a leader is genuine, ethical, and values aligned. When leaders demonstrate integrity, by standing by their word, taking accountability, and showing vulnerability, it cultivates respect and strengthens professional relationships. Participant 11 stated, "Everyone has the capacity to be a leader, but you have to respect your staff enough that you want to be better for them." Here, leadership is not simply positional; it is earned through day-to-day integrity. This quote underscores how respect for others and personal accountability are central to being seen as a credible and honorable leader.

Participant 9 similarly noted the powerful impact of maintaining credibility through personal responsibility: "I've had staff come to me and say, 'I was thinking of leaving, but I stayed because you care.'" This reflection implies that emotional integrity, where leaders demonstrate that they truly value their staff, can influence retention more than compensation or operational efficiency. Leaders who are perceived as sincere in their efforts to support others build reputations that promote loyalty and long-term commitment.

Conversely, the interviews reveal how compromised reputations, often due to poor communication, inconsistency, or favoritism, can damage both leadership credibility and organizational culture. Participant 12 emphasized the value of feedback and inclusion in decision-making as a way to preserve mutual trust: "I think everyone should be involved, field staff can tell management where they could improve, managers may not reflect inwardly." This quote suggests that leaders who fail to practice self-awareness and collaborative dialogue risk being seen as isolated or out of touch, ultimately harming their professional standing. Furthermore, the absence of such integrity creates divisions between frontline teams and management.

Several participants addressed how leaders must take ethical stands in high-pressure environments. Participant 11 stated: "If a CEO is just sitting there pushing stuff down, but isn't talking to the little man, nothing changes." This reflects the perceived disconnect between institutional power and moral responsibility. Leaders who fail to engage ethically with frontline workers risk being perceived as detached or even exploitative, which erodes integrity and damages the leader's and organization's reputations.

Participant 7 added a complementary insight, noting the need for alignment between leader actions and organizational standards: "The trainings that they purchase, aren't necessarily specific to your organization. They're more just broad." This illustrates how credibility is linked not only to individual behavior but also to the systems leaders choose to endorse or ignore. When leaders implement generic or disconnected solutions, it raises questions about their commitment to meaningful improvement.

In high-accountability environments, such as the ones described by Participants 11 and 2, reputation becomes more than just a reflection, it becomes a metric. Participant 11 explained: "My corporation, you get dinged for your retention rates. We have a

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meeting for it every single month where we have to go speak if somebody leaves." Here, reputation is actively monitored and carries institutional consequences. A leader's ability to retain staff reflects directly on their perceived competence and integrity, reinforcing the idea that reputation is a leadership currency in health care settings.

The analysis of this theme reveals that reputation and integrity are not ancillary traits but foundational to effective nurse leadership. They influence staff perceptions, shape the workplace culture, and directly impact retention outcomes. Leaders who lead with authenticity, ethical clarity, and alignment between their actions and words earn reputations that stabilize teams and foster long-term trust.

Conversely, when integrity is compromised, through inauthentic communication, inconsistent enforcement of values, or hierarchical detachment, it undermines both individual leadership and institutional credibility. Therefore, integrating ethical leadership, open communication, and inclusive practices into leadership development programs is essential for reinforcing a culture where professional integrity is both valued and protected.

Ultimately, the data suggest that reputation and integrity are built not through titles or authority, but through relational leadership grounded in effective communication and consistent ethical action. Leaders who actively listen, uphold shared values, and remain attuned to their team's needs earn the credibility that sustains trust and enhances satisfaction and retention over time.

- *Theme 2: Conformity vs. Individuality*

The theme conformity versus individuality emerged from participants' discussions around leadership training, organizational culture, and their own development as leaders. It reflects the inherent tension between standardized leadership expectations, often mandated from upper-level management or corporate policy, and the autonomy, innovation, and authenticity that frontline leaders seek to bring to their roles. Participants repeatedly highlighted how rigid structures and impersonal training models often clashed with their lived experiences, leadership instincts, and the unique demands of their teams.

Within the instruction category, participants shared that much of the leadership training they received lacked quality training and effective training strategies tailored to the real-world complexities of their roles. Several expressed frustrations with overly generalized, computer-based modules that failed to engage learners or allow time for meaningful development, with one participant stating, "We're expected to learn leadership by clicking through a screen while also trying to do our regular job. It's garbage." The lack of adequate time and relevant, hands-on learning opportunities contributed to a perception that training was performative rather than purposeful, forcing conformity to generic leadership ideals rather than supporting individualized growth and development. Participants also noted a lack of instructional clarification, which further reinforced feelings of detachment from the training process.

The communication category added depth to this theme, particularly as participants emphasized the absence of two-way dialogue between staff and decision-makers. When communication and identifying needs were insufficient, leaders felt constrained by expectations they had little input in shaping. Several participants expressed a desire to be included in conversations about what effective leadership should look like within their specific context. The absence of collaborative communication limited their ability to express innovative ideas, leading to a disconnect between corporate directives and frontline realities. Participants indicated that conformity is often reinforced when leadership does not actively solicit feedback or adjust training based on the lived experiences of those in the field.

The theme was further supported by the peer interaction category, where leaders described how teamwork, team inclusion, and accountability could either challenge or reinforce conformity. Leaders who cultivated inclusive environments were more likely to empower individuality and creativity among their teams. Conversely, when peer interaction was minimal or strictly hierarchical, staff often felt pressured to conform rather than collaborate. Participant 12 noted, "I think everyone should be involved, field staff can tell management where they could improve," emphasizing the importance of team inclusion in leadership development and organizational decision-making.

The theme of conformity versus individuality captures more than a philosophical difference in leadership styles, it reflects the structural and cultural barriers that prevent personalized leadership from thriving. When instruction is standardized, communication is top-down, and peer interaction is limited, individuality is stifled. However, when training is contextualized, communication is collaborative, and peer relationships are inclusive, leaders are empowered to lead authentically and effectively in a way that resonates with their teams.

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Table 4 Theme Conformity vs. Individuality and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
When there is a balance between promoting organizational conformity and honoring individual staff identities, strengths, and learning preferences, organizations can see an improvement in the retention and satisfaction of U.S health care frontline leaders.	"Everybody doesn't learn the same, and sometimes the expectation is that we all do... you can't do that in nursing. There are people that learn better in scenarios and some that learn better with the book knowledge." (P01)	"You have to look at the individual and hire them into a spot that you know they would grow. If you don't, you'll lose them." (P07)	"I think you can fake it. I think you honestly can say the right things. You could be a politician, but that may not be your best leader. I think that if they're not sincere… you'd lose a lot of good leaders that way." (P05)	I think every nurse, every nursing organization needs to be involved. Everybody needs to have an input, because everybody brings in different life experiences, different communities to the table, sometimes we all get in our little bubbles and don't see other perspectives or other cultures or other ways of doing things. (P08)

- *Conformity vs. Individuality and Instruction*

Several participants expressed frustration with leadership training programs that required conformity to generic models, often at the expense of context or clinical applicability. Participant 8 stated, "The training we do is just CBTs. They're checkbox tasks. People don't care about them, and they don't utilize them." Also, Participant 7 stated, "The trainings that they purchase… aren't necessarily specific to your organization. They're more just broad."

These quotes reveal a pattern in which leadership development is designed for administrative convenience rather than frontline impact, pressuring nurse leaders to conform to pre-packaged curricula that may not align with the fluid and emotional realities of clinical leadership. Such forced conformity creates disengagement and stifles innovation.

In contrast, Participant 2 praised her facility's more personalized approach: "We have a 7-class training for leadership, they now, if you show leadership skills, will put you in those classes so that you have a better understanding of how to be a good nurse leader." Here, individual strengths are recognized and supported, allowing leaders to cultivate a leadership style aligned with both personal identity and organizational goals. This approach fosters a sense of ownership, as opposed to resistance.

- *Conformity vs. Individuality and Peer Interaction with Communication*

Participant 12 noted: "There needs to be more team-building events, where you can bond, and not have the stress of work involved." This participant's focus on customizing leadership culture to meet relational and emotional needs reveals resistance to sterile, policy-driven management, and an embrace of leadership that is emotionally intelligent, adaptive, and human-centered.

Some participants described how conformity is not only encouraged but expected, particularly in larger, hierarchical systems. Participant 11 commented: "If a CEO is just sitting there pushing stuff down, but isn't talking to the little man, nothing changes." This critique reflects the disconnect between executive-driven conformity and frontline individuality, where top-down initiatives are implemented without meaningful feedback or adaptation. Leaders in such systems may feel silenced or sidelined, forced to perform leadership in ways that contradict their own judgment. Leaders thrive when they are trusted to think critically and flexibly, not merely follow orders.

Despite these challenges, participants acknowledged the need for some degree of structure and shared standards, especially when linked to accountability and equity. However, they consistently advocated for leadership development that allows individuality to flourish within that structure, emphasizing emotional intelligence, creativity, and authentic relationships over one-size-fits-all directives. Participant 11 stated, "You can't do a good job if you don't have the tools and the knowledge to do it. My leaders made sure I had the tools, and the education." This statement reflects how systems can support individuality when they provide resources, flexibility, and developmental encouragement, rather than imposing rigid expectations.

The theme of Conformity versus Individuality illustrates a critical dynamic in nurse leadership, effective leaders seek to personalize their approach, build meaningful relationships, and serve their teams through adaptive, context-aware strategies. Yet they often work within organizations that emphasize compliance, standardization, and bureaucratic efficiency.

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To bridge this gap, health care organizations must foster environments that balance structural integrity with individual leadership expression. Leadership development programs should offer flexibility, choice, and context-driven tools, empowering nurse leaders to shape their practice in ways that reflect their team's unique needs and their own authentic leadership styles.

When individuality is supported, not stifled, leadership becomes more engaging, more ethical, and more effective. Conversely, when conformity is enforced without space for creativity or reflection, leadership risks becoming impersonal and ineffective, undermining both satisfaction and retention.

- *Theme 3: Emotional Intelligence*

The theme of emotional intelligence (EI) surfaced repeatedly in discussions about communication, conflict resolution, relational leadership, and team morale. Participants described both the benefits of emotionally intelligent leadership, and the challenges faced when these skills were underdeveloped or unsupported by organizational training programs. Through interviews, it became clear that emotional intelligence, defined by attributes such as self-awareness, empathy, social skills, and emotional regulation, was considered an essential yet often overlooked component of effective nurse leadership.

Within the leadership category, participants highlighted that emotionally intelligent leaders were those who created a positive work environment, practiced active listening, and inspired confidence through consistent and compassionate behavior. These leaders demonstrated an ability to improve work attitudes not through authoritative control, but through relational leadership that validated staff experiences and responded to individual and team needs. Leaders who possess and model emotional intelligence were seen as better equipped to manage stress, navigate conflict, and foster resilience among their teams.

The communication category further reinforced the importance of emotional intelligence, particularly through the codes active listening and identifying needs. Participants emphasized that emotionally intelligent communication was not simply about relaying information but about creating space for honest dialogue and responding in ways that acknowledged emotions and complexities. When communication lacked empathy or attentiveness, it often led to disconnection and frustration. In contrast, when leaders truly listened and adapted their communication to the emotional tone of their teams, they cultivated trust, psychological safety, and shared understanding. As one participant noted, "Managers may not reflect inwardly, but they should," suggesting that emotional intelligence in communication is rooted in self-awareness and a willingness to grow.

The peer interaction category also played a critical role in shaping how emotional intelligence manifested within teams. Codes such as teamwork, team inclusion, and accountability demonstrated that emotionally intelligent teams are not only built on individual skills, but also on a culture where staff feel heard, respected, and involved. Participants described emotionally intelligent environments as those where feedback was constructive, roles were collaborative, and contributions were valued across all levels. Leaders who facilitated team inclusion, especially by welcoming diverse perspectives and modeling respectful engagement, helped establish emotionally attuned peer dynamics that benefited both staff morale and patient outcomes.

The theme of emotional intelligence intersects powerfully with leadership behavior, communication practices, and team interaction. It is through emotionally intelligent leadership, rooted in empathy, listening, and relational accountability, that trust is built, morale is lifted, and retention is supported. Despite its significance, participants agreed that EI remains underrepresented in formal leadership development, highlighting a critical gap and opportunity for future training and organizational investment. Integrating emotional intelligence into leadership practice is not only a personal competency but a systemic imperative that directly influences the quality and sustainability of nursing leadership.

Table 5 Theme Emotional Intelligence and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
When organizations incorporate emotional intelligence, fostering empathy, communication, and stronger interpersonal relationships within teams, they can see an improvement in retention and satisfaction of U.S. health care frontline leaders.	So, you may have a lead nurse who is then chosen, for you know the nurse manager position, who had a lot of seniority, but no managerial experience, and you saw the same type of internal conflict happen on the floors where they did not know how to lead or manage people. (P01)	If you know about yourself, you know what your triggers are, the toxicity on a unit is going to be greatly decreased. If you can't teach those [soft skills], I think you could have a better employee, they're going to know themselves better, hopefully have that emotional intelligence. (P05)	So, we've really been focusing on like how to best bring. Have those hard conversations without it being like, oh, like you're coming at me, or you're attacking me. It's more of a how. How do we have this good hard conversation and a lot of times they tell us, like, okay, like, say something beneficial, something good about the situation,	I think training programs should include talking about the mindset and how to build the environment of the staff member. So, building trust between leadership and staff. I think talking about that and having an exploration in regards to that, because I feel that the foundation and job satisfaction

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			or about the nurse, and then be like. But let's work on this, or but this wasn't the correct action like next time do this communication definitely have talked on. But I think the criticism and hard conversations is the main like, soft words aren't working in my head right now. (P04)	and retention is that if your staff members do not trust you and believe in your leadership role and your philosophy, which is huge, they're less likely to stay in the environment that they're in, regardless of if it's the best environment ever. (P07)

- *Emotional Intelligence and Leadership with Effective Instruction*

Multiple participants expressed concern that while technical and procedural aspects of leadership were covered in training, the relational and emotional aspects were frequently missing. Participant 9 stated, “Nobody teaches you how to handle conflict. I was promoted, and suddenly I had to mediate between two staff members yelling at each other. I froze. I wasn’t trained for that.” This quote reflects how emotional labor and interpersonal management are integral parts of leadership, yet frontline leaders often enter their roles without adequate preparation in these areas. Participant 7’s experience suggests that emotional intelligence is assumed rather than developed, and that failure to prepare leaders for emotionally charged situations can lead to stress and uncertainty.

Participant 8 echoed this concern, emphasizing the absence of soft skill training: “You just need more hands-on in the medical field, there is 0 time allotted for emotional intelligence or how to deal with conflict. That was a very hard lesson to learn.” This highlights not only a training gap but also a systemic undervaluing of EI as a legitimate, teachable leadership competency. Participant 8’s reference to it being a "hard lesson" suggests that leaders are expected to acquire these skills through trial and error rather than structured support.

Participants noted that emotionally intelligent leadership contributes directly to employee loyalty and retention. Leaders who show empathy, understanding, and personal support are remembered and valued. Participant 9 stated, “I’ve had them come up to me and say, ‘But I’m loyal to you.’” This sentiment reveals how emotional bonds between leaders and staff can buffer against burnout and turnover. Loyalty is not just organizational, it is personal. When nurse leaders demonstrate high EI by acknowledging others’ emotions, validating concerns, and building trust, it creates an emotionally safe environment that encourages staff to stay, even amid systemic pressures.

Participant 11 provided further support for this idea: “You can’t do a good job if you don’t have the tools and the knowledge to do it. My leaders made sure I had the tools, and the education. That’s why I stayed.” Though participant 11 highlights tangible support, it’s the emotional context of that support, feeling seen, valued, and equipped, that reinforces commitment and morale. Her reflection suggests that emotional intelligence is embedded not only in what leaders do, but how they do it.

- *Emotional Intelligence and Leadership with Effective Communication*

Participant 12 addressed emotional intelligence from a systems perspective, emphasizing reflection, humility, and empathy as tools for improvement and connection. *“*I think everyone should be involved, field staff can tell management where they could improve, managers may not reflect inwardly.” This statement reflects a key facet of EI: self-awareness. Emotionally intelligent leaders invite feedback, reflect on their behavior, and adjust their leadership to better serve others. This approach challenges top-down power structures and promotes transparency and psychological safety, both hallmarks of emotionally intelligent work environments.

Participant 2 also tied emotional intelligence to leadership buy-in and team trust: “If you're bought in, then you're loyal to your company.” Here, emotional engagement is positioned as a driver of professional investment. Staff are more likely to commit when leaders are authentic and emotionally attuned, when they connect with the heart of their work, not just the logistics.

Participant 11 critiqued leadership practices that lacked emotional transparency: *“*If a CEO is just sitting there pushing stuff down, but isn’t talking to the little man, nothing changes.” This quote illustrates a disconnect between positional authority and emotional presence. Leaders who fail to engage with staff emotionally and relationally risk being perceived as inauthentic or out of touch, eroding their credibility and diminishing their influence.

Despite its importance, participants noted that few organizational systems actively support the cultivation of emotional intelligence. Participant 12 stated, “There needs to be more team-building events, where you can bond, and not have the stress of

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work involved." This quote underscores the value of relationship-building and emotional connection as part of leadership development. Without protected time and space to engage meaningfully with colleagues, leaders struggle to develop the relational capital that underpins emotionally intelligent behavior.

Across all interviews, emotional intelligence emerged as a critical, though underdeveloped, aspect of nurse leadership. Participants described how emotionally intelligent behaviors, such as empathy, communication, humility, and reflection, enhance staff engagement, reduce conflict, and support retention. Conversely, the lack of formal EI training in leadership development was seen as a missed opportunity that places both new and experienced leaders at risk of failure or burnout.

To address this gap, health care organizations must integrate emotional intelligence into leadership development curricula through targeted modules on communication, emotional regulation, feedback delivery, and team dynamics. Furthermore, institutional support for team building, mentorship, and reflective practices can help embed EI into the organizational culture.

Emotional intelligence is not a soft optional skill; it is a core leadership competency that sustains both people and practice in the demanding world of health care.

- *Theme 4: Mentoring and Professional Networking*

The theme of mentoring and professional networking emerged as a crucial but often under-leveraged component of effective leadership development in the United States health care system. Participants frequently described mentoring as one of the most impactful forms of growth and support, both in terms of developing leadership competencies and fostering a sense of belonging. At the same time, several described an absence of formal mentorship structures or inconsistencies in how they were applied. This theme encompasses how leaders learn from others, develop through interpersonal exchange, and remain engaged through relationships beyond task-based management.

Within the leadership category, mentoring was viewed as essential for building confidence, modeling respect, and cultivating a positive work environment. Participants emphasized that when seasoned leaders offered guidance, encouragement, and constructive feedback, emerging leaders felt empowered and better equipped to handle the complex demands of the role. These mentoring relationships helped foster improved work attitudes and reinforced a culture where leadership was seen not just as authority, but as relational support and investment in others' growth. One participant noted that team members often stayed not because of policy or pay, but because of the trust and mentorship provided by their direct leaders, a clear reflection of mentoring's influence on satisfaction and retention.

The instruction category also revealed gaps in how mentoring was supported or embedded into leadership training programs. Participants consistently reported that formal training often lacked the depth and relatability that mentoring naturally provides based on the quotes that are outlined in the following sections. While quality training and effective training strategies were discussed, participants emphasized that formal instruction was often one-dimensional or overly theoretical, missing the personalized and adaptive qualities that mentorship offers. In contrast, participants who experienced informal mentoring described it as an organic extension of learning that reinforced concepts in real time. Several suggested that integrating mentoring into training programs, through shadowing, leadership cohorts, or peer coaching, could greatly enhance leadership development by combining structured instruction with relational learning.

From the perspective of resource availability, the absence of structured mentoring programs was not simply an oversight, but a reflection of insufficient resources, limited access to training, and the lack of continuous training opportunities. Participants described how time constraints, staffing shortages, and minimal organizational prioritization created barriers to developing mentoring networks. Even when leaders were willing to mentor others, a lack of administrative support or protected time made it difficult to sustain these relationships. Additionally, the absence of hands-on learning experiences within formal leadership pathways meant that many nurse leaders had to rely on informal peer guidance, which, while valuable, was inconsistently available and often depended on personal initiative rather than organizational strategy.

The theme of mentoring and professional networking reflects a missed opportunity within leadership development frameworks that too often rely solely on formal instruction. Participants made clear that mentoring, when supported by strong leadership, effective instructional design, and adequate resources, has the potential to enhance leadership readiness, team cohesion, and long-term retention. The integration of mentorship into structured training programs, alongside expanded access to hands-on and ongoing development opportunities, represents a critical next step in strengthening the pipeline of confident, collaborative nurse leaders.

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Table 6 Theme Mentoring and Professional Networking and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
When organizations include mentoring and professional networking, which provide guidance, support, and opportunities for career growth and connection, they can improve the retention and satisfaction of U.S. health care frontline leaders.	Your leaders above you are also in those training courses, so that gives you a chance to kind of communicate with them, they want to hear about what your goals are, you're then having those conversations with the people that can kind of put the train in motion right to get you where you want to be. (P02)	"Typically the 1st week is spent more in the administrative side, that plugs them into week 2 where they're more out with the field team, and it also helps develop that chain of command right off of the bat." (P06)	We try to round on the people within our within, on our unit at least minimally every 2 months, and ask them what we can do to help develop. What's their goals? Where do they want? Where do they see themselves? What is their ultimate 5 Year Plan? What can I do to help you get there? (P05)	They get to go and shadow directors all over the United States, and the really high performing directors that do well, and they 2 days, 2 days, or one week out of the month, you would go and be with that director, you would still hold your current job. But you would go with that director. (P05)

- *Mentorship and Professional Networking and Resource Availability with Effective Instruction*

Participants described mentorship, both formal and informal, as instrumental in their leadership journey. For many, the presence of a mentor offered emotional support, professional guidance, and a tangible model for successful leadership behavior. Participant 11 stated, "You can't do a good job if you don't have the tools and the knowledge to do it. My leaders made sure I had the tools, and the education."

Though Participant 11 referred to "tools and knowledge," their emphasis on the leadership presence behind this support reflects the value of relational guidance. Leaders who act as mentors help build confidence, role clarity, and decision-making capacity, key qualities that impact satisfaction and performance.

Similarly, Participant 2 highlighted how leadership development can grow through peer identification and organizational recognition: "We have a 7-class training for leadership… they now, if you show leadership skills, will put you in those classes so that you have a better understanding of how to be a good nurse leader." Here, mentorship is implied in the recognition and elevation of emerging leaders, creating a pathway for development that is grounded in observation and support. This kind of scaffolding, where potential is identified and cultivated through structured engagement, functions as a form of mentorship, even if not formally labeled as such.

- *Mentorship and Professional Networking and Leadership Interaction*

Beyond one-on-one mentorship, participants expressed the need for interpersonal learning spaces and professional networking. These spaces help nurse leaders learn from each other's experiences, broaden their perspectives, and build relational trust. Participant 12 stated, "There needs to be more team-building events, where you can bond, and not have the stress of work involved." Participant 12's emphasis on relationship-building in a low-pressure environment suggests that networking is more than just a professional strategy, it's a survival tool for nurses navigating emotionally demanding roles. Team building promotes cohesion and social capital, which in turn strengthens collaborative leadership practices. This insight reflects the importance of peer-to-peer networking, where shared problem-solving and knowledge exchange improve leadership practice. When leaders are networked, across units, shifts, or even organizations, they develop a wider understanding of challenges and resources, which enhances their effectiveness and morale.

Despite recognizing the value of mentorship, several participants noted that formal mentorship programs were either absent or inconsistent. Participant 9 stated, "Nobody teaches you how to handle conflict. I froze. I wasn't trained for that." While this quote addresses conflict resolution, the underlying concern is a lack of preparatory support, which mentorship would typically provide. Ashley's leadership experience was shaped by reactive learning rather than proactive guidance, indicating that mentorship is not always embedded in leadership pipelines.

Participant 1 reinforced this challenge in terms of limited resources: "There's just not enough time in a day." This barrier reflects not only time constraints but also a systemic lack of prioritization for relational development. In the absence of scheduled mentorship, leaders must navigate complex responsibilities without the benefit of wisdom transfer or emotional buffering that mentoring relationships provide.

A recurring subtext in the interviews was the connection between mentorship and retention. Leaders who felt supported were more likely to remain in their roles, and those who supported others fostered loyalty among their teams. Participant 9 stated, "I've had staff come to me and say, 'I was thinking of leaving, but I stayed because you care.'" Here, participant 9's leadership presence, and by extension, mentorship, creates a stabilizing force within the team. This emotional and professional investment demonstrates

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that mentorship not only builds competence but cultivates commitment, which is essential in high-turnover environments. Mentorship, in this framing, becomes a moral obligation, a way for experienced leaders to cultivate the next generation through intentional support and example-setting.

The analysis of mentoring and professional networking reveals a clear gap between what nurse leaders need and what is structurally available. While participants found tremendous value in supportive relationships and learning from peers, many lacked access to formalized mentorship or consistent networking opportunities.

To improve satisfaction and retention among frontline leaders, health care organizations should implement structured, tiered mentorship programs designed to provide consistent and meaningful support. These programs should include the regular pairing of new leaders with seasoned mentors to ensure guided development and professional modeling. Organizations should also allocate protected time specifically for leadership reflection and development conversations, allowing leaders the opportunity to engage thoughtfully with their growth process. Additionally, peer networking events across units and departments should be incorporated to foster collaboration, share best practices, and strengthen leadership communities. Finally, mentorship feedback should be formally integrated into leadership evaluations to reinforce the value of relational development and to ensure accountability for fostering a supportive work environment.

In addition, organizations should foster a culture that views mentorship not as optional or informal, but as a strategic imperative, one that improves engagement, cultivates emotional intelligence, and anchors nurse leaders in relationships of trust and mutual growth.

- *Theme 5: Perceived Effectiveness of Training Programs*

The theme of perceived effectiveness of training programs emerged consistently across participant interviews, with most expressing critical views about the content, format, and applicability of existing leadership development opportunities. Leaders evaluated training based on its practical relevance, engagement quality, and whether it led to meaningful personal and team improvement. While a few participants acknowledged recent improvements or beneficial experiences, the majority highlighted gaps in design, delivery, and follow-through that limited the true value of training initiatives.

From an instruction standpoint, many participants voiced frustration over the reliance on computer-based training modules, which they described as disengaging and disconnected from real-world leadership challenges. The lack of quality training and effective training strategies created a perception that leadership development was more of a compliance task than a meaningful growth opportunity. Several participants noted that training lacked instructional clarity and failed to incorporate interactive or scenario-based learning, making it difficult to retain or apply new skills. This gap was particularly concerning given that leadership success was often tied to on-the-job experience rather than structured educational support. In contrast, participants who had access to hands-on learning, such as simulations or team-based leadership exercises, reported significantly more confidence in their abilities and a clearer understanding of leadership expectations.

The leadership category also revealed how training, or the lack thereof, impacted leaders' self-perception and their ability to support their teams effectively. Many participants described entering leadership roles with minimal preparation and learning through trial and error rather than intentional development. This lack of structured support often resulted in reduced confidence, increased stress, and a reactive rather than proactive leadership approach. Leaders who did receive more personalized instruction or mentorship reported better outcomes in terms of improving work attitude among staff and cultivating a more positive work environment. This underscores the importance of equipping leaders not only with knowledge but also with tools to model emotional intelligence, adaptability, and resilience.

Challenges in resource availability further limited the effectiveness of training programs. Participants frequently cited limited access to training, time constraints, and a lack of continuous training opportunities as barriers to their development. Training was often squeezed between clinical duties or provided without protected time, leading to rushed or superficial engagement. Even when leaders were motivated to grow, inadequate resources, such as lack of mentorship, training personnel, or educational materials, created frustration and stagnation. Some participants expressed a desire for ongoing development that adapted over time, rather than one-time sessions with no follow-up or application.

The perceived effectiveness of training programs was closely tied to the intersection of leadership support, instructional design, and the availability of organizational resources. When training was relevant, accessible, and supported by leadership structures that valued personal development, participants reported more meaningful learning and greater satisfaction in their roles. However, when training was generic, inconsistently delivered, or logistically burdensome, it hindered growth and left nurse leaders underprepared to lead. The findings highlight the need for health care organizations to invest not just in creating training, but in ensuring that it is engaging, continuous, and fully integrated into the leadership development pipeline.

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Table 7 Theme Perceived Effectiveness of Training Programs and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
When organizations view well-designed programs as essential tools for fostering a competent and satisfied workforce U.S. health care frontline leaders are encouraged to be retained by the organization and remain satisfied.	"But it's like 7 different trainings, different teaching points pertaining to leadership where they now, if you show leadership skills before they ever put you into leadership. They'll put you in those classes so that you have a better understanding of how to be a good nurse leader." (P02)	"It's not job specific. Therefore, I feel like a lot of it is more. Let me just hurry up and get through this. Let me hurry up and get it done. You know we see the same thing every year. Let me just hurry up and get it done." (P03)	"I think it's definitely more beneficial, because a lot of times, I think some people, especially with online modules, they just like click, click, click, click, click, click so having it refresh more often is good." (P04)	"Since the leadership training that I've gotten. It was eye-opening for me, because it was right on. When I answered those questions honestly, there were quite a few things that I was made aware that I needed to work on. And since then they actually gave me the practice and told me skills on how I can work on those. They actually gave me the answers, okay, well, when communicating with this, I have a horrible, had a horrible time having crucial conversations with people when I really like them as a person." (P05)

- *Effective Training Programs and Resource Availability and Effective Instruction*

One of the most recurring sentiments was that leadership training often failed to reflect the actual responsibilities and relational demands of frontline leaders. Several participants described formal training programs, particularly those using computer-based modules (CBTs), as ineffective, disengaging, and disconnected from clinical practice. Participant 8 stated, "The training we do is just CBTs. We're expected to learn leadership by clicking through a screen while also trying to do our regular job. It's garbage." Also, Participant 7 stated, "The trainings that they purchase, aren't necessarily specific to your organization. They're more just broad." These quotes suggest that participants perceived training as a box-checking exercise, often mandated by external authorities or corporate structures without consideration of the contextual needs of nurses. The lack of customization or relevance diminished the perceived value of the training and failed to enhance leadership capability or engagement.

Participants frequently noted that when training lacks interactive or experiential elements, it does little to inspire reflection, confidence, or behavioral change. As Participant 8 emphasized, "People don't care about them, and they don't utilize them," pointing to a disconnect not only in content but in learner motivation and usability. The sentiment that training was something to "get through" rather than grow through underlines a systemic problem in how leadership development is designed and implemented. Participant 8 stated, "They are just trying to get through the afternoon and check the boxes." This lack of emotional and intellectual investment translates to minimal knowledge retention, diminished job satisfaction, and missed opportunities for professional transformation.

Despite widespread criticism of generic or passive formats, some participants identified training programs that felt meaningful, particularly when they involved hands-on experiences, team-based learning, or scenario-based simulations. Participant 9 stated, "They really flourish when we do our code scenarios." Also, Participant 2 stated, "In our ER, we have quarterly leadership development days, hands-on, with real scenarios. It makes a difference when you can practice, not just listen." These insights reveal that training is perceived as more effective when it mirrors real-life challenges, allows for experiential learning, and fosters reflection. Simulations and team-based exercises were valued for reinforcing leadership skills such as delegation, communication, and decision-making in high-pressure environments.

- *Effective Training Programs and Leadership Interaction*

Participants noted that even potentially effective training loses impact if not supported by the broader organizational culture or followed by real opportunities to apply what was learned. Participant 9 stated, "Nobody teaches you how to handle conflict, I froze. I wasn't trained for that." Participant 9's reflection highlights a critical gap between theoretical instruction and applied leadership practice. The absence of role-playing, guided mentorship, or shadowing experiences left new leaders unprepared to manage interpersonal dynamics, a core aspect of nursing leadership. In this case, the training may have existed but was not perceived as effective because it lacked depth, feedback, and reinforcement.

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A few participants noted positive changes, signaling that some health care systems are beginning to move toward more structured and intentional leadership development. Participant 2 stated, "We have a 7-class training for leadership, they now, if you show leadership skills, will put you in those classes so that you have a better understanding of how to be a good nurse leader." This quote illustrates a shift toward performance-based and personalized development pathways, which were viewed favorably. When leadership training is built around observed potential, tailored content, and meaningful incentives, it is perceived not only as effective but as empowering and career-sustaining.

The theme of Perceived Effectiveness of Training Programs reveals that the value of leadership development is not determined solely by its existence but by how relevant, engaging, and applicable it is to the realities of nursing practice. Participants frequently criticized training formats that were generic, overly time-consuming, and disconnected from their day-to-day responsibilities, often describing these programs as ineffective and demotivating. In contrast, training experiences that were hands-on, emotionally resonant, and closely aligned with the organizational culture were perceived as far more impactful and meaningful.

Effective leadership development requires more than just delivering content, it depends on context, cultural alignment, and sustained support. For training programs to be truly effective, organizations must prioritize several key elements: the provision of tailored, role-specific content; the use of experiential learning modalities; structured follow-up through mentorship and evaluation; designated time for training participation; and consistent opportunities for leadership modeling and reflective practice. When these components are integrated into the design and delivery of leadership training, the result is more than improved knowledge, training becomes a catalyst for increased engagement, enhanced leadership capability, and improved retention among frontline leaders in the United States health care system.

- *Theme 6: Leadership Perspectives and Priorities*

The theme of leadership perspectives and priorities explores how frontline leaders define effective leadership, set goals in their practice, and navigate competing expectations from their teams and institutions. Interview data revealed that nurse leaders prioritize empathy, team support, ethical responsibility, and staff development, often in tension with administrative or corporate performance measures. Their reflections underscore a human-centered, values-driven leadership style that centers around trust, respect, and adaptability.

Within the leadership category, participants consistently emphasized that effective leadership is not merely about meeting metrics but about fostering a positive work environment and cultivating confidence among team members. Leaders who demonstrated respect and inspired loyalty were perceived as more effective than those who strictly enforced policies without regard for staff needs. For many participants, the true measure of leadership success was reflected in the morale, retention, and growth of their team, not in the completion of checklists or performance audits. One participant shared, "Everyone has the capacity to be a leader, but you have to respect your staff enough that you want to be better for them," reinforcing that effective leadership begins with self-awareness and a commitment to others.

The role of communication was also central to how participants conceptualized leadership. Leaders who practiced active listening and consistently identified needs were seen as credible and responsive, particularly in high-stress or rapidly changing environments. Several participants noted that strong communication from leaders-built trust and empowered staff to share concerns without fear of dismissal or retaliation. Conversely, poor communication, especially when leadership failed to explain the rationale behind decisions or training requirements, contributed to staff disengagement and frustration. Effective communication also extended to how leaders connected their work to the organization's mission and goals, ensuring that expectations were not only clear but aligned with shared values and purpose.

The category of resource availability further shaped leadership priorities, as many participants described how limited access to training, staffing shortages, and inadequate resources impacted their ability to lead effectively. Even highly motivated leaders expressed concern that they were being asked to support their teams and meet organizational goals without the proper tools or time to do so. This lack of systemic support often forced leaders to prioritize urgent operational needs over developmental opportunities, leaving little room for reflection, mentorship, or long-term planning. Leaders who had access to sufficient resources, whether in the form of protected time, hands-on training, or professional development programs, reported feeling more prepared, less stressed, and better able to support their teams.

The theme of leadership perspectives and priorities reveals that frontline nurse leaders place high value on relational leadership, clear and compassionate communication, and adequate resources to support both their staff and their own growth. Their perspectives challenge organizations to look beyond metrics and recognize the human dimensions of leadership that drive team cohesion, satisfaction, and retention. When leaders are empowered with the resources, communication tools, and cultural support needed to lead effectively, they are more likely to foster resilient, high-functioning teams that reflect the core values of health care.

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Table 8 Theme Leadership Perspective and Priorities and Supporting Narrative

Theme	Quote 1	Quote 2	Quote 3	Quote 4
Effective training strategies through the lens of their leadership priorities, emphasizing confidence, teamwork, and inclusion, and aligning training with organizational values to drive improvement in retention and satisfaction.	I think the focus for us is, we did a director development program which really focused on how to build morale, how to focus on how to speak to different personalities and how to be able to motivate, develop, and also just try to allow the people that you are that are working for you. See, see themselves the way that you see them. So, see what their challenges are, make them aware of their challenges, and then develop them into what their ultimate goal would be. (P05)	So, I think, participating in training programs. One makes sure that you're completely equipped to do your job. If you know if you don't have all the tools and resources necessary. You're not going to be effective. And when you're not effective in your job, you know, you can easily experience burnout or feel like you're unsupported and that could lead to some dissatisfaction and ultimately higher turnover. (P05)	I think we can always benefit from more conflict resolution training. You know, every situation is very different. The details are different, how people perceive, and handle information is different. And so, I think a lot of conflict, resolution training, has to teach you how to adapt in the moment versus you know there's not. There's not one skeleton outline that can tell you exactly how to handle conflict until it arises. So, you kind of have to know how these different things present, and how to address them as they come. (P06)	They purchase products that are already made but they barely, or if ever, give us an opportunity to pick the products in which they want to implement for their training programs. So there lies some of the problem. (P07)

- *Leadership Perspectives and Priorities and Leadership with Effective Communication*

A central element of participants' leadership perspectives was the belief that leadership is about caring for people, not commanding them. The most impactful leaders, they explained, were those who listened, advocated, and showed up consistently for their teams. Participant 9 stated, "I've had staff come to me and say, 'I was thinking of leaving, but I stayed because you care.' That makes all the difference. They feel like they matter." Also, participant 12 stated, "I think it's important to have leadership that's approachable. If your team can't come to you, then it's not leadership, it's just a title." This orientation toward emotional presence and availability reflects a deep understanding of leadership as a stabilizing and humanizing force within stressful health care environments. Leaders who make time for staff concerns and prioritize interpersonal connections reinforce a sense of safety and belonging that directly affects retention.

Participants frequently described the importance of self-reflection and personal accountability in leadership. Several noted that effective leaders are those who continuously evaluate their behavior, own their mistakes, and model integrity. Participant 12 stated, "Managers may not reflect inwardly, but they should. Leadership isn't about being right all the time. It's about listening and learning." These insights emphasize a humble, ethical approach to leadership that values growth and authenticity. Leaders who are seen as honest and evolving, not authoritarian, tend to earn more credibility and influence within their teams.

Participants acknowledged that institutional pressures, such as staffing ratios, retention targets, and productivity metrics, often shaped their roles and constrained their leadership priorities. Participant 11 stated, "My corporation, you get dinged for your retention rates. We have a meeting every single month where we have to go speak if somebody leaves. It's not just about leading anymore, it's about explaining." Also, participant 8 stated, "We're given these metrics to hit, but no one asks how we're supposed to get there with what we have." These statements highlight the conflict between organizational expectations and leadership values. Leaders want to prioritize people but often feel pushed to conform to systems that value performance over personhood. This tension can lead to frustration and emotional exhaustion, particularly when support or resources are lacking.

- *Leadership Perspectives and Priorities and Resource Availability*

Many participants viewed leadership not as a static role but as a continuous process of lifting others up. Mentoring, guiding, and preparing the next generation of leaders was seen as a moral and professional responsibility. Participant 2 stated, "We have a 7-class training for leadership, they now, if you show leadership skills, will put you in those classes so that you have a better understanding of how to be a good nurse leader." Also, participant 9 stated, "I'm always asking, 'Who's next?' Who can we train, who can we develop? Leadership shouldn't stop with me." This priority placed long-term growth and succession planning at the

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heart of leadership. For these participants, empowering others was not only a way to reduce turnover but a way to create shared leadership and resilience within teams.

Several participants underscored the importance of adaptive leadership, being able to shift strategies, listen to different perspectives, and respond to dynamic team and patient needs. Participant 8 stated, "We need to be more adaptable in our approach, bringing different people's perspectives into the mix can definitely help make leadership better." Also, Participant 1 stated, "You can't have one style. What works for one person might not work for another. Good leadership is knowing how to switch gears when you need to." Flexibility, humility, and inclusive dialogue emerged as key practices that allow leaders to remain effective amid shifting clinical and organizational pressures.

Finally, many participants spoke about their role in shaping unit culture, setting the tone for how teams work, communicate, and support one another. They saw leadership not only as a role but as a cultural force that could enhance or undermine morale. Participant 12 stated, "I always say, the energy I bring into the room matters. If I come in stressed, they'll feel it. So, I try to lead by example." Also, participant 7 stated, "Leadership is how we build the team. If the culture is bad, people leave. It starts with who's in charge." These statements reinforce that leadership is inseparable from culture, and that nurse leaders must actively shape the emotional and operational environment to support team satisfaction and performance.

The theme of Leadership Perspectives and Priorities illustrates that frontline leaders view their roles as deeply relational, morally grounded, and inherently developmental. Their leadership priorities center on supporting staff, modeling ethical behavior, fostering inclusion, and cultivating new leaders, even in the face of organizational demands that can shift focus to compliance and metrics.

Leadership is not viewed as a destination, but as a practice of presence, responsiveness, and care. These leaders define their success not by their titles, but by the loyalty of their teams, the growth of their staff, and the trust they build every day. To align leadership development with these values, organizations must design training and policies that affirm these human-centered priorities and empower leaders to lead with authenticity, flexibility, and integrity.

- *Theoretical, Practical, or Policy Implications of the Findings*

The findings of this study provide meaningful theoretical, practical, and policy implications regarding the effectiveness of frontline leadership development as it pertains to satisfaction and retention. Theoretically, the study reinforces and expands current understandings of leadership in nursing by aligning closely with the principles of contemporary relational leadership models. Specifically, the findings support recent research on transformational and authentic leadership approaches, which emphasize the importance of relational trust, emotional intelligence, and individualized consideration (Boamah et al., 2018). These qualities align with studies, such as Boamah et al., (2018), emphasizing the need for emotionally intelligent leadership as a core competency in nursing. Furthermore, the results support the theoretical foundation that emotionally responsive leadership not only enhances team morale but contributes directly to the retention of nursing staff, by creating a more positive environment from the patient outcomes to the overall work environment that follows (Boamah et al., 2018).

From a practical standpoint, the findings highlight serious gaps in the structure and delivery of leadership development programs. Participants frequently criticized existing training formats, particularly computer-based modules, as generic, disengaging, and misaligned with the realities of clinical leadership. These critiques are consistent with current literature that points to the ineffectiveness of passive learning strategies and emphasizes the importance of experiential, scenario-based, and context-specific leadership development (Cummings et al., 2018). Programs that were interactive, emotionally resonant, and embedded within team-based learning environments were perceived as far more valuable. Additionally, participants stressed the absence of training in soft skills such as conflict resolution, emotional regulation, and effective communication, skills that studies have shown to be essential to frontline health care leader success (Wei et al., 2018). There is a clear practical implication that leadership training must go beyond theoretical instruction to include reflective practice, real-world application, and relational engagement if it is to be considered effective.

The policy implications of these findings are equally significant. As the health care industry continues to face rising nurse turnover and burnout, there is a pressing need for leadership development to be treated not as an optional or administrative task, but as a strategic priority. Participants described institutional pressures such as staffing quotas and retention metrics that often conflicted with their ability to lead effectively (Kelly et al., 2021). This tension points to a need for health care policies that prioritize leadership development through protected time, resource allocation, and the integration of leadership metrics into organizational quality frameworks. Recent policy recommendations emphasize the need for system-level support for frontline leadership, advocating for mentorship infrastructure, leadership succession planning, and development pathways tailored to different career stages. Moreover, incorporating frontline input into the design of leadership programs, as suggested by participants, would ensure that leadership training remains relevant and effective across diverse clinical settings (Kelly et al., 2021).

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In summary, the study demonstrates that effective leadership development, when it is emotionally intelligent, contextually grounded, and relationally focused, positively influences both satisfaction and retention among frontline leaders. These findings contribute to ongoing theoretical conversations about leadership models in health care while offering practical guidance for improving current training practices. They also support policy changes that treat leadership development as a cornerstone of workforce sustainability and organizational resilience.

- *Application and Benefits*

This research contributes to the growing body of literature on frontline health care leadership development by offering context-rich, experience-based insights that deepen and extend current theoretical and practical understandings. While previous studies have established the importance of leadership styles such as transformational and authentic leadership in improving nurse satisfaction and retention (Boamah et al., 2018), this study advances the field by capturing frontline leaders lived experiences with training processes, highlighting the disconnection between leadership theory and training implementation.

Specifically, this study builds upon the growing emphasis on emotional intelligence, mentorship, and participatory leadership models in contemporary nursing leadership research (Kim et al., 2021; Wei et al., 2018). Participants expressed frustration with passive, generic training modules, calling instead for emotionally intelligent leadership and hands-on learning strategies. These findings reinforce literature calling for leadership development that incorporates emotional regulation, interpersonal skills, and resilience training as some core components (Wei et al., 2018).

Additionally, the study fills an important gap in the literature by documenting the practical and organizational constraints that limit the impact of leadership programs. While leadership frameworks often highlight the desired competencies of effective leaders, few studies have captured how institutional factors, such as lack of protected time, ineffective delivery formats, and insufficient mentorship, inhibit leaders' ability to grow and apply new skills (Wei et al., 2018). By surfacing these constraints directly from participants' perspectives, this study contributes valuable qualitative evidence that can inform more realistic and supportive training models.

Moreover, the findings add to existing scholarship on the role of mentorship and professional networks. Studies emphasize that formal mentorship and peer relationships are key to developing leadership capacity and reducing nurse leader burnout (Lee et al., 2019). This study confirms these findings and adds new insight by showing how mentorship is inconsistently implemented and often absent in structured leadership pathways, leading to unnecessary trial-and-error experiences for emerging leaders.

The research also introduces a participatory leadership perspective, with participants advocating for training that reflects frontline realities and includes staff feedback in its design. This supports recent calls for inclusive, bottom-up leadership models that empower nurse leaders to co-create leadership initiatives and influence organizational culture (Nikpour et al.,2022). Unlike prior studies focused primarily on managerial metrics, this research elevates the relational and contextual dimensions of leadership, providing a richer understanding of how leadership is experienced and enacted in daily practice.

The study also contributes to the extension of existing knowledge by empirically linking leadership development with quantifiable outcomes in staff satisfaction and retention, areas often treated separately in literature. While theories such as Bass's transformational leadership model (Bass & Riggio, 2006) provides a foundational framework, this research adds specificity by demonstrating how targeted training interventions can operationalize these theories in contemporary health care settings. Moreover, the research helps clarify the mechanisms by which leadership behaviors influence staff attitudes, offering granular insights into how factors like communication quality, inclusion in decision-making, and mentorship dynamics affect employee engagement.

Importantly, the study fills a notable gap in the literature concerning the lack of longitudinal, practice-based evidence on how leadership development initiatives directly impact health care staff retention. While many existing studies explore leadership styles or staff turnover in isolation such as Becker et al. (2025), few integrate these areas into a cohesive intervention-based framework that tracks outcomes over time. This research introduces a replicable model that organizations can use to assess leadership impact and return on investment (ROI) for development programs, an area of increasing interest amid ongoing staffing crises in health care. Furthermore, it introduces methodological innovations such as using mixed methods designs to capture both the measurable effects of leadership training (e.g., turnover rates, engagement scores) and the lived experiences of staff undergoing organizational change.

By offering a structured approach to leadership development, grounded in both theory and empirical evidence, this research not only informs organizational decision-making but also strengthens the evidence base used by policymakers and stakeholders to design more resilient and supportive health care work environments. It serves as a catalyst for future inquiry and cross-sector collaboration, fostering a culture of continuous improvement and leadership accountability.

In summary, this study contributes to the advancement of leadership development research in nursing by a) demonstrating the limitations of current training delivery formats, b) emphasizing the need for emotional intelligence and mentorship, c) highlighting organizational constraints that impair leadership growth, and d) offering new insights into inclusive, experience-based leadership

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development. These contributions help close the gap between leadership theory and the actual development, satisfaction, and retention of nurse leaders in clinical practice.

➢ *Implications*

- *Recommendations for Policy*

Leadership development in health care settings should center on transformational leadership, a style consistently shown to enhance staff satisfaction, well-being, and retention while reducing burnout. In a comprehensive evidence review, transformational leadership was strongly associated with increased job satisfaction and decreased staff stress among nurses (Weberg D., 2010). By empowering staff, promoting shared vision, and fostering organizational commitment, transformational leaders not only build trust but also support a culture where retention thrives.

Expanding on this foundation, transformational leadership equips leaders with the skills to engage their teams emotionally and intellectually, encouraging innovation, autonomy, and continuous professional growth. Leaders who embody this style serve as role models, demonstrating integrity, compassion, and a commitment to excellence that inspires those around them. In doing so, they create a psychologically safe environment in which staff feel valued and motivated to contribute meaningfully to organizational goals. This leadership approach contrasts sharply with transactional models, which tend to emphasize compliance over creativity and may fail to cultivate intrinsic motivation among employees.

Moreover, transformational leadership supports effective communication, a critical element in high-stress health care environments. Leaders who communicate openly and supportively are more likely to identify issues early, provide timely feedback, and reduce the risk of conflict and misunderstandings. This proactive communication helps decrease feelings of isolation or frustration, especially among frontline staff who may otherwise feel disconnected from organizational decision-making processes. According to research by Boamah et al. (2018), transformational leadership is also associated with greater patient satisfaction and improved safety outcomes, underscoring its role in enhancing not only employee well-being but also the overall quality of care.

In the context of organizational change, a constant in health care, transformational leaders play a key role in guiding teams through transitions with clarity and purpose. Their ability to articulate a compelling vision for the future enables them to unite diverse professional groups, maintain morale, and drive adoption of new initiatives. This is particularly vital in addressing workforce challenges such as high turnover, staff shortages, and declining engagement. By aligning personal and organizational values, transformational leaders create meaning in the work, leading to increased loyalty and a deeper sense of purpose among employees.

Implementing policies that prioritize the development of transformational leadership competencies, such as emotional intelligence, strategic thinking, and mentoring skills, can therefore have far-reaching impacts. Training programs should emphasize real-world application, reflection, and feedback to cultivate these traits in emerging and existing leaders. As health care organizations face growing pressure to improve both staff and patient outcomes, transformational leadership emerges not only as a preferred model but as a necessary strategy for long-term sustainability and resilience.

Complementing leadership style, structured coaching programs, particularly those that emphasize delegation, empowerment, and skill development—have been shown to reduce turnover among early career nurses. One study of psychiatric-mental health nurses found coaching strongly correlated with retention during the critical, first two years of practice (Gold T. K., 2025). This suggests that embedding coaching into leadership development can reinforce nurse empowerment and mitigate attrition.

Similarly, formal mentorship programs contribute significantly to job satisfaction and retention. Meta-analytic evidence indicates that mentorship supports both mentors and mentees through psychosocial and career-related guidance, with mentored employees displaying substantially higher retention rates (Goens & Giannotti, 2024). Structured mentorship enhances engagement, belonging, and professional growth, especially for diverse or early-career staff.

Experiential learning should form the backbone of training curricula. Programs combining theoretical content, simulations, and real-world quality improvement (QI) projects, followed by reflective debriefs, foster lasting behavioral change. Embedding longitudinal formats rather than single workshops ensures sustained leader development aligned with organizational priorities.

Encouraging reflective practice and clinical supervision further boosts satisfaction and retention. Contextualized reflection, such as post-shift debriefs or incident reviews, promote self-awareness while clinical supervision frameworks reduce burnout and absenteeism. These practices build resilience and improve care quality by enhancing team cohesion and continuous improvement.

To maximize engagement, programs should incorporate accessible e-learning modules on leadership, change management, and cultural competence. Digital platforms allow asynchronous learning and use of analytics to monitor engagement, ensuring flexible access to development opportunities.

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Clear communication and feedback loops are also essential. Transparent updates on leadership initiatives, along with structured channels for staff input, foster trust and acceptance, key factors in sustaining participation and ownership of development programs.

Integrating cultural competence and collaborative leadership further enriches leadership capacity. Training focused on equity, diversity, and inclusion cultivates leaders who can effectively guide diverse teams and patient populations, while enhancing job satisfaction and well-being.

Resilience and stress management must be embedded into leadership curricula. Leaders trained in mindfulness, stress recognition, and supportive responses can better address burnout and promote organizational health. Organizational support, such as flexible scheduling, rest breaks, and mental health programs, help sustain a positive work environment.

Finally, robust evaluation frameworks are crucial. Programs should define KPIs like retention rates, satisfaction scores, burnout indices, and patient outcomes; include pre- and post-training assessments; and tie leadership growth to performance appraisals. Aligning leadership metrics with broader organizational goals ensures accountability and continuous improvement.

By implementing these policies, combining transformational leadership, coaching, mentorship, experiential learning, reflection, accessible e-learning, transparent communication, DEI, resilience training, and outcome measurement, health care organizations can foster leadership excellence. This integrated development strategy not only improves leader satisfaction and retention but also enhances team performance and patient care outcomes.

- *Recommendations for Practice*

This study exploring frontline leadership development in United States health care systems in relation to satisfaction and retention offers the opportunity to reshape health care practice by providing actionable, evidence-based recommendations. Findings from such a study can directly inform the design and delivery of leadership training programs that are responsive to the unique needs of frontline leaders. Practice can be changed by embedding structured leadership pathways within nursing career progression, incorporating leadership competencies into annual performance appraisals, and prioritizing continuous leadership training as part of professional development (Cummings et al., 2018).

One immediate change that health care organizations can implement is the integration of modular leadership development programs that emphasize transformational leadership principles, effective communication, and emotional intelligence. Transformational leadership, in particular, has been shown to reduce burnout, enhance job satisfaction, and foster staff retention (Boamah et al., 2018; Weberg, 2010). These training modules should be delivered in flexible formats, such as online asynchronous content or blended learning, to ensure accessibility for nurses working variable shifts. Additionally, the study may support the institutionalization of mentorship and coaching programs, which help new or junior nurses develop confidence, competence, and professional relationships that foster long-term commitment to their organizations (Nowell et al., 2017).

Health care systems should also implement structured reflection and feedback mechanisms, such as routine leadership huddles and peer feedback loops. These strategies are not only cost-effective but also contribute to continuous leadership growth and enhanced psychological safety in the workplace (Shanafelt et al., 2015). Early incorporation of leadership concepts during onboarding and orientation further signals that leadership development is a priority and that all nurses are viewed as potential leaders from the outset of their careers.

Another actionable step involves allocating protected time for leadership activities. One of the barriers to leadership development cited in the literature is the lack of time due to high workloads. Organizations can address this by embedding leadership development within existing continuing education frameworks or by integrating it into unit-based quality improvement initiatives, thus minimizing disruption to clinical care while promoting professional growth.

The benefits of implementing these recommendations include improved staff morale, greater role clarity, and lower turnover-related costs. In turn, organizations may see better team cohesion, fewer absences, and more consistent patient care (Laschinger et al., 2012). Importantly, transformational nurse leaders are also associated with improved patient safety outcomes and reduced adverse events (Boamah et al., 2018), emphasizing that investing in leadership is both a workforce and a patient care strategy.

While the outcomes of implementation should be interpreted with measured expectations, even small adjustments, such as formalizing mentorship relationships or incorporating leadership behaviors into performance reviews, can produce tangible improvements. These improvements are particularly significant in high-turnover environments such as acute care and long-term care settings.

Future research directions may include evaluating the long-term impact of leadership development programs across various health care contexts, such as rural or under-resourced facilities. Comparative studies could explore different modalities of training, such as online versus in-person, or peer-led versus expert-facilitated, and their respective cost-effectiveness and outcomes.

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Additionally, examining demographic variables such as race, gender, and generational cohort may offer insights into how to personalize leadership development to maximize engagement and equity.

In summary, this research provides concrete strategies for improving frontline leadership that can be applied in real-world settings. While outcomes may vary depending on local contexts, adopting these evidence-based practices has the potential to improve satisfaction, reduce burnout, and retain skilled nursing staff, critical goals for ensuring sustainable and high-quality health care delivery.

- *Recommendations for Future Work*

In exploring frontline leadership development in the United States health care system and its relationship to satisfaction and retention, several areas for further research have emerged that could extend, validate, or clarify initial findings. While the study provides strong preliminary evidence for the positive impact of leadership development on workplace satisfaction and retention rates, certain methodological and contextual limitations suggest the need for additional inquiry.

One key area for further research is the longitudinal impact of leadership development programs. While short-term gains in job satisfaction and engagement are promising, it is not yet clear whether these outcomes are sustained over time or how long it takes for such programs to affect turnover rates in measurable ways. Future studies employing longitudinal designs could assess the durability of training effects and provide insight into the optimal frequency and duration of leadership interventions (Cummings et al., 2018).

Another important area is the differential effectiveness of leadership development across various demographic groups, such as gender, race/ethnicity, generational cohort, or years of experience. Research has shown that leadership experiences and perceptions of workplace support can vary significantly by demographic characteristics, yet this study may not have fully captured those nuances (Huston, 2008). Future research should consider intersectional analyses and incorporate inclusive leadership frameworks to ensure that development programs are equitable and effective across diverse nursing populations.

Additionally, comparative research examining different types of leadership training, such as transformational vs. transactional, in-person vs. virtual, or peer-led vs. expert-facilitated, could help identify which formats and styles produce the most effective outcomes in specific contexts (Boamah et al., 2018). Tailoring programs to fit organizational culture and unit-specific demands could enhance adoption and impact.

Exploration of organizational support systems and how they interact with leadership development to affect satisfaction and retention is also warranted. For example, the presence of mentorship programs, access to continuing education, or structural support like protected leadership time could significantly moderate the effectiveness of leadership training. Understanding the interplay between individual leader development and organizational context is essential for sustained improvement (Laschinger et al., 2012).

Finally, there is a need to explore how leadership development affects patient outcomes through improved nurse engagement and team cohesion. Although this study focused on workforce metrics, expanding the scope to include indicators such as patient satisfaction, adverse event rates, and quality of care could strengthen the case for leadership development as a strategic investment in both staff and patient outcomes (Wong et al., 2013).

Several limitations in the current study suggest caution in generalizing findings. First, the use of self-reported survey data introduces the possibility of response bias or social desirability effects, especially when participants are asked to evaluate their own leadership abilities or satisfaction. Future research should incorporate objective measures such as actual turnover rates, absenteeism, or performance evaluations to complement subjective data.

Second, the cross-sectional design of the study limits the ability to make causal inferences. Although associations between leadership development and improved outcomes were observed, longitudinal or experimental designs (e.g., randomized controlled trials) are necessary to establish causality (Creswell & Poth, 2018).

Third, the study may be limited by sampling bias, particularly if participants were drawn from a single organization or geographic region. This reduces the generalizability of the findings to broader health care contexts. Future work should involve larger, more diverse samples across multiple settings (urban, rural, acute care, long-term care) to enhance external validity.

Lastly, while the study identified broad outcomes such as satisfaction and retention, it did not fully explore the mechanisms of change, that is, what specific elements of leadership development programs (e.g., role modeling, feedback, emotional intelligence training) contributed most to observed improvements. Identifying and isolating these components could lead to more focused and cost-effective interventions.

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Several unanswered questions remain. For instance, to what extent do frontline health care leaders feel empowered to apply what they learn in leadership training programs? What organizational barriers prevent newly trained leaders from enacting change or leading effectively? Also, how does the broader institutional culture either support or hinder leadership growth? Exploring these questions through qualitative interviews or focus groups could yield rich insights that survey data alone cannot provide. Moreover, the ideal timing for introducing leadership training (e.g., during orientation, mid-career, or in response to burnout) remains unclear. Clarifying this could help tailor interventions to career stage and readiness.

- *Conclusion*

This study set out to explore how frontline health care leadership development influences job satisfaction and retention, and the results offer clear and compelling insights. The findings reveal that the perceived effectiveness of leadership training hinges not merely on its availability, but on its relevance, relational focus, and real-world application. Participants consistently described current training programs as too generic, lacking in emotional intelligence, and disconnected from the realities of nursing leadership. Conversely, hands-on, mentorship-driven, and emotionally intelligent approaches were viewed as transformative, building loyalty, strengthening team dynamics, and encouraging professional growth.

Importantly, the study achieved its goals by capturing the authentic voices of nurse leaders and highlighting the organizational and cultural barriers that hinder leadership development. It adds to existing knowledge by connecting leadership effectiveness to contextual experience, emotional presence, and adaptive capacity, elements often overlooked in traditional models. In doing so, it contributes to a deeper understanding of what leadership in health care truly demands and offers actionable insights for reshaping development programs to meet those needs.

Ultimately, this work affirms that investing in responsive, relational, and inclusive leadership development is not just beneficial but essential. As health care systems face increasing pressure to retain talent and sustain morale, the voices of frontline health care leaders must inform both practice and policy. This research shines a light on what matters most to those who lead at the bedside—and in doing so, lays the groundwork for more human-centered, effective, and enduring leadership in nursing.

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