

A Concept Map Development: Articulation of the Alignment between Relational Nurse
Leadership & Team Building Strategies in order to Support RN Team Leader Practice

by

Nancy Vording RN
Masters in Nursing Education, University of Victoria, 2015
BSN, University of Victoria, 2012

A Masters Project Submitted in Partial Fulfillment
of the Requirements for the Degree of

Masters of Nursing Education

in the Post Graduate Nursing Program at University of Victoria

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Supervisory Committee

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Abstract

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ABSTRACT

Canadian RNs have recently been faced with the new challenge of being removed from the bedside in order to fulfill the position of team leader. However, as the majority of frontline RNs may not be equipped with the skills, traits, or abilities necessary to execute such a role (Eddy et al., 2009; Heller et al., 2004; Pate, 2013), this MN project was undertaken as a way to help me grasp how the skills, traits, and abilities promoted within some *relational nurse leadership* works and within some *team building tools and strategies*, aligned with one another. In order to uncover alignment between these two areas, I employed Novak and Gowin's (1984) systematic concept mapping methodology as a way to develop two concept maps that explicitly articulated the skills, traits, and abilities endorsed within the resources reviewed on *relational nurse leadership* and *team building*. Then, the *theory of the relational work of nurses* (Terrizzi DeFrino, 2009) was enlisted as a way to help me analyze how the skills depicted on my two maps aligned and reflected the three main theoretical assertions described by Terrizzi DeFrino (2009). In doing this, I was able to locate nine main aligning skill sets that were then illustrated within a visual *spider map* (All, Huycke & Fisher, 2003). I believe that this *spider map* could one day be used or tailored by hospital nurse leaders, clinicians, or educators as a way to help inform or guide RN team leaders for their new practice roles.

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Acknowledgments

I would like to thank my husband and my two children for loving and supporting me during the development of this concept mapping MN project. Their patience and understanding regarding the immense work and dedication needed to complete such a project was invaluable and greatly appreciated.

Moreover, I would like to thank the many supportive colleagues and life long nursing educator friends I have made over the past two and half years in this Masters of Nursing Education Program. These colleagues and peers have continually kept me motivated, inspired, and encouraged and have exemplified to me how respectful communicative, cohesive, and collaborative community of practice teams can provide students with much needed support, insight, strength, and guidance.

Finally, I would like to thank my supervisor, Dr. Gweneth Hartrick Doane, and my committee member, Dr. Noreen Frisch for their time and dedication in making this MN project a reality.

A Concept Map Development: Articulation of the Alignment between Relational Nurse Leadership & Team Building Strategies in order to Support RN Team Leader Practice

Recently in Canada, hospital administrators have instituted a cost cutting strategy that has created new challenges for acute healthcare bedside workers. For instance, in Ontario, thousands of bedside registered nurse (RN) positions have been eliminated (ONA, 2013; ONA, 2014), and now many acute healthcare teams include more licensed practical nurses (LPNs) and healthcare aides (HCAs) than ever before (Pringle, 2009). But what may be even more interesting about this care reform tactic is the latest requirement by hospitals officials to position remaining frontline RNs into team leadership roles. Specifically, many bedside RNs are now being positioned to oversee and coordinate bedside care within newly revised and reformed care teams.

However, a vast majority of practicing bedside RNs may be actually ill-equipped to become team leaders since leadership preparedness and training is most often endorsed within post graduate university courses and is not normally embedded within basic, undergraduate nursing programs (Eddy et al., 2009; Heller et al., 2004). Because most bedside RNs only require an undergraduate degree or a past nursing diploma to practice, many of these nurses may lack leadership skills, traits, or knowledge (Pate, 2013) needed for the competent execution of this role. Nonetheless, as some RNs are now being directed into these team leadership positions they will need to obtain leadership expertise and related knowledge in order to attend to their professional and ethical “fitness to practice” obligation (CNA, 2008, p. 18).

One viable avenue that RN team leaders may wish to explore is the adoption of *relational nurse leadership* traits, skills and abilities (Balasco Cathcart, 2014; Cummings

et al., 2008; Dahinten et al., 2014; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013) with the inclusion of some key *team building tools/strategies*, as well (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). Recently, I have examined the literature on these two concepts to decipher if it may be beneficial for RN team leaders to explore these concepts as well. For example, *relational nurse leadership* has been argued by scholars as being a very valuable leadership approach for today's healthcare settings (Cummings et al., 2008; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Relational nurse leaders are deemed to be inter-personal leaders, who are "grounded in...positive psychological capacities, honesty and transparency, strong ethics and behavioural integrity" (Wong, Cummings & Ducharme, 2013, p.719). Furthermore, their intentional inter-personal and relational working skills are believed to be beneficial for enhancing positive staff (Wong, Cummings & Ducharme, 2013) and patient outcomes (Thompson et al., 2011).

Additionally, scholars working in the field of *team building tools and strategies* insist that those working within groups or teams need to be trained for the attainment of interpersonal working skills and abilities. For instance, some *team building* workshops and programs have been argued as being specially crafted to ensure team mates learn how to work cohesively, collaboratively, and respectfully together (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). Moreover, other *team building* scholars have suggested that their team building workshops or programs can be used to promote safer, quality patient care incentives at the bedside through effective team communication and collaboration practices (Johnson et al., 2011; Marshall & Manus, 2007).

During my exploration of the literature on *relational nurse leadership* and *team building strategies and tools*, I noted a potential congruence or *alignment* between these two seemingly separate constructs. The notion that such an alignment could have existed between them prompted me to return to the literature to discover exactly *how* these concepts aligned. After additional investigation and scrutiny of the resources, I began to notice several similarities between the interpersonal skills, traits, and abilities promoted by the scholars of each field, such as the endorsement that care providers possess specific competencies so that they can work cohesively and collaboratively within healthcare teams (Andreatta, 2010; Balasco Cathcart, 2014; Howe, 2014; Wong, Cummings & Ducharme, 2013).

Specifically, I noted within the literature that some scholars argued that ineffective healthcare team coordination and lack of team cohesiveness occurs when healthcare teams are re-structured (Aitken et al., 2000; Duffield et al., 2010), and when newer types of care workers are introduced into acute care areas (Rushmer, 2005; Spilsbury & Meyer, 2005). Given the recent shifts in care team structures and introduction of newer care providers within acute care settings in Ontario (ONA, 2014; Pringle, 2009), I realised that bedside care teams here may be suffering from similar outcomes that researchers in this area have previously noted (Duffield et al., 2010; Rushmer, 2005; Spilsbury & Meyer, 2005). Thus, I wondered if there was a way that *I* could support newly revised care teams during current care reform transitions. More specifically, I wanted to locate a way to help inform or guide newly appointed RN team leaders so that they might maintain that their bedside care teams remained cohesive and collaborative, even during care reform changes.

As I noted an inherent alignment between *relational nurse leadership* and *team building tools and strategies*, I wondered if the explicit expression of this alignment could be used as a way to inform or guide RN team leaders for their new leadership practice roles. Thus, for this MN project, I returned to the literature to discover a meaningful and comprehensive method that would help me articulate the alignment between *relational nurse leadership* and *team building tools and strategies*. My findings led to me enlist a concept mapping methodology as a way to articulate the perceived alignment between these two aforementioned concepts.

Relevant scholars claim that concept maps are visual, schematic charts, or creative road maps that outwardly portray how various constructs inter-relate, connect, or align with one another (Noonan, 2011; Novak and Gowin, 1984). Hence, I believed that the construction of a concept map on each of these two concepts would allow me to detect and articulate the similarities, commonalities, and *alignment* hidden between them, and explicate this alignment within a clear, concise, and visual manner.

Intriguingly, the use of concept maps within the nursing profession has grown significantly (Noonan, 2011). Concept maps are now being developed by nurse educators as a logical means to plan and structure courses (Hills and Watson, 2011). Moreover, concept mapping methodologies are being taught to nursing students as a way to help them learn and grasp highly abstract concepts (All & Havens, 1997; All, Huycke & Fisher, 2003; Irvine, 1995; Noonan, 2011). Additionally, concept maps are being used by hospital nurse clinicians and leaders as a way to develop care plans and hospital protocols (Noonan, 2011).

Because of the utility and versatility in using concept maps within nursing practice (Noonan, 2011), I decided to enlist this methodology as a way to help me visually express to RN team leaders what they may need to know or embody for their new team leadership practice realities. Therefore, the overall intention of my MN project was to develop a well-articulated, well-defined concept map that could one day be used or tailored to guide RN team leaders in some of skills, traits and abilities they may need to empower their care team peers at the bedside, *and* ensure patient care is enacted safely, ethically, collaboratively, cohesively, and competently.

Background & Main Concern Informing my Concept Map Project

Recent Canadian healthcare reforms have dramatically altered bedside team structures so much so, that RNs may no longer be the primary care providers at the bedside (Pringle, 2009). Current trends suggest that RNs are now being asked to assume *team leadership* roles that require them to coordinate bedside care with diverse frontline healthcare workers such as LPNs and HCAs, that has led to the claim that LPNs and HCAs are now the main bedside care givers of patients and families in many acute care areas (Pringle, 2009; ONA, 2013). But what may be significantly troubling about this particular care reform strategy is the underlying assumption by hospital officials that *all* practicing bedside RNs can safely, competently, and ethically transition into team leadership roles. This particular notion is concerning, especially since most practicing RNs may have never been properly prepared nor sufficiently trained within key leadership skills or knowledge from within their basic diploma or undergraduate nursing education programs (Eddy et al., 2009; Heller et al., 2004).

Furthermore, recent research indicates that some practicing RNs may not be completely familiar with the unique and diverse roles or scopes of some of their new bedside care peers, like HCAs (Chu, Wodchis & McGilton, 2014; Howe, 2014). Some scholars believe that the introduction of HCAs into acute care settings contributes to increased interpersonal team tensions or conflict within care teams (Duffield et al., 2010; Rushmer, 2005; Spilsbury & Meyer, 2005) that leads to poorer quality patient care at the bedside (Aiken et al., 2000). Because some scholars have discovered that quality patient care may be comprised when nurses are asked to work with newer forms of bedside care providers (Aiken et al., 2000; Duffield et al., 2010; Spilsbury & Meyer, 2005), RN team leaders are thus reminded of their professional and *ethical* obligation to find newer ways in which to better communicate, relate, understand, and collaborate with these new peers, so that the entire team maintains safe, ethical, high quality patient care at the bedside (CNA, 2008).

While many Canadian practicing RNs were not involved in the decision to transition their role away from the bedside and into team leadership positions (Pringle, 2009), Pate (2013) sees this current situation as being a potential positive opportunity for nurses to cultivate and hone their leadership skills and competencies. For instance, Pate believes that all RNs (regardless of their position or rank), have the potential in becoming vital, influential frontline nurse leaders. Moreover, she sees nursing leadership as a fundamental core component to basic nursing practice that all RNs are required to possess. Pate argues that because RNs expertly coordinate, collaborate, and communicate effectively with various forms of care providers at the bedside, they need to obtain key leadership skills and competencies so that they can become expert communicators and

collaborators, who recognize that “quality healthcare is the responsibility of *all* care providers [emphasis mine]” (p.192).

Similarly, there are others who align with Pate’s (2013) position that *all* RNs envision themselves as influential and visible frontline leaders (Propp et al., 2010; Willcocks, 2012). For instance, Propp et al. (2010) discovered that a frontline RN team leader’s ability to effectively and relationally communicate with their team peers was integral for promoting “team synergy” *and* for upholding safer patient care initiatives (p.26). Likewise, the notion that all RNs should be sufficiently trained and empowered in becoming frontline leaders was noted within the Canadian Nurses Association leadership position statement (2011). Within this leadership position statement, CNA officials suggested that *all* RNs become “strong, consistent, and knowledgeable leaders who are visible, inspire others, and support professional nursing practice” (p.1). Additionally, within the CNA (2011) position statement, officials endorsed the “maximizing the leadership potential of *every* nurse [emphasis mine]...to achieve quality care and quality practice environments” (p.1). Hence, the need for nurses to obtain frontline leadership competencies and skills is indeed a key objective that *all* nurses must achieve, as doing so ensures that they adhere to their own professional mandates for practice.

Frontline Nurse Leadership or Management? However, it must also be made explicitly clear that the concept of RN team leader for this project not be confused with traditional notions that nurse leaders are nurse managers or administrators (Laurent, 2000; Pate, 2013). Indeed, many scholars appear to confuse nurse leadership with nursing management and so, it must be made clear that these constructs are not one in the same (Grossman & Valiga, 2013; Laurent, 2000; Pate, 2013). For instance, for one to become

an influential nurse leader, one does not necessarily need to become a nurse manager (Grossman & Valiga, 2013). Thus, for the purpose of this MN project, I suggest that key nurse leadership traits, skills, and abilities are essential competencies needed to help inform and empower frontline nurse leaders for their new team leadership roles.

For example, during my previous review of the literature on *relational nurse leadership*, scholars argued that the overall benefits of relational nurse leaders related to their abilities in ensuring staff felt valued, respected, and heard (Cummings et al., 2008; Wong, Cummings & Ducharme, 2013). Dahinten et al. (2014) reasoned that relational nurse leaders were able to accomplish this because they intuitively embraced and invited staff to “participat[e] in decision making”, and “provid[ed] [their nurses] autonomy or control over [their own] work” environments (p.18).

Additionally, *relational nurse leadership* capabilities were seen as being useful for the enhancement of patient safety outcomes (Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Scholars argued that relational nurse leaders did this by encouraging staff to become co-partners in patient care decision making processes, and by integrating their innovative ideas and suggestions into mutually developed policies and care plans (Balasco Cathcart, 2014; Cummings et al., 2008; Wong, Cummings & Ducharme, 2013).

But another underlying assertion that scholars claimed made relational nurse leaders more effective in today’s healthcare settings (Balasco Cathcart, 2014), was their ability to employ their own intuitive, inter-personal *power* in their practice. This inter-personal power allowed leaders to relationally connect, support, empower and motivate their staff (Cummings et al., 2008; Dahinten et al., 2014; Wong, Cummings &

Ducharme, 2013). Wong, Cummings and Ducharme (2013) stated that relational nurse leaders “focus on people and relationships...to achieve common goals” (p.710). These scholars argued that relational nurse leaders used a “human relations approach” when interacting with staff that is based on “appreciation and support” and “genuin[e] concern for their [nurses] welfare” (p.710). Thus, these scholars concluded that relational nurse leaders employ interpersonal powers with others and that they do not try to manipulate or try to control staff in order to achieve goals.

During my examination of some key *team building strategies and tools*, I noted that scholars in this area promoted the instruction of all types of bedside care providers so that everyone is able to learn how to work cohesively, collaboratively, and respectfully together (Andreatta, 2010; Howe, 2014; Johnson et al., 2011; Manus & Marshall, 2007). Scholars of the team building programs I reviewed argued that team peers must learn how to become respectful and more communicative with each other (Andreatta, 2010; Howe, 2014; Johnson et al., 2011) because doing so ensured they sustained patient safety incentives at the bedside (Marshall & Manus, 2007). For example, Marshall and Manus (2007) claimed that team mates who were open, honest, and communicative with one another prevented patient tragedies or errors at the bedside.

Moreover, Howe (2014) and Marshall and Manus (2007), asserted that one of the biggest barriers for ensuring bedside care is coordinated safely was related to the existence of negative hidden power dynamics proliferating within healthcare teams. Hidden power dynamics between healthcare teams has been known to contribute to the prevention of some bedside providers from coming forward and speaking on behalf of patients (Ewashen, McInnis-Perry & Murphy, 2013). Prevention of all care team

members in coming forward on behalf of their patients is believed to be related to authoritative notions that only higher level ranking providers have the right to speak or act on behalf of patients and families (Ewashen, McInnis-Perry & Murphy, 2013). However, Marshall and Manus (2007) specifically argued that *all* bedside providers (regardless of rank) have an ethical obligation to speak up on behalf of their patients. These scholars stated that care providers who stopped others from coming forward and speaking out contributed to negative patient outcomes.

Therefore, my initial exploration of the literature illuminated to me that nurses and their peers must endeavour to gain *relational nurse leadership* and *team building* knowledge, skills, and competencies so that they can ensure bedside healthcare teams become cohesive, collaborative, and communicative with one another. Thus, I believed that newly appointed RN team leaders might benefit from the skills, traits and abilities declared by the scholars of these two areas. More specifically, I noted several similarities and congruencies between the skill sets described with both fields, and felt that *relational nurse leadership* and *team building* somehow *aligned* with one another.

However, as my review of the literature allowed me to identify that there was an alignment between the two constructs of *relational nurse leadership* and *team building tools and strategies*, the key skills, traits, or abilities that aligned between these two concepts was something I still needed to identify and explicate. Hence, the idea to find a meaningful way to articulate their alignment as a way to help support RN team leader practice was what led me to consider concept mapping for the completion of this MN project.

Why use Concept Mapping?

In order to investigate how *relational nurse leadership* and *team building strategies and tools* aligned with one another, I decided to undertake a concept mapping process as a way to help me describe this alignment to others. Concept maps are detailed representations of how one grasps, correlates, and “recognize[s] new relationships and hence new meanings” between concepts “that were not previously recognized or related” (Novak & Gowin, 1984, p.17). I believed that by employing a concept map development process for this MN project, I would be able to illustrate how these two concepts aligned with one another. Moreover, I felt that the enlistment of this strategic methodology would allow me to create a visual roadmap or guideline that articulated the skill sets found to be congruent between these two concepts, so that this roadmap could one day be tailored or used to inform or guide RN team leaders for their new practice realities.

Project Question & Purpose

The key components guiding this MN project paper included the enlistment of the concept map development methodologies and processes, as depicted by Novak and Gowin (1984, p.8) and All, Huycke, and Fisher (2003). The central questions of this MN project included: How are *relational nurse leadership* and *team building tools and strategies* conceptually linked? How do the skills, traits, and abilities of relational nurse leadership *align* with team building tools and strategies?

By developing and constructing an innovative, visual, well-defined concept map, my central goal was to articulate any distinguishable alignment between the constructs of *relational nurse leadership* and select *team building tools and strategies*. I posited that my finalized concept map could one day be used as a viable guideline to inform and

support new RN team leaders with the necessary knowledge, skills, and capabilities needed to safely and competently execute their new team leadership roles.

Searching for an Alignment. The noun, *alignment* is defined as “the process of adjusting parts so that they are in proper relative position” with one another (Retrieved from website: <http://www.thefreedictionary.com/alignment>). Thus, in order to locate and explicitly identify the key components that aligned and inter-related between *relational nurse leadership* and select *team building tools* and *strategies* on my concept map, I had to return to the literature to critically assess their similarities in greater depth by developing two concept maps on each of these constructs. Additionally, I chose to enlist an appropriate theory as way to analyze the aligning skills sets found between *relational nurse leadership* and *team building*. I shall now describe the theory I enlisted to help structure and analyze my critical thought processes in order to locate alignment between these constructs.

Philosophical/Theoretical Analysis Method used to help Uncover Alignment:

The ‘Theory of the Relational Work of Nurses’

Terrizzi DeFrino (2009) developed her relational nursing work theory by considering the scholarly “psychodynamic” theoretical feminist work originally conducted by Fletcher, Jordan, and Miller (2000, p.244). Fletcher, Jordan, and Miller (2000) studied and discovered the existence of relational interpersonal working skills that were enacted by women and their coworkers in the workplace. These scholars recognized that the supposed relational skills or traits portrayed by female employees were quite often overlooked by their employers, but were perceived by the scholars as being crucial

for “mutual psychological growth-such as empathy, mutuality, authenticity and empowerment” between co workers (pp. 251-253).

Intriguingly, the relational skills employed by female employees with their peers appeared to create “a certain kind of ‘relational intelligence’-that has to do with a specific way of seeing the world and thinking about what makes things work and how people learn” (p. 253). Therefore, Fletcher, Jordan Miller (2000) hypothesized that the powerful, intuitive, and emotional work embodied by female workers served to unify, solidify, and create tighter bonds between them and their co workers, which these scholars believed led to group work activities becoming more cohesive *and* more productive.

In seeing an inherent connection between Fletcher, Jordan, and Miller’s (2000) work with nursing, Terrizzi DeFrino (2009) argued that it could be customized to help explicate the taken for granted work of nurses *and* their team mates at the bedside. Terrizzi DeFrino (2009) believed that by tailoring the theory for nursing she would be better able to appropriately articulate how “power and knowledge lie in the relational work” (p.294) of nurses *and* their team mates. More specifically, she argued that a relational theory describing the beneficial skills and abilities nurses enacted with their bedside peers might help nurses recognize the need to shift “the focus from the individual to the collective” so that bedside care coordination could be enacted cohesively and collaboratively (p.296).

Thus, Terrizzi DeFrino (2009) developed three main “assumptions” for her theory that were originally derived from the feminist work of Fletcher, Jordan and Miller (2000) (p.229). Their original theoretical assumptions included: “preserving work”, “mutual empowering”, “self achievement”, and “creating team” (Terrizzi DeFrino, 2009, pp.299-

300). In keeping with these particular ideals, Terrizzi DeFrino (2009) modified these assertions slightly to tailor her own assumptions regarding the relational work of nurses *and* their peers at the bedside.

For instance, the first modified assumption proposed by Terrizzi DeFrino (2009) was that nurses promote the “growth, achievement, and effectiveness, between the nurse and others [that] occur best within a network of connection and support” (pp.298-299). She contested that the nurse not be seen as a separate entity from her or his bedside colleagues, but be seen as a contributing and cohesive part of a bigger whole.

Terrizzi DeFrino’s (2009) second tailored assumption was for nurses and their peers to endorse “interdependence between the nurse and others in the workplace” (p.299). This assertion reinforced that nurses promote each other’s roles; that they let go of their need to *control* others; and that they trust the whole team to do their very best.

Finally, the last adjusted theoretical assertion proposed by Terrizzi DeFrino (2009) was for nurses to “professionally and clinically” become “reliant on one another” and *empower* their allied co workers at the bedside (p.299). She claimed that “work outcomes include [not only] what the nurse achieves alone but also what the nurse enables” others he/she “works with to achieve” (p.299). Thus, this assertion asks that nurses recognize how cohesive and collective efforts of the entire team are crucial for the enactment of higher quality patient care.

In terms of this MN project, I employed Terrizzi DeFrino’s (2009) theory after completing my two concept maps on *relational nurse leadership* and *team building tools* and *strategies*. I chose to use this theory to analyze and uncover the alignment between them as I realized this theory appropriately addressed the population and context I was

examining in this MN project: the inter-personal working dynamics, skills and abilities employed by nurses and their bedside care provider peers. For instance, Terrizzi DeFrino's (2009) theory explicated how nurses and their peers embody intuitive inter personal and relational *powers* with one another. I saw this inter personal power as being one of '*power with*' or '*power for*' others, rather than '*power over*' others. Because this type of positive interpersonal power appeared to reflect what the scholars of *relational nurse leadership* also described (Balasco Cathcart, 2014; MacPhee et al., 2014; Wong, Cummings & Ducharme, 2013), and what scholars of *team building tools and strategies* had promoted (Chinn, 2013; Howe, 2014; Marshall & Manus, 2007) I believed that Terrizzi DeFrino's (2009) theory was indeed a relevant theory to use as a way to help decipher alignment between my two concept maps.

As, Terrizzi DeFrino (2009) rejected the notion of nurses inflicting control over or manipulating others in the work environment, she used her theory as a way to show how bedside nurses support and encourage their coworkers in coming forward and sharing their unique perspectives, roles, and capacities with everyone on the team. Thus, I perceived a similar endorsement for the *collective power* of nurses and their peers within the concepts of *relational nurse leadership*, *team building* and within *the theory of the relational work of nurses* (Terrizzi DeFrino, 2009), and hence felt that this theory was relevant in attending to the population and to the interpersonal context embodied by nurses and their colleagues.

Moreover, I specifically used this theory as way to analyze how similar or consistent skills, traits, and abilities found between my two concept maps on *relational nurse leadership* and *team building*, reflected or aligned with Terrizzi DeFrino's (2009)

three main theoretical assertions. In using this analytical methodology to uncover alignment, I was also able to create another concept map or *spider map* (All, Huycke, & Fisher, 2003) that visually illustrated my discovered alignment to readers.

Theoretical Basis behind Conceptual Maps

Conceptual or concept maps are explicit, comprehensive thinking strategies that outwardly express how a learner perceives and grasps commonalities or *alignment* between two or more concepts (All, Huycke, & Fisher, 2003; Noonan, 2011; Novak & Gowin, 1984). Some scholars state that concept maps reflect “an individual’s personal expression of meaning for the selected material or subject matter” (All & Havens, 1997, p.1210). Historically, the notion of concept mapping was developed and adopted for educational use by Novak and Gowin (1984). These educators believed that by incorporating a detailed thinking and learning process, students would be granted the ability to creatively articulate how they understand, link, and connect learned concepts or constructs with one another. Thus, as concept maps are considered by Novak and Gowin (1984) as being personal and individual representations of a student’s own understanding of complex concepts, these maps should not be considered as definitive truths, but should be regarded as expressions of personal understanding and meaning of how learners perceive concepts inter relating or connecting with others.

Novak and Gowin (1984) based their ideas for concept map development on the philosophical underpinnings of a learning theory first “proposed by David Ausubel” (p.7). This theory posited that “meaningful learning” strategies must be sought over traditional “rote learning” teaching and learning strategies, as the latter does little to assist students in connecting new knowledge to past learning or experiences (p.7). More

specifically, the theory endorses that educators use “discovery learning” methods with students to help achieve more meaningful learning (p.7). Thus, I shall now detail how I enlisted the Novak and Gowin (1984) concept map methodology for this MN project, within the following sections.

Outline for the Development of My Concept Mapping Work

Because of the complex nature of trying to explore which skills, traits, and abilities connected or aligned between *relational nurse leadership* resources and the select *team building tools* and *strategies* reviewed for this MN project, I decided to divide my methodology into two workable portions: Phase One and Phase Two.

Outline of Phase One. For this first portion of my MN project, I used Novak and Gowin’s (1984) five step systematic concept mapping construction methodology process as a way to help me identify the skills, traits, and abilities promoted by the scholars of six resources on *relational nurse leadership* and the five sources reviewed on *team building tools* and *strategies*. Moreover, the five concept mapping steps outlined by Novak and Gowin (1984) allowed me to articulate which essential skills or traits were expressed the most or were endorsed the least within the literature, so that I could develop the hierarchy within each of my concept maps based on these assertions.

Additionally within *Phase One*, I was required to re-examine the six literature sources on *relational nurse leadership* as a way to identify the skills, traits or abilities demonstrated by relational nurse leaders. In doing this, I was able to create my concept map on *relational nurse leadership* by enlisting Novak and Gowin’s (1984) five step methodology. Similarly, I applied this same strategy whilst reviewing the literature on the following *team building tools* and *strategies*: “TeamSTEPPS” (Andreatta, 2010; Johnson

et al., 2011), “TeamTalk” (Howe, 2014), “Safer Healthcare” (Marshall & Manus, 2007), and “peace and power” (Chinn, 2013). In re-investigating all of these works, I was able to identify numerous skills and abilities promoted by the scholars of these resources and then used this knowledge to create a Novak and Gowin (1984) inspired concept map to explicitly articulate what I found. I will now briefly outline and describe the five steps inherent to the Novak and Gowin (1984) concept mapping methodology employed during *Phase One* of this MN project.

The Novak & Gowin (1984) Concept Mapping Methodology

Novak and Gowin (1984) stated that in order to create a well detailed concept map, one must follow their five methodological steps. These scholars assert that all concepts maps be created to follow their main three assertions: that a clear “hierarchal” order be represented between concepts depicted; that “appropriate linking words” be shown; and that “cross links...[be clearly] indicated” in some manner within the map itself (p.105). Here is a brief outline on the five steps for concept map construction as described by Novak and Gowin (1984).

Step One. Novak and Gowin (1984) ask that concept map developer’s clearly identify and list the key, main concept(s) they are exploring, on a rough or hand drawn map. For instance, if one creates a concept map on the notion of the ‘season of spring’, one would list this phrase at the very top of his or her concept map. This phrase is then used to help locate other concepts that inherently relate it (see *Appendix A*). For instance, the themes of ‘after winter’ and ‘before spring’ might be depicted under the main phrase of ‘the season of spring’ with sub themes of ‘melting of snow’ and ‘growth and regeneration of plants/trees’ illustrated underneath these two themes (see *Appendix A*).

Step Two. Novak and Gowin (1984) ask that concept map developers assess “the nature and role of concepts and the relationship between concepts” by “isolating [key] concepts and [their] linking words” (pp.24-28). Thus, under the main heading depicted, one would need to decipher coordinating ideas that relate to the main conceptual phrase being explored that become the map’s main *themes*. These themes help incite the location of more *themes*, *subthemes*, or *propositions* that are proposed and explored in greater detail, underneath the main conceptual phrase.

However, Novak and Gowin (1984) suggest that themes, subthemes, and propositions be illustrated and listed in a downward or *hierarchal* fashion from the main topic phrase or idea being explored. This process is thus, repeated and further exemplified underneath each of the main constructs explored with the map (see *Appendix A* for an example of hierarchy).

Step Three. Next, Novak and Gowin (1984) assert that specific *linking words* be identified and described on the map. *Linking words* or *linking phrases* are located as a way to help express alignment, relationship, or connections perceived between various ideas or notions that are then depicted on the very lines or arrows used to connect themes, sub themes, and propositions with one another, and/or to the main concept. For instance, in *Appendix A*, the *linking word*, ‘comes’ has been used to connect the main phrase, ‘the season of spring’ to the themes of ‘after winter’ and ‘before summer’. Also, the *linking words* of ‘allows for’ have been used to show the relationship between the sub themes of ‘melting of snow’, ‘growth and regeneration of plants/trees’, and to the sub theme of ‘return of wildlife’ (see *Appendix A*).

Step Four. For this step, Novak and Gowin (1984) request that “two or three equally valid ways to link two concepts” (p.35) be presented in some manner on the map. For instance, one might use “arrows” and “lines to show that the meaning relationship expressed” (p.35) connected separate ideas with others, on the map. Indeed, the scholars suggest using long or broader arrows to link one theme to another set of themes, subthemes, or propositions located on the map. For instance, in *Appendix A*, broad arrows are used to show the relationship between ‘the season of spring’ to the themes of ‘after winter’ and ‘before summer’. Moreover, longer arrows may be shown to depict unilateral or bilateral directions between concepts. For example, in *Appendix A*, the sub themes of ‘gradual increase in temperatures’ and ‘sunshine’ have a bilateral directional flow positioned between them, in order to demonstrate a two way relationship between concepts.

Step Five. Finally, for this last step, Novak and Gowin (1984) believe that “[c]oncept maps need to be redrawn” (p.35). The scholars insist that concept mapping is an *evolutionary process* that takes time and patience to perfect. Thus, one would need to continually revise and re-configure propositions initially made or even remove or relocate ideas several times before “clarity of the relationships between the concepts” (p.35) under exploration become fully known. This clarity can be further made through *cross linkages* proposed between concepts. *Cross linkages* indicate how the concept map developer perceives inter-connections and inter-relationships between separate themes, subthemes, or propositions depicted on the map. Novak and Gowin (1984) suggest that concept developer’s employ brightly colored arrows as a way to help readers distinguish *cross linkages* proposed with other connections made on the map.

Phase One: Applying the Novak & Gowin Method

Part One: Relational Nurse Leadership Concept Mapping Process

Step One. In order to complete this first step of the Novak and Gowin (1984) concept map generational process, I needed to first define the main area of interest I was exploring on my first map, and then identify key related ideas and notions associated with this main idea. Thus, for *Part One* of *Phase One*, my main area of interest related to the “proclaimed traits, skills and abilities of relational nurse leaders” found within the six relational nurse leadership resources reviewed for this MN project. Hence, this sentence became the definitive main topic phrase I employed to help guide my thinking processes for my first concept map (see *Appendix B*).

Additionally within this step, I needed to locate all of the explicated skills, traits and abilities of relational nurse leaders that were declared by scholars within the literature. Thus, in February of 2015, I returned to the literature resources I had previously reviewed on *relational nurse leadership* to explore these in greater detail.

Initially, when I first examined works in this area of interest, I recognized that most academics categorized the *relational nurse leadership* with other “emotionally intelligent leaders[hip]” types such as “resonant nurse leaders[hip]” (Cumming, Hayduk & Estabrooks, 2005, p.2) and “transformative nurse leaders[hip]” (Wong, Cummings & Ducharme, 2013, p.710). Because I wanted to ensure the works I examined explored the traits, skills, and abilities of *relational* nurse leaders, I systematically removed resources that did not explicitly declare this outright, and was left with the following six main resources: Balasco Cathcart (2014), Cummings et al. (2008), Dahinten et al. (2014),

MacPhee et al. (2014), Thompson et al. (2014), and Wong, Cummings and Ducharme (2013).

From these six main resources, I was able to distinguish many essential skills, traits, and abilities that scholars argued were crucial for these leaders to embody and role model in practice (see *Appendix B*). Upon close examination of these six works, I was able to identify thirty nine skills, traits and abilities (see *Appendix C*) that I used for the development and creation of my first *relational nurse leadership* concept map (see *Appendix D*).

Step Two. For this step, I was required to identify how individual concepts were related or connected with one another, and provide “linking words” to articulate their inherent relationship with one another (Novak and Gowin, 1984, p.28). Hence, as many of the skills, traits and abilities found during *Step One* (see *Appendix C*) appeared to similar to others, I realized that some these could be further combined or linked with others on the list. In doing this, I was able to develop main *themes* indicative of the core traits or skills expressed by the scholars of the six *relational nurse leadership* works reviewed.

Initial Analysis of Findings. Upon further examination, I deciphered and categorized nine initial main *themes* that I used to help outline the hierarchy of the expressed skills and traits discovered within the literature on *relational nurse leadership* (see Table 1). These nine *themes* were: ‘collaborative’, ‘creative’, ‘empowerment’, ‘respectful’, ‘developer of trust’, ‘reflective’, ‘caring’, ‘authenticity’, and ‘professionally accountable’ (see Table below).

Table 1

Initial Themes discovered from the literature on relational nurse leadership

Initial Discovery of Main Themes	Which includes the skills, traits, abilities
Collaborative Creative	Relationship Builder, Inclusive, Communicative Innovative, Upstream thinker
Empowerment Respectful	Motivational, Supportive, Encouraging, Inspiring Fair, Culturally Sensitive, Non-punitive & Non-manipulative, Attentive
Developer of Trust Reflective	Aware of Self & Others, Considerate of Others
Caring	Empathetic, Compassionate
Authenticity	Ingenuous & Genuine, Honest, Transparent, Open
Professionally Accountable	Competent, Self Determined, Adaptable & Flexible, Influential, Knowledgeable

For instance, I recognized that the scholars of *relational nurse leadership* resources insisted that these type of nurses leaders were active and ‘collaborative’ with their staffers (Balasco Cathcart, 2014; Cummings et al., 2008; Dahinten et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). More specifically, these types of leaders were seen as employing interpersonal skills to become ‘relationship builders’ (Cummings et al., 2008; Dahinten et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). They were also described as being intentionally ‘inclusive’ (Balasco Cathcart, 2014; Cummings et al., 2008; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013), and openly ‘communicative’ with their staffers (Balasco Cathcart, 2014; Cummings et al., 2008; Dahinten et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013).

For example, Dahinten et al. (2014) noted how relational nurse leaders were able to empower and encourage staff in becoming involved in patient care decision making processes. Theses scholars stated that relational nurse leaders fostered “fair treatment and trust” between them and their staff, that led to increased staff dedication and commitment

to their units, and enhanced patient outcomes (p.25). Hence, these skills or abilities were then articulated as being ‘the ways in which [leaders] are collaborative’.

As well, the literature suggested that relational nurse leaders were ‘creative’ (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013) and ‘innovative’ (Cummings et al., 2008; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013), and encouraged staff to become creative and innovative as well (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013). Balasco Cathcart (2014) felt that relational nurse leaders should remain “curious and open” and should “include...staff members in conversations so that [they] might learn from one another (p.45). Moreover, some scholars suggested that relational nurse leaders were skilled ‘upstream thinkers’ who had the ability to view situations more broadly, and who consciously took into account the larger context of their staff and patients (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013). Hence, this grouping of skills and abilities was linked and combined to reflect the ‘ways in which [relational nurse leaders] are creative’.

Additionally, several scholars argued that relational nurse leaders were ‘empowering’ of their staff (Balasco Cathcart, 2014; Cummings et al., 2008; MacPhee et al., 2014) and were ‘motivational’ leaders on their respective units (Balasco Cathcart, 2014; Dahinten et al., 2014; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2014). Moreover, they were endorsed as being ‘supportive’ (Cummings et al., 2008; Dahinten et al., 2014; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013); ‘encouraging’ (Thompson et al., 2011; Wong, Cummings & Ducharme, 2013); and ‘inspiring’ (MacPhee et al., 2014; Thompson

et al., 2011) to their staffers. For instance, MacPhee et al. (2014) argued that relational nurse leaders used “empowering behaviors [to] enable and support staff” to participate and collaborate in patient care decision making processes (p.5). More importantly, encouraging staff to willingly participate and be involved was role modeled by relational nurse as these leaders who intentionally fostered positive interpersonal work relationships with their staffers (Cummings et al., 2008; Dahinten et al., 2014; Wong, Cummings & Ducharme, 2013). Hence, empowering or motivational traits used to invite and endorse others to become involved were linked to the ways in which relational leaders enact the skill of ‘empowerment’. Thus, an appropriate *linking word or phrase* for this cluster of skills was deemed as being ‘the ways in which empowerment is enacted’.

Moreover, authors indicated that relational nurse leaders were ‘respectful’ of others, especially their staff (Balasco Cathcart, 2014; Dahinten et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). As well, these leaders were perceived as being ‘ethical and moral’ (Balasco Cathcart, 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013), who were ‘fair’ (Dahinten et al., 2014), ‘culturally sensitive’ (Balasco Cathcart, 2014); and ‘non-punitive and non manipulative’ of others (MacPhee et al., 2014; Thompson et al., 2011). Also, they were described as being fully ‘attentive’ within the presence of others (Balasco Cathcart, 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013).

For example, Balasco Cathcart (2014) asserted that for one to “do relational work, it’s necessary to be engaged in the particular situation in an open and attentive way” (p.44). Moreover, this scholar argued that “the relational skill of involvement” that demanded leaders be respectful of others was “first and foremost a moral skill because

it's directly connected to the ethical demand of nursing practice" (p.44). Whereas, Thompson et al. (2011) stated that in order for relational nurse leaders to become ethical, they must also be conscious of their obligation to enhance patient safety at the bedside. These scholars argued that safety would be sustained if leaders were willing to "promote active listening" with and among their staff, and were willing to "foster a no-blame response to error[s]" when mistakes were made (p.485). Because relational nurse leaders were described as being ethical and consciously respectful to others, this cluster of skills and traits were linked to the 'ways in which respect was enacted'.

Intriguingly, almost every resource on *relational nurse leadership* indicated that relational nurse leaders employed the skill of 'trust' with others (Balasco Cathcart, 2014; Dahinten et al., 2014; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Trust was argued as being crucial for the development and successful building of interpersonal "relationships with staff" (Thompson et al., 2011, p. 480), and was seen as a crucial component of the relational nurse leader's "authentic connection" with others (Balasco Cathcart, 2014, p.44). Alternatively, the creation of mutual trust between relational nurse leaders and staff was believed to ensure staff felt they had "greater control over work-related decisions" (Dahinten et al., 2014, p.18). Thus, because of the multiple ways in which relational leaders employed the skill of developing 'trust' with others, I decided to rename this skill as being the 'developer of trust' (see Table 1), but initially decided to leave it as a 'stand-alone' skill set.

Additionally, scholars within *relational nurse leadership* literature conveyed that relational nurse leaders were 'reflective' (Cummings et al., 2008; Wong, Cummings & Ducharme, 2013), and consciously 'self aware and aware of others' (Cummings et al.,

2008; MacPhee et al., 2014). These assertions were made through the notions of “situational” (Balasco Cathcart, 2014, p.44; Wong, Cummings & Ducharme, 2013) and “contextual” awareness (Wong, Cummings & Ducharme, 2013, p.721) that relational nurse leaders were said to embody.

Comparably, some scholars proposed that relational nurse leaders were also ‘considerate of others’ (Wong, Cummings & Ducharme, 2013). For example, Balasco Cathcart (2014) stated that relational “know-how is learned when the manager has the openness and humility” to listen to others. This skill required that leaders enhance their “focused attentiveness and recognition, and [create] an environment in which reflection on experience is deliberate” (p.45). Because of the connected nature of these concepts, the linking phrase, ‘the ways in which [relational leaders] are reflective’ was created to exemplify how these skills or abilities related with one another.

In addition, scholars of *relational nurse leadership* works expressed that relational nurse leaders were distinctive from other types of leaders because they were ‘caring’ (Cummings et al., 2008; Wong, Cummings & Ducharme, 2013), were ‘empathetic’ (Wong, Cummings & Ducharme, 2013) and ‘compassionate’ (Cummings et al., 2008). For instance, Cummings et al. (2008) studied relational nurse leaders of some oncology units who “provide[d] nurses with opportunities to reflect on the emotional stresses associated within oncology nursing” by creating open debriefing forums for staff. Nurses would partook in these sessions “reported that these rounds revitalized and reconnected the sense of compassion, caring, and emotional support that is so much the essence of oncology nursing practice”, and prevented them from succumbing to “high levels of emotional exhaustion” (p.516). Intentional caring strategies implemented by relational

nurse leaders to help address the health and well being of their staff, demonstrated how relational nurse leaders were indeed caring practitioners (Cummings et al., 2008). Thus, in considering this cluster of skills, traits, and abilities, I connected and linked these together to show the ‘ways in which caring is enacted’ by relational nurse leaders.

Furthermore, notions that relational nurse leaders were ‘authentic’ (Balasco Cathcart, 2014), ‘genuine’ (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013), ‘honest’ (Wong, Cummings & Ducharme, 2013), ‘transparent’ (Wong, Cummings & Ducharme, 2013), and ‘open’ (Balasco Cathcart, 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013) were considered and linked to reflect ‘the ways in which authenticity is enacted’. For instance, Wong, Cummings and Ducharme (2013) argued that relational nurse leaders employed “positive psychological capacities, honesty, and transparency, strong ethics and behavioral integrity” in their practice (p.719). Balasco Cathcart (2014) echoed these notions, and argued that relational nurse leaders did this through the “authentic connection” they carefully crafted with others (p.44). This author suggested that the building of such a connection led to enhanced “trust” between leader and staff that helped to “influence clinical nurses to do the arduous work that their roles require” (p.44).

Lastly, scholars of *relational nurse leadership* resources indicated that relational nurse leaders were ‘professionally accountable’ (Cummings et al., 2008), ‘competent’ (Dahinten et al., 2014), ‘self determined’ (Dahinten et al., 2014), ‘adaptable and flexible’ (MacPhee et al., 2014), ‘influential’ (Balasco Cathcart, 2014; MacPhee et al., 2014), and ‘knowledgeable’ (Wong, Cummings & Ducharme, 2013). For instance, Wong, Cummings and Ducharme (2013) posited that the skilled efforts of relational nurse leaders “to

provide vision, support, staffing...and leadership” demonstrated their unique professional competencies, “abilities, knowledge, [and] skills” that were believed to be “integral to the achievement of patient outcomes” (p.720). Moreover, MacPhee et al. (2014) argued that the relational nurse leaders’ ability to empower or motivate others in practice was a professional competency they employed to create positive workplace environments. Thus, these skills were intrinsically linked the ‘ways in which [relational nurse leaders] are professionally accountable’.

Secondary Analysis of Findings. After much consideration, it appeared that two of my nine hierarchal themes (‘collaborative’, ‘creative’, ‘empowerment’, ‘respectful’, ‘developer of trust’, ‘reflective’, ‘caring’, ‘authenticity’, and ‘professionally accountable’) could further be been paired or combined with other themes.

For instance, the theme ‘developer of trust’ could be linked to the ways in which relational nurse leaders are ‘collaborative’ in practice (see Table 2). Nurse scholars argued that staff only became actively involved in patient care decision making process when they felt completely trusted by their nurse leaders to do so (Balasco Cathcart, 2014; Dahinten et al., 2014; MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Thus, the notion that staff first needed to feel trusted by their leader in order to actively participate or collaborate with others seemed to align well with the theme of relational nurse leaders enacting ‘collaborative’ skills with others.

Additionally, the theme of relational nurse leaders being ‘reflective’ was considered as aligning well with the theme of ‘caring’ (see Table 2). For instance, Balasco Cathcart (2014) argued that relational nurse leaders must become more reflective and aware in their respective practices. She posited that relational nurse leaders were not only

reflective and consciously aware of their own past experiences, but were thoughtful and considerate of the past context and experiences of others during decision making processes. Hence, the need to develop the skill in becoming more ‘reflective’, being ‘aware of self and others’ and being ‘considerate of others’ was perceived as being reflective of the way in which leaders were ‘caring’ in their practice (see Table below).

Table 2

Secondary Analysis of main themes of relationship leadership discovered from Initial Analysis

Secondary Discovery of Main Themes	Which includes the skills, traits, abilities
Collaborative	Relationship Builder, Inclusive, Communicative, Developer of Trust
Creative	Innovative, Upstream Thinker
Empowerment	Motivational, Supportive, Encouraging, Inspiring
Respectful	Fair, Culturally Sensitive, Ethical & Moral, Non-Punitive & Non Manipulative, Attentive, Trustworthy
Caring	Empathetic, Compassionate, Reflective, Aware of Self & Others, Considerate of Others
Authenticity	Ingenuous & Genuine, Honest, Transparent, Open
Professionally Accountable	Competent, Self Determined, Adaptable & Flexible, Influential, Knowledgeable

Step Three. By this step, I was required to create my concept map by demonstrating the main topic of interest under exploration, identifying relating concepts or notions that were reflective of this main topic of interest, and deciphering ways in which to link related concepts together on my map. Thus, for this step, I created my first concept map that articulated ‘the proclaimed traits, skills and abilities of relational nurse leaders’ and their correlating concepts (see *Appendix D*).

For my first concept mapping attempt, I used the following *linking words* that were developed during *Part One Step Two* that included: ‘the ways in which leaders are

collaborative’, ‘the ways in which leaders are creative’, ‘the ways in which empowerment is enacted’, ‘the ways in which respect is enacted’, ‘the ways in which caring is enacted’, ‘ways in which authenticity is enacted’, and ‘the ways in which leaders are professionally accountable’. These *themed linking phrases* were utilized to help connect the seven and final emerging themes developed during my secondary analysis of the literature in *Part One Step Two*. I represented my *linking phrases* within long, broad arrows that pointed downward to the subsequent sub-themes and propositions that succeed these ideas (see *Appendix D*).

In addition to employing these *linking phrases*, I also developed *linking words* on my map of ‘which includes’ as a way to link the main topic phrase ‘proclaimed traits, skills and abilities of relational nurse leaders’ to my seven main themes (see *Appendix D*). These *linking words* allow readers to grasp how the seven main themes were indicative of the main core skill sets explicated by the scholars of the six *relational nurse leadership* resources explored in this MN project (see *Appendix D*).

Step Four. Next, I was asked to locate other meaningful ways to connect concepts proposed on one side of my map with others located elsewhere. Thus, I used black directional arrows as a way to demonstrate how the main topic phrase connected to my seven main themes by using black directional arrows (see *Appendix D*). For instance, two way directional arrows are depicted to illustrate how the subthemes or propositions of ‘communicative’, ‘inclusive’, and ‘relationship builder’ were consistent and reflective of the main theme of learning how to become more ‘collaborative’ (see *Appendix D*). Moreover, the use of two way arrows on this map exemplified how each of these

subsequent skills could be directly linked back to the main theme trait of being ‘collaborative’ (see *Appendix D*).

Finally, I created my first map to illustrate the skills, traits or abilities that reflected the order in which they were expressed and promoted by the scholars of the literature reviewed. As well, my hierarchy included how *I* perceived and categorized these influential skill sets through the development of my seven main themes (see Table 2). For example, under the theme of ‘creative’, the sub-theme of ‘innovative’ was noted as being stressed within five out of the six resources reviewed on *relational nurse leadership*. However, as the proposition of ‘upstream thinker’ was only depicted once within the six resources, it was presented last underneath the concept cluster of ‘creative’ (see *Appendix D*).

Step Five. Finally, for this last stage, I recognized that I would need to re-draw and re-consider my map, so that meaningful linkages, relationships, and connections could be better articulated and represented. Hence, I re-created a second concept map on *relational nurse leadership* that better illustrated how I perceived connections, relationships, and alignment between the various concepts presented on one side of the map to those proposed elsewhere (Novak & Gowin, 1984). Relationships and connections proposed between separates, or *cross linkages* were illustrated on my map through the means of short and long red arrows (see *Appendix E*).

For instance, the proposition of needing to become a ‘relationship builder’ (depicted under the concept cluster of ‘collaborative’) was related to the propositional concept of learning how to become more ‘considerate of others’, listed under the concept cluster of ‘caring’ (see *Appendix E*). The notion that relational nurse leaders need to learn

how become positive ‘relationship builder[s]’ who are also more ‘considerate of others’, was expressed by Wong, Cummings and Ducharme (2013), who argued that relational leaders “contribute[d] to positive practice settings and staff work engagement by providing support and encouragement...open and transparent communication...[through the] individual consideration” of others (p.720). Moreover, these scholars observed that the positive and empowering interpersonal working relationships leaders developed with their staff positively contributed the enhancement of patient outcomes. Thus, the pairing of the concept of ‘relationship builder’ with that of learning how to be more ‘considerate of others’ appeared to work well within this second representation of my concept map on relational nurse leadership.

Furthermore, the concept of ‘relationship builder’ was connected to the concepts of being more ‘supportive’, ‘encouraging’, and ‘inspiring’, which were subthemes listed under the concept cluster of ‘empowerment’ (see *Appendix E*). Balasco Cathcart (2014) argued that in order to become a ‘relationship builder’ leaders also needed to learn how become more encouraging and supportive of others and to “remain curious and open” to staffer’s contributions (p.45). Moreover, Wong, Cummings and Ducharme (2013) felt that relational nurse leaders who offered “vision”, “support”, and “encouragement” to their staffers did so by “creating opportunities for meaningful dialogue” with their staffers (p.720).

Another poignant *cross linkage* proposed between one set of concept clusters with another can be deciphered (see *Appendix E*) between the subtheme of ‘competent’ (located under the concept cluster of ‘professional accountability’) with the subtheme of ‘reflective’ (found under the concept cluster of ‘caring’). The belief that relational nurse

leaders foster the skill of being reflective in order to become professionally competent in their practice was noted throughout the literature (Balasco Cathcart, 2014; Cummings et al., 2008; Wong, Cummings & Ducharme, 2013). Moreover, the concept of being ‘competent’ was connected to the concept of being ‘ethical or moral’ (found under the concept cluster of being ‘respectful’), that was also related to the concept of being ‘reflective’. Balasco Cathcart (2014) stressed that positive changes in the workplace required relational nurse leaders to increase their “focused attentiveness and recognition [of others]” through the promotion of “reflection on experience” (p.45). This scholar believed that intentional reflective practices allowed relational leaders to carefully consider the context, the opinions, and insights of others before making bedside care decisions on their units. Moreover, this scholar promoted that such decisions be mutually co-created, and should not be something the leader did alone.

Overall, a total of thirty-six *cross linkages* were developed and represented within long and short red arrows depicted on the second concept map created on *relational nurse leadership* (see *Appendix E*). It must also be noted that additional *cross linkages* could have been made within this map, as Novak and Gowin (1984) claim that concept maps are never truly completed because relationships between concepts can always be re-considered and re-configured, again and again.

Part Two: Team Building Tools/Strategies Concept Mapping Process

Step One. As with *Part One of Phase One* of this project, I also needed to identify the main area of interest I was exploring in my second concept map on *team building*, and to articulate the key ideas and notions associated with this second main concern. Hence, the main interest or guiding phrase used on my second concept map was

‘the skills, traits, and abilities promoted within the *team building tools and strategies*’ reviewed. This main phrase allowed me to decipher the skills, traits and capacities that the scholars of the *team building tools and strategies* promoted for cohesive and collaborative bedside team practice.

Additionally, for this step, I was once again required to return to the literature and re-examine the five *team building* resources I had previously explored to detect all of the explicated skills and abilities declared by the scholars of these works and depict these on a second map.

While previously trying to locate meaningful and relevant resources on *team building tools and strategies*, I recognized that many team building tools were not specifically promoted for use of bedside care teams. For instance, a great deal of the team building literature explored the need to enhance and promote inter-disciplinary healthcare team dynamics such as provision of communication strategies that nurses can use with physicians (Flicek, 2012). As the goal for this MN project was to locate meaningful methods to help enhance collaboration and sustain cohesiveness within *bedside* healthcare teams, I decided to use the following five resources by Andreatta (2010), Chinn (2013), Howe (2014), Johnson et al. (2011), and Marshall and Manus (2007), because these were specific strategies that any type of care provider could easily integrate and employ to promote respectful, communicative, and collaborative bedside practice.

After a thorough examination of these five literary resources, I was able to identify and define thirty-five main skills, traits, and abilities that the scholars of these *team building tools and strategies* proclaimed as being the most essential for the enhancement of cohesive, communicative, and collaborative bedside care practice (see

Appendix G). These endorsement of these skill sets in the literature was then used to help me decipher the hierarchy or level of themed skill sets that would be depicted at the highest level of skill sets on the map. For instance, the most declared or the most stressed skill sets were considered as the traits that were positioned at the top of my map and the least declared skills or abilities were the ones positioned *underneath* the most promoted skill sets (see *Appendix H*).

Step Two. For this second step, I located diverse ways in which to connect or relate concepts together with others, through the use of *linking words* or *phrases* (Novak & Gowin, 1984). During my *Part Two: Step One* analysis of the literature, I was able to decipher the most professed thirty-five *team building* skills, traits and abilities promoted by the various authors of this field (see *Appendix G*). However, like with *Part One: Step Two*, I also recognized that many of these discovered traits and abilities appeared to be very similar others, and thus, could be further connected so that newer main themes could emerge (see Table 3).

Initial Analysis of Part Two Findings. Upon identifying thirty-five skills or traits promoted by the scholars of five *team building* resources examined for this project (see *Appendix G*), I noted that many of these could be linked or combined to form the following seven hierarchal main *themes* or concept clusters: ‘awareness of self/others’, ‘communicative’, ‘dedicated and committed to the cause’, ‘supportive’, ‘assertive’, ‘competent’, and ‘respectful’ (see Table 3). These seven main themes were considered by reflecting upon on the most promoted skills and traits noted within the five literature resources reviewed on *team building* for this project (see *Appendix F*).

Table 3

Initial Analysis to discover themes from the team building resources explored

Initial Discovery of Main Themes	Which includes the skills, traits, abilities
Awareness of Self & Others	Conscientious, Open, Honouring & Valuing of Others, Intuitive
Communicative	Attentive, Receptive, Interactive, Cooperative, Forth Coming & Sharing of Info
Dedicated & Committed to the Cause	Ethical & Moral, Accountable, Responsible, Reliable
Supportive	Empowering, Motivational, Capacity Builder, Relationship Builder, Appreciative,
Assertive	
Competent	Autonomous, Adaptable, Critical Thinker & Problem Solver
Respectful	Trust, Collaborative, Non-manipulative & Non Controlling, Honest, Reverent, Democratic, Inclusive

For example, I realized that several key skills seemed to revolve around the notion of ‘awareness of self and others’ (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). Howe (2014) argued that the *TeamTalk* team building initiative highlighted the need for “heightened awareness” by healthcare aides and their peers, so that these bedside providers would be able to grasp how “challenging issues or concerns” at the bedside impact the provision of quality care (p.135). Andreatta (2010) termed this learned skill as being “situational awareness” and claimed as something that all care providers needed to learn so that teammates would become more open and aware of each other’s respective roles, views, knowledge, and unique contributions to care (p.346). Moreover, this skill was essential in ensuring that care was coordinated more seamlessly and efficiently, as duplication in roles or tasks at the bedside would be minimized.

Thus, while deciding if other skills also aligned or reflected the skill of ‘awareness of self and others’ (see Table 3), I recognized how becoming more

‘conscientious’ (Chinn, 2013), ‘open’ (Andreatta, 2010; Chinn, 2013; Johnson et al., 2011; Marshall & Manus, 2007), learning the benefits of ‘honoring and valuing or others’ (Chinn, 2013), and learning how to employ ‘intuitive’ skills for practice (Chinn, 2013), could all be linked to reflect ‘the ways in which awareness of self and others are enacted’ (see *Appendix H*).

Moreover, while exploring how the skill of becoming more ‘communicative’ with others (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007) related to others, I noted how the skills of becoming more ‘attentive’ (Andreatta, 2010; Chinn, 2013; Howe, 2014; Marshall & Manus, 2007), ‘receptive’ (Marshall & Manus, 2007), ‘interactive’ (Chinn, 2013), ‘cooperative’ (Chinn, 2013), and more ‘forth coming and sharing of info’ (Andreatta, 2010; Chinn, 2013; Howe, 2014; Marshall & Manus, 2007) could be easily related to one another to reflect ‘the ways in which one learns how to become more communicative’ with others (see *Appendix H*).

For example, Chinn (2013) stated that learning to become more attentive by honing and cultivating one’s own active listening skills, ensured that peers knew how to “liste[n] inwardly to [one’s] own senses as well as listening intently and actively to others” (p.11). Howe (2014) argued that when healthcare aides became more communicative after gaining attentive listening skills from the *TeamTalk* team building initiative, these providers expressed that they “felt...nurses listened to them more attentively when they reported problems to them” (p.135). More importantly, care aides recognized that these skills allowed them become more open and forth coming of their own knowledge, views, and insights with others. Thus, Howe (2014) believed these skills

were vital for enhancing team mates' respect for one another, and for promoting team collaboration and cohesiveness.

Next, I also noted many skills and traits around the need to become more 'ethical and moral' (Marshall & Manus, 2007), 'accountable' (Johnson et al., 2011), 'responsible' (Chinn, 2013), 'reliable' (Andreatta, 2010), and more 'dedicated and committed to the cause' at hand (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). For instance, Johnson et al. (2011) described how the *TeamSTEPPS* team building program allowed teammates to recognize their own interdependence from the team, but their "individual accountability" (p.186) to one another and to the team's main goals. As well, skills endorsed in this program for greater team collaboration required that a team leader coordinate "team huddle[s]" at various points throughout the day (p.188). These frequent gatherings demonstrated how team leaders "were responsible for presenting key information identified during [the] team huddle" to their peers, so that all team members were aware of the issues or concerns of the day, and were granted the opportunity to discuss possible strategies for resolving these concerns together, as a unified group (p.188).

Alternatively, Marshall and Manus (2007) saw the need for team members to recognize their own moral duty in preventing significant "medical errors" at the bedside in order to realize how the *Safer Healthcare* program sustained that bedside care teams elect patient safety as their team's top priority (p.994). Thus, while considering how all of these skills were intrinsically connected, I noted how they were reflective of the 'ways in which one is dedicated and committed to the cause' or goal of the team.

Like with *relational nurse leadership* skills and traits, scholars of *team building tools* and *strategies* similarly endorsed ‘supportive’ skills and abilities to teammates to employ with one another in practice (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). Indeed, learning how to become more ‘empowering’ (Chinn, 2013; Johnson et al., 2011), ‘motivational’ (Johnson et al., 2011), or learning how to become a ‘capacity builder’ (Andreatta, 2010; Chinn, 2013), or a ‘relationship builder’ (Chinn, 2013; Johnson et al., 2011; Marshall & Manus, 2007), and learning how to become more ‘appreciative’ (Chinn, 2013) were abilities declared within the literature. For instance, Andreatta (2010) detailed how the *TeamSTEPPS* program allowed teammates to “coordinate task work based on shared knowledge of each other’s capabilities and strengths” (p.351). Because “mutual support” was a foundational capacity promoted within the program, Andreatta (2010, p. 352) felt that the development of mutual support within care teams would foster and empower care providers during “intrateam [*sic*] conflicts” (p.352). She saw supportive skill sets as necessary for empowering diverse care providers to work out their differences and “build interpersonal relationships” with one another, even during challenging times (p.351). Hence, while trying to connect all these positive, empowering, and motivational skills together, I was able to see how they were the ‘ways in which one is supportive’ with one’s teammates.

Furthermore, the skill of becoming more ‘assertive’ was considered and was left as a stand-alone theme (see Table 3). For instance, Howe (2014) believed that the ability in becoming more ‘assertive’ at the bedside allowed healthcare aides to “gai[n] confidence in speaking with the team and recognizing the value of their [own] input in how the team functions” (p.135). Because the concept of ‘assertiveness’ may be argued as

a skill that is employed to purposely control or influence another person's actions or behaviors, I carefully reflected upon this skill and decided to leave it as a stand-alone theme.

As well, the trait or ability in becoming more 'adaptable' (Johnson et al., 2011), 'competent' (Andreatta, 2010; Howe, 2014), or learning how to become a 'critical thinker and problem solver' (Johnson et al., 2011; Marshall & Manus, 2007) were all identified within the literature. For example, Andreatta (2010) stated that team building programs were tailored to ensure team "members are competent in performing individual task work" and "team-based competencies such as situation awareness, knowledge of roles and responsibilities, and strategies for communication and collaboration". She felt that the *TeamSTEPPS* team building workshop for instance, would ensure that teammates gained skillful professional competencies needed so that care providers would be able to mutually work together for a common goal. Thus, these competencies and related skills and abilities were linked to form 'the ways in which one is [professionally] competent' within the team (see *Appendix H*).

Lastly, the notion of being 'respectful' with others seemed to be heavily promoted within the literature on *team building*. Traits like how to build 'trust' with others (Andreatta, 2010; Chinn, 2013; Marshall & Manus, 2007); how to be 'collaborative' (Andreatta, 2010; Chinn, 2013; Johnson et al., 2011); 'non manipulative and non controlling' (Chinn, 2013; Howe, 2014; Marshall & Manus, 2007); 'honest' (Chinn, 2013); 'reverent' (Chinn, 2013), democratic' (Chinn, 2013; Howe, 2014; Marshall & Manus, 2007), and 'inclusive' (Chinn, 2013; Johnson et al., 2011) were all considered as relating to one another. For example, Marshall and Manus (2007) proclaimed that their

Safer Healthcare team building program allowed care workers to “establish an atmosphere of mutual trust and respect” with one another (p.1001). Similarly, Andreatta (2010) argued that the team building tool *TeamSTEPPS* exemplified and endorsed positive, interpersonal, “constructive team behaviors” that teammates employed as a way to build trust and respect to make the team more unified and cohesive (p.351). Thus, this cluster of core skills and abilities was linked to reflect ‘the ways in which one must learn how to become more respectful’ of his or her teammates and peers (see *Appendix H*).

Secondary Analysis of Part Two Findings. Upon examining the seven core themes or concept clusters created during *Part Two*, I re-considered themes to see if I could make further connections within them. For instance, as I decided to move and link the skill of becoming ‘adaptable’ with that of being ‘accountable’, ‘responsible’, ‘reliable’ and ‘competent’ (see Table 4), as I felt these linkages reflected ‘the ways in which one is competent’ in practice.

Moreover, I also decided to move the stand-alone theme of being ‘assertive’ with that of being more ‘communicative’ with others (see Table 4). It seemed to me that becoming more assertive as Howe (2014) described it, ensured that care providers learned how to become open, vocal, and more communicative with their peers. Thus, I thought this combination appropriately reflected ‘the way in which one learns how to become more communicative’.

Additionally, I considered the skill of ‘dedicated and committed to the cause’ as being reflective of how one is professionally ‘competent’ (see Table 4). Marshall and Manus (2007) argued that a care team member’s ethical obligation surrounded the need to uphold patient safety at the bedside. Thus, this goal reflected their commitment to their

patients and exemplified their dedication in being professionally competent in sustaining quality patient care at the bedside. Hence, the skill of ‘dedicated and committed to the cause’ was considered as being a core component of one’s professional competencies, and was linked to the main theme of ‘competent’ (see Table 4).

Table 4

Secondary analysis of themes derived from the team building literature

Secondary Analysis of Main Themes	Which includes the skills, traits, abilities
Awareness of Self & Others	Conscientious, Open, Honouring & Valuing of Others, Intuitive
Communicative	Attentive, Receptive, Interactive, Cooperative, Forth Coming & Sharing of Info, Critical Thinker & Problem Solver, Assertive
Supportive	Empowering, Motivational, Capacity builder, Relationship Builder, Appreciative
Competent	Ethical & Moral, Accountable, Responsible, Reliable, Dedicated & Committed to the Cause, Adaptable
Respectful	Trustworthy, Collaborative, Non Manipulative & Non Controlling, Honest, Reverent, Democratic, Inclusive

Therefore, after much careful consideration and deliberation during this secondary analysis phase, I was able to re-create and articulate five main themes that would then become the hierarchy of skill sets I would employ during the construction of my *team building* concept map. These five main hierarchal themes or concept clusters included: ‘awareness of self and others’, ‘communicative’, ‘supportive’, ‘competent’, and ‘respectful’ (see Table 4).

Step Three. For this step, I constructed second concept map based on a clearly defined topic of interest, and displayed concepts that related to this main topic of interest, within the map (Novak & Gowin, 1984). Hence, in *Appendix H*, I created my first concept map on *team building tools and strategies* by enlisting the following main phrase

‘the skills, traits, and abilities promoted within the team building tools and strategies’. I then used five *linking phrases* discovered during my literature analysis work and illustrated these within long broad arrows that appear to stem down from my main topic phrase (see *Appendix H*). The five *linking phrases* were also indicative of the five concept clusters that categorized the skills and traits declared by scholars of the five *team building* resources examined. The five *linking phrases* were: ‘the ways in which awareness of self and others are enacted’, ‘the ways in which one learns how to become more communicative’, ‘the ways in which one is supportive’, ‘the ways in which one is competent’, and ‘the ways in which one must learn to become more respectful’ (see *Appendix H*).

Furthermore, I established the following *linking words*, ‘which includes’ as a way to connect my main topic phrase to my five linking phrases or concept clusters (see *Appendix H*). Similar to my *relational nurse leadership* map, the use of ‘which includes’ allowed readers to grasp how I perceived that these five main themes represented the most explicated skills, traits and abilities noted within the literature reviewed on *team building tools and strategies* in this MN project (see *Appendix H*).

Step Four. Next, I visually identified how I connected, aligned, or linked concepts to others on the map (Novak & Gowin, 1984), the through the use of shorter black directional arrows illustrated between the various themes, subthemes and propositions presented on my map. For instance, under the main phrase ‘the skill, traits and abilities promoted within the team building tools and strategies’, I used black, one way arrows to indicate the directional relationship perceived between the main topic of interest to the five main concept cluster themes (see *Appendix H*).

Additionally, under the main concept cluster of ‘supportive’, subthemes and propositions proposed underneath illustrated their inherent relationship with the main theme, through use of two way arrows (see *Appendix H*). Thus, the sub theme of ‘capacity builder’ was proposed as being directly related to the sub theme of ‘empowering’, which could also be conceived as being directly related to the main theme of ‘supportive’ (see *Appendix H*).

Like with my *relational nurse leadership* concept map (see *Appendix D*), the careful articulation of the established hierarchy of skills or traits shown within my *team building* concept map was reflective of how these were expressed by scholars of the literature, *as well as* indicating how *I* perceived these skills were indicative of the five main themes discovered during my secondary analysis work (see Table 4). For example, under the first main theme of ‘awareness of self and others’, the following sub themes or propositions of ‘open’, ‘honoring and valuing of others’, ‘intuitive’, and ‘conscientious’ were depicted within an intentional hierarchal format determined by examining which skill sets were most to least declared within the literature (see *Appendix F*). So, in the case of the skill of becoming ‘open’ (considered as being important for the successful achievement of ‘awareness of self and others’), it was noted that this ability was repeatedly proclaimed within four of the five *team building* resources reviewed (see *Appendix F*). Thus, it was listed first under the main theme of ‘awareness of self and others’, while subsequent subthemes or propositions like ‘honoring and valuing of others’, ‘intuitive’, and ‘conscientious’ were listed in the order in which they were promoted within the *team building* resources (see *Appendices F & H*).

Step Five. Finally, I was required to re-create and re-consider my *team building* concept map so that inter-relationships between concepts were clearly identified between separate concepts proposed on this second map (Novak & Gowin, 1984). Thus, for this step I not only re-drew my map, but used long and short red arrows to indicate the *cross linkages* or conceptual relationships and connections I made between separate concepts (Novak & Gowin, 1984). In doing this, I was able to establish a total of twenty nine *cross linkages* that outwardly indicate to readers how I saw some categories of skills as being inherently related to others (see *Appendix I*).

For instance, one *cross linkage* proposed on the map (see *Appendix I*) demonstrated that I perceived a connection between the skill of ‘honoring and valuing of others’ (found underneath the concept cluster of ‘awareness of self and others), with that of learning how to become more ‘attentive’ (found underneath the concept cluster of ‘communicative’). Additionally, I noted that ‘honoring and valuing of others’ was related to the concept of learning how to become more ‘appreciative’, located under the concept cluster of ‘supportive’ (see *Appendix I*). Moreover, I recognized how ‘honoring and valuing of others’ was connected to the concept of ‘inclusive’, found under the main concept cluster of ‘respectful’ (see *Appendix I*). Each of these relationships were made by considering assertions made by both Johnson et al. (2011), Howe (2014), and Marshall and Manus (2007), who each stressed that in order for care providers to work more cohesively at the bedside, they must first learn how to honor and value one another. In doing this, the scholars believed that teammates would also learn how to become open and attentive with one another and thus, recognize the value inherent to another’s views and insights on patient care (Chinn, 2013; Howe, 2014; Marshall & Manus, 2007).

Moreover, as allowing others to speak and be heard was perceived as being reflective of ‘honoring and valuing of others’, it was also conceived as leading to the full appreciation of others. Howe (2014) and Marshall and Manus (2007) each contended that if care providers were not appreciative of other’s unique contributions, observations, and knowledge, then these would be lost. Both authors expressed that if a care provider’s views were not heard or appreciated-patient care would indeed be compromised.

However, the discovery and articulation of these skill sets within both my concept maps on *relational nurse leadership* and *team building* still needed to be carefully considered in order to uncover the alignment between them. I will now present how alignment between my two concept maps was discovered in the following sections.

Phase Two: Applying the Theory of the Relational Work of Nurses to help Uncover Alignment

Outline of Phase Two

Like with my first phase of this concept mapping development process, I chose to partition the second phase of my MN project into two distinctive parts: Part One and Part Two. For the first part of *Phase Two*, I enlisted Terrizzi DeFrino’s (2009) *theory of the relational work of nurses* as an analytical method in which to consider and interpret alignment between the identified skills, traits and abilities depicted within my two concept maps. Specifically, I used this theory to help me consider how skill sets were similar or consistent with one another, and more importantly, how aligning skill sets reflected the three main theoretical assumptions proclaimed within *the theory of the relational work of nurses* by Terrizzi DeFrino (2009).

As previously discussed, Terrizzi DeFrino's (2009) three main theoretical assumptions explicated how nurses and their bedside colleagues relationally fostered a "network of connection and support" with one another (pp.298-299); how they endorsed each other's roles and scopes, and promoted that "interdependence" be "not a deficient state" (p.299); and lastly, how they empowered each other at the bedside and became "professionally and clinically powerful to be reliant on one another" (p.299).

Yet, in order to consider how all the declared skills, traits, and abilities on my two maps aligned with one another *and* reflected these three main assumptions, I decided to further compartmentalize *Part One of Phase Two* into two workable portions: an initial thematic analysis and a secondary thematic analysis. I shall outline how I uncovered alignment between my two concept maps, in the following sections.

Part One: Application of DeFrino's (2009) theory to Illuminate Alignment

Initial Theoretical Interpretation of my Two Concept Maps. Terrizzo

DeFrino's (2009) first theoretical assertion surrounded the idea that nurses and their co-workers co-create "a network of connection and support" with one another at the bedside (pp.298-299). This underlying notion was indeed noted within many of the themes, sub themes, and propositions proposed within the concept map on *relational nurse leadership*, as it was on the concept map on *team building*.

For example, several of skills and traits depicted within the *relational nurse leadership* concept map outlined the need for relational nurse leaders to learn how to become 'supportive', 'collaborative', 'communicative', 'inclusive', 'open', 'attentive', 'motivational', 'encouraging', 'inspiring', as well as becoming a 'relationship builder' (see *Appendix G*). Terrizzi DeFrino (2009) stated that the "nurse facilitates connections

with...health care team members” and “supplies relational skills when working with” their peers at the bedside. For instance, within all of the *relational nurse leadership* literature reviewed, these type of nurse leaders were endorsed as being able to interpersonally connect and support with their staff (Balasco Cathcart, 2014; Cummings et al., 2008; Dahinten et al., MacPhee et al., 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Wong, Cummings and Ducharme (2013) argued that relational nurse leaders intentionally “provid[ed] support and encouragement” to their staffers (p.720), while Dahinten et al. (2014) detailed how “the quality of leader-staff relationships” was found to be related to these leaders’ skillful abilities in being supportive, present, and connected to their frontline staff (p.17).

Indeed, many supportive relational nurse leadership skills were noted and exemplified within the literature, such as ‘supportive’, ‘collaborative’, ‘communicative’, ‘inclusive’, a ‘relationship builder’, ‘motivational’, ‘encouraging’, ‘inspiring’, ‘open’, and attentive’ (see Table 5). For example, skills or traits of learning how to become more ‘open’ and ‘attentive’ were seen to as being related to the enhancement of supportive and connected interpersonal working relationships between nurse leaders and their staff. Scholars within the literature resources on *relational nurse leadership* described that these skill sets allowed relational nurse leaders to become more accepting and nonjudgmental in their communication strategies with others (Wong, Cummings & Ducharme, 2013), or allowed them to become more active and attentive listeners (Balasco Cathcart, 2014).

Balasco Cathcart (2014) argued that in order to “do relational work” leaders needed “to be engaged in the particular situation in an open and attentive way” (p.44).

Wong, Cummings and Ducharme (2013) stated that in order for relational nurse leaders to create “positive practice settings” they must offer “support and encouragement, positive and constructive feedback, open and transparent communication and individual consideration” to their frontline staff (p.720).

However, as the reflection of this first theoretical assumption was indeed distinguished within the concept map on *relational nurse leadership*, it still needed to be considered for my second concept map on *team building tools and strategies*. For example, scholars of all five *team building* resources reviewed exemplified how teammates needed to learn how to develop meaningful interpersonal working skills and relationships with their peers (Andreatta, 2010; Chinn, 2013; Howe, 2014; Johnson et al., 2011; Marshall & Manus, 2007). Indeed, several key themes, subthemes and propositions such as the ‘honoring and valuing of others’, the need to become more ‘collaborative’, ‘communicative’, ‘open’, ‘conscientious’, ‘attentive’, ‘motivational’, ‘supportive’, ‘interactive’, ‘cooperative’ and ‘inclusive’, as well as needing to learn how to become a ‘relationship builder’ (see *Appendix I*) were considered as being essential supportive skills or traits needed for the development of supportive interpersonal working relationships between teammates.

For example, Chinn (2013) detailed in her *peace and power* team building tool that teammates must learn to “support one another in a constructive way, and...consistently treat one another respectfully” (p.86). Moreover, it appeared that the skill of becoming more ‘open’ and ‘attentive’ were also described in my *team building* map as they were within my *relational nurse leadership* map, that were also represented of how one learns to become more communicative with others. For instance, Andreatta

(2010) argued that teammates become more effective, productive, communicative, and collaborative once they learned how to positively develop and cultivate “interpersonal dynamics that impact team effectiveness through direct or indirect interactions with each other” (p.346). This scholar concluded that the *TeamSTEPPS* team building tool was vital in ensuring that teammates gained key skills to learning how to become more open, communicative, and attentive with others so that they could “build interpersonal relationships” with their co workers.

Intriguingly, I discovered that the following skill sets of becoming more ‘supportive’, ‘communicative’, ‘collaborative’, ‘open’, ‘inclusive’, ‘attentive’, ‘motivational’, and being a ‘relationship builder’ were all skills or traits that were promoted within my *relational nurse leadership* map (see *Appendix E*) as well as in my *team building* map (see *Appendix I*). And so, as these supportive skill sets reflected Terrizzi DeFrino’s (2009) first theoretical assertion, they were discovered as being aligning skill sets because they poignantly demonstrated how teammates and relational nurse leaders developed supportive interpersonal work connections with others (see Table 5 below).

The second assertion proposed by Terrizzi DeFrino (2009) was “that interdependence between the nurse and others in the workplace [be] something to strive for” (p.299). Terrizzo DeFrino (2009) suggested that nurses put their trust and faith in their peers and that they never consciously try to control or manipulate their peers in order to achieve a desired goal. Thus, while examining my two concept maps, I recognized that this second theoretical assumption was indeed exemplified within several of the proposed themes, sub themes, and propositions displayed on both of my maps.

For instance, in exploring my map on *relational nurse leadership* I noted that scholars in this area proclaimed that nurse leaders were more successful because they were more ‘ethical and moral’, ‘non manipulative and non controlling’; were ‘developer[s] of trust’; were ‘culturally sensitive’, ‘knowledgeable’, ‘fair’, ‘respectful’, ‘competent’, and ‘self determined’. These skills and traits were considered as being essential capacities needed by relational nurse leaders to promote the interdependence of their staffers.

For example, Cummings et al. (2008) outlined that relational nurse leaders honored and promoted their staffers’ professional mandates and roles at the bedside. These scholars noted how relational nurse leaders invited and encouraged staff to participate in patient and “policy decisions” (p.512), while Balasco Cathcart (2014) urged that relational nurse leaders value the staffers’ ideas and insights and embed these into care decision making processes. Alternatively, Thompson et al. (2011) saw the promotional efforts by relational nurse leaders to honor their staffers’ roles as crucial for the enactment of “point-of-care problem solving” and for the enhancement of patient safety (p.485).

Additionally, I examined the *relational nurse leadership* skill sets or themes of ‘awareness of self and others’, being ‘reflective’, and being more ‘considerate of others’ and decided that these skills additionally aligned with Terrizzi DeFrino’s (2009) second theoretical assumption. For instance, Terrizzi DeFrino (2009) posited that the ‘nurse reflects on [his/her] own behavior in order to work with others effectively” and employs reflective practices “as a source of data to understand and anticipate reactions and consequences to care” (p.300). Thus, the need for nurses to not only reflect upon their

own actions, but to do so within the context and consideration of others' knowledge, insights or observations, was considered as being a necessary skill needed for the promotion and enhancement of staffer's interdependent and professional roles at the bedside (see Table 5).

Similar notions to promote the interdependence of one's peers were also identified within several of the themes, subthemes, and propositions expressed within the concept map on *team building tools and strategies*. For instance, scholars of *team building* resources reviewed endorsed the need for teammates to cultivate and promote the interdependence of their colleagues' roles and scopes at the bedside. The following skill sets of learning how to become more 'forth coming and sharing of info', 'dedicated and committed to the cause', 'assertive'; 'ethical and moral', 'responsible', 'non manipulative and non controlling', 'adaptable', 'respectful', 'awareness of self and others', and 'trustworthy' were noted as skill sets that were deemed as promoting the interdependence of one's teammates (see Table 5).

For example, Marshall and Manus (2007) asserted that the *Safer Healthcare* program was a tool used to trained frontline care staff in "team building and communication" that allowed them "to establish an atmosphere of mutual trust and respect" (p.1001). Indeed, the *Safer Healthcare* program was proclaimed as an effective *team building* tool for training bedside staff, because it stressed that peers respect and value each other's voices, contributions, and roles at the bedside. Moreover, Marshall and Manus (2007) claimed that when all teammates recognized their ethical obligation in sharing their unique views and observations with others, they would contribute to the achievement of safer patient care initiatives at the bedside.

Furthermore, I noted how the *team building* skill of learning how to cultivate ‘awareness of self and others’ and becoming ‘appreciative’ of others are both connected to the second theoretical assertion proclaimed by Terrizzi DeFrino (2009). For example, Howe (2014) and Marshall and Manus (2007) each noted that awareness of others resulted in the inclusion of others into decision making processes at the bedside. These scholars felt that disallowing certain care providers in becoming actively involved in care decision making would result in negative patient outcomes. Hence, they promoted that diverse care providers learn how to become more consciously aware and appreciative of their bedside peers, as doing so was crucial for the sustainment of higher quality care.

Therefore, many interdependent or role promoting *team building* and *relational nurse leadership* skills and traits were identified between both of my concept maps. Indeed, many of these skills aligned with one another (see Table 5 below), including the notion of ‘trustworthiness’ or the ‘developer of trust’; being ‘non manipulative and non controlling’; being ‘respectful’, ‘ethical and moral’, and being more ‘aware of self and others’ (see Table 5).

Finally, the last theoretical assertion proclaimed by Terrizzi DeFrino (2009) was for nurses to become more empowering of their peers and be “professionally and clinically powerful...[and] reliant on one another” (p.299). Terrizzi DeFrino (2009) argued that “[v]aluable work outcomes include what the nurse achieves alone but also what the nurse enables those [she/he]...works with to achieve” (p.299). Hence, this last theoretical assertion was considered in a twofold fashion: how the nurse values reliance with and among his or her peers for the achievement of bedside care goals, and how he or

she empowers or and motivates others in order to achieve these goals (see Table 5 below).

While considering how both of my concept maps related and reflected Terrizzi DeFrino's (2009) third and final theoretical assumption, I realized that several of the themes, sub themes, and propositions proposed within my *relational nurse leadership* and *team building* maps promoted these two assertions. For example, within the concept map on *relational nurse leadership*, I noted how scholars in this area suggested that relational nurse leaders were empowering ('empowerment') of their staff and were more 'creative', 'innovative', 'reflective', 'professionally accountable', and 'caring' (see Table 5).

Balasco Cathcart (2014) asserted that relational nurse leaders "teach and coach staff members to practice in a better way" and that they accomplish this by "build[ing] on their [staffers'] individual and collective strengths" (p.46). Moreover, this scholar insisted that relational nurse leaders actively empower and invite staff to contribute to unit based decision making processes and that these leaders do not see the crafting of such decisions as being the sole requirement of the leader to execute alone.

Comparably, MacPhee et al. (2014) stated that relational nurse leaders were "associated with more innovative behaviors and creative engagement among staff" because they had "the capacity to inspire others" (p.5). These scholars noted how some of the influential traits of relational leaders seemed to relate to their capacity to inspire and empower others.

Moreover, the literature on *relational nurse leadership* indicated that these types of nurse leaders were reliant on their staff, but were also accountable to them. For instance, Cummings et al. (2008) discussed that relational nurse leaders were "visible"

leaders who “consult[ed] with [their] staff” and embedded their “innovative ideas” into patient care decision making processes (p.512). Moreover, these scholars suggested that relational nurse leaders recognized when staff needed their assistance to deal with difficult care situations through the provision of staff “opportunities to reflect on the emotional stress associated” with their bedside duties (p.516). Reflective debriefing activities provided by nurse leaders were endorsed as essential strategies for the prevention of “emotional exhaustion” among frontline care staff (p.516). Thus, these scholars exemplified how relational nurse leaders’ reliance and reciprocal working relationships with staff aided not only their own leader practice, but assisted the practice of their staff as well.

Thus, the skill of ‘professional accountability’ which was depicted within my *relational nurse leadership* concept map, was perceived as being reflective of how nurses recognize that they are “reliant on one another” at the bedside (Terrizzi DeFrino, 2009, p.299). Therefore, the dual notion proposed by Terrizzi DeFrino (2009) that nurses and their peers not only rely on but are accountable to one another, and that they also empower and motivate each other at the bedside, were noted within my map on *relational nurse leadership* (see Table 5 below).

Additionally, similar skill sets were also identified within my *team building tools* and *strategies* concept map. For instance, the skill of being more ‘accountable’, ‘reliable’ and ‘responsible’ were proposed on my concept map and were considered as being reflective of Terrizzi DeFrino’s third theoretical assertion that nurses are indeed “reliant on one another” (p.299). For example, Andreatta (2010) suggested that the *TeamSTEPPS* team building workshop would highlight and instruct teammates in the following skill

sets “competence, cooperativeness, reliability, communicativeness and interpersonal skills” (p. 346). This scholar argued that teammates needed to recognize their own professional obligation for “team membership and associated role behaviors in the provision of patient care” (p.346), so that they recognized their role within the team to achieve their team’s goals.

Johnson et al. (2011) also believed that teammates who partook in the *TeamSTEPPS* workshop would gain a better understanding of learning how to become reliant on their peers to become accountable and responsible to them, and to the entire team. Thus, these particular *team building* skill sets were considered as being reflective of Terrizzi DeFrino’s (2009) third assumption, that nurses and their peers become “professionally and clinically....reliant on one another” (p.299).

While uncovering how the empowerment piece within Terrizzi DeFrino’s (2009) third theoretical assumption was reflected within my concept map on *team building*, I noted that following skill sets of becoming more ‘intuitive’, ‘appreciative’, ‘empowering’, and enhancing one’s ‘awareness of self and others’ aligned well with this third theoretical assertion. For example, Chinn (2013) claimed that her *peace and power* team building initiative endorsed the skill of “empowerment” as a “growth of personal strength, power, and ability to enact one’s own will and love for self in the context of love and respect of others” (p.11). She asserted that empowerment of one’s teammates included the need to cultivate the skill of listening fully to oneself *and* others, and to role model this conscious awareness so that others could do the same. Thus, the second portion of Terrizzi DeFrino’s (2009) third assumption that nurses empower their coworkers at the bedside, was indeed articulated within the concept map on *team*

building, as it was on *relational nurse leadership* (see Table 5 below). The aligning skill sets noted between the two maps were that of being ‘professionally accountable’ or ‘accountable’, and being ‘empowering’ or ‘empowerment’ (see Table 5).

Table 5

Theoretical comparisons made by looking at my concept map findings derived from the literature on relational nurse leadership and team building with that of Terrizzi DeFrino’s (2009) three assumptions regarding the relational work of nurses and their co-workers.

Theoretical Assertions made by Terrizzi DeFrino (2009) in her theory on the relational work of nurses and their peers	Related themes, sub-themes, propositions noted on the Relational Nurse Leadership Concept Map (see <i>Appendix H</i>)	Related themes, sub-themes, propositions noted on the Team building Concept Map (see <i>Appendix I</i>)
1. Fostering a “network of connection and support” (pp.298-299)	Supportive, Collaborative, Communicative, Inclusive, Relationship Builder, Motivational, Encouraging, Inspiring, Open, Attentive	Supportive, Collaborative, Communicative, Open, Honouring & Valuing of Others, Conscientious, Attentive, Relationship Builder, Motivational, Interactive, Cooperative, Inclusive
2. “Interdependence is not a deficient state” (p.299).	Developer of Trust, Non-Manipulative & Non Controlling, Culturally Sensitive, Fair, Competent, Self Determined, Respectful, Ethical & Moral, Knowledgeable, Aware of Self & Others, Reflective, Considerate of Others	Forth Coming & Sharing of Info, Assertive, Dedicated & Committed to the Cause, Ethical/Moral, Non Manipulative & Non Controlling, Adaptable, Respectful, Trustworthy,
3. Nurses must be empowering and “professionally and clinically powerful to be reliant one another” (p.299)	Professionally Accountable, Creative, Innovative, Caring, Empowerment	Accountable, Reliable, Responsible, Intuitive, Empowering, Awareness of Self & Others, Appreciative

Secondary Theoretical Examination of the Alignment. After my initial analysis

I discovered that there was a noticeable alignment emerging between my two concept

maps, when their skills, traits and abilities were considered in light of Terrizzi DeFrino's (2009) three main theoretical assertions. Yet, the need to further articulate and detail this alignment in a more clear and concise manner, still needed to be undertaken.

For example, while interpreting how my two maps reflected the first assertion made by Terrizzo DeFrino (2009) that nurses promote "a network of connection and support" between their peers and themselves (pp.298-299), it was discovered that the skill sets of being 'supportive', 'communicative', 'collaborative', 'open', 'motivational', 'attentive'; and learning how to become a 'relationship builder' (see Table 6) appeared to align between both concept maps. However, as some of these skills or traits could be combined with others or could be reflective of other theoretical assumptions. Thus, I decided to re-consider and contemplate how best to articulate all of the aligning skill sets discovered in my initial analytical work.

For instance, I decided to pair the skill set of becoming 'open' and 'attentive' with the skill set of learning how to become more 'communicative'. Within the *relational nurse leadership* and *team building* literature scholars described the skills of becoming 'open' and 'attentive' within the context of learning how to become more effective communicators with others (Balasco Cathcart, 2014; Chinn, 2013; Marshall & Manus, 2007). Chinn (2013) stated that cohesive and respectful teammates cultivated effective communication practices within the teams when teammates "listen[ed] actively and deliberately to every concern or idea that others [brought] to the group" (p.26). Moreover, Wong, Cummings and Ducharme (2013) mentioned that relational nurse leaders were influential with their staff because of they provided "positive and constructive feedback, open and transparent communication" with them (p.720).

Thus, the refined skill sets of learning how to become more ‘communicative’ with others within the literature in both fields suggested that becoming more ‘open’ and more ‘attentive’ with others was vital for the enhancement of communication between care providers or teammates. Hence, the pairing of these skill sets together to create one main theme of ‘communicative’ was considered and developed (see Table 6).

Moreover, I realized that the first theoretical theme of being ‘inclusive’ aligned well with the theme of being ‘collaborative’ (see Table 6). Johnson et al. (2011) argued that the *TeamSTEPPS* program reinforced that teammates gain competencies in becoming more communicative, collaborative, and cohesive with others. These scholars claimed that the program exemplified “affective collaboration” amongst team members so that they would learn how to better “communicate with peers but also desire to participate and share ideas” with one another (p.186). These scholars believed that through team members’ collaborative efforts, peers would be fully supported as “individuals [who] value the goals and success of the group, thus supporting each other individually and collectively” (p.186). Therefore, the notion to honor the *collective* over the individual, which was also promoted within Terrizzi DeFrino’s (2009) first theoretical assumption, was re-considered and thus, I decided to pair the skill of being ‘inclusive’ with that of being ‘collaborative’ to create one main theme of ‘inclusive and collaborative’ (see Table 6).

In re-examining Terrizzi DeFrino’s (2009) second theoretical assumption that nurses endorse that “interdependence [be] not a deficit state”, the following aligning skill sets of being ‘trustworthy’ or learning how to become a ‘developer of trust’; being more ‘respectful’, being ‘ethical and moral’, being more ‘reflective’, and being ‘non

manipulative and non controlling' with others were also re-considered. For instance, the *team building* skills and abilities around being more 'trustworthy' were indicative and reflective of the relational nurse leadership skill of "developer of trust'. Thus, these two skill sets were easily linked to create one core theme of 'developing trust' (see Table 6).

Furthermore, the *relational nurse leadership* skill sets of becoming more 'reflective' with that of 'awareness of self and others' were additionally re-considered. For instance, in the literature on *relational nurse leadership* scholars suggested that these leaders were intentionally 'reflective' and highly cognizant of the need to consider others (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013). Awareness of others and reflection of their others' abilities and contributions were also highly promoted within the team building literature (Andreatta, 2010; Chinn, 2013; Howe, 2014; Marshall & Manus, 2007). Thus, I wondered if the skill sets of being 'reflective' and being more cognizant of others were two skill sets that could be further linked to one another.

For example, Balasco Cathcart (2014) and Cummings et al., (2008) argued that relational nurse leaders contemplated and considered the unique contexts and opinions of their staff before they made any patient care or unit based decision. These scholars noted that relational nurse leaders were fully aware of their staffer's views and valuable knowledge, and thus invited them to partake in care decision making meetings. Comparably, Andreatta (2010) detailed how teammates must learn to become aware of each other's views, roles, and scopes, so that care can be coordinated and "based on [the] shared knowledge of each other's capacities and strengths and the needs of the environment" (p.351). Thus, I decided to combine these two skill sets together to create the main theme of 'reflection and awareness of self and others' (see Table 6).

However, I also recognized that the aligning themes of becoming ‘respectful’, ‘ethical and moral’, and being ‘non-manipulative and non-controlling’ could all be linked together in order to develop one main theme of ‘respectful’ (see Table 6). Because Terrizzi DeFrino (2009) described that the relational interpersonal work of nurses and their peers promoted a *collective power* between bedside teammates, I felt that these themes could be appropriately combined together to form one main theme of ‘respectful’.

Terrizzi DeFrino (2009) stated that the “nurse facilitates connections with others by absorbing stress, reducing conflict, and creating structural practice that encourage[s] interdependence” (p.300). She claimed that nurses relationally promote the full enactment of their peers’ roles and scopes at the bedside and thus, I perceived that in order for nurses to do this, they would need to be respectful, and would not manipulate or control others they worked with for the achievement of a desired goal. Thus, the combination of these skill sets to create one main theme of ‘respectful’ was developed (see Table 6).

As well, I wondered how the skill set of learning how to become more ‘considerate of others’ aligned with the trait of being more ‘appreciative’ of others. The *team building* skill set of being more ‘appreciative’ was previously considered as being reflective of Terrizzi DeFrino’s (2009) third theoretical assumption, but upon consideration, I decided that for one to be ‘considerate of others’ one must also need to be ‘appreciative’ of their views, roles, abilities or strengths.

For instance, Wong, Cummings and Ducharme (2013) stated that relational nurse leaders were considerate of their staff and openly “express[ed] appreciation and support” to them, as well as being “genuinely concerned for their welfare” (p.710). Chinn (2013) discussed how teammates needed to learn how to be appreciative with one another. She

believed that teammates should positively point out and “acknowledg[e] something someone did or said” as a way to encourage teammates to “share” their unique ideas and knowledge in the future (p.85). Thus, I decided to blend these two similar traits together to create a core theme of ‘appreciation and consideration of others’, and then re-aligned this new core theme with Terrizzi DeFrino’s second theoretical assertion (see Table 6).

Also, I realized that the skill sets reflecting Terrizzi DeFrino’s (2009) third assumption that nurses empower others and become more “professionally and clinically... reliant on one another” (Terrizzi DeFrino, 2009, p.299) could all be re-considered as well. For instance, the skill of ‘empowerment’ promoted on my *relational nurse leadership* concept map could easily be combined with the *team building* skill set of becoming ‘empowering’ (see Table 6).

Moreover, as the skill of being ‘motivational’ was initially considered as being reflective of Terrizzi DeFrino’s (2009) first theoretical assertion that nurses create “a network of connection and support” (Terrizzi DeFrino, 2009, pp.298-299), I pondered how this skill set might be more representative of Terrizzi DeFrino’s (2009) third theoretical assumption that nurses empower their teammates at the bedside. Johnson et al. (2011) asserted that effective and cohesive teams were ones that motivated one another at the bedside. These scholars stated that “[m]otivation occurs when individuals value the goals and successes of the group, thus supporting each other individually and collectively” (p.186). Wong, Cummings and Ducharme (2013) suggested that relational nurse leadership “styles” were influential because relational nurse leaders can “positively” encourage, empower, and “motiv[at]e” their “nurse’s....to perform” (p. 720).

Thus, the theme of ‘motivational’ was re-evaluated and paired with the skill set of ‘empowerment’ to create the main theme of ‘motivation and empowerment’ (see Table 6).

Finally, the *team building* skill sets of learning how to become ‘accountable’ was deemed as aligning well with the *relational nurse leadership* skill of ‘professional accountability’. Thus, I decided to pair these two very similar skill sets together to create the main theme of ‘professionally accountable’ (see Table 6).

Therefore, by carefully re-examining the aligned skills, traits, and abilities found between my maps on *relational nurse leadership* and *team building* during my initial theoretical analysis work, I was able to re-consider many skill sets in order to identify nine final, main aligning themes. These nine themes included: ‘supportive’, ‘inclusive and collaborative’, ‘communicative’, ‘developing trust’, ‘respectful’, ‘reflective and awareness of self/others’, ‘appreciation and consideration of others’, ‘professionally accountable’, and ‘motivational and empowerment’ (see Table 6).

Table 6

A secondary thematic analysis was undertaken to help distinguish nine core main aligning themes/sub themes duly proclaimed within both concept maps, whilst using the ‘theory of the relational work of nurses’ as my theoretical lens (Terrizzi DeFrino, 2009).

Theoretical Assumptions proposed by Terrizzi DeFrino (2009)	Aligning Skills, Traits & Abilities deciphered within both concept maps whilst using this theoretical lens
1. Fostering a “network of connection and support” (pp.298-299)	Supportive, Inclusive & Collaborative, Communicative (includes Open & Attentive)
2. “Interdependence is not a deficient state” (p.299).	Developing Trust (includes Trustworthy), Respectful (includes Ethical & Moral & Non Manipulative & Non Controlling), Reflection & Awareness of Self & Others, Appreciation & Consideration of Self & Others

- | | |
|---|--|
| 3. Nurses must be empowering and “professionally and clinically powerful to be reliant one another” (p.299) | Professionally Accountable (includes Accountability), Motivational & Empowerment |
|---|--|
-

A clearer articulation of the alignment discovered between the two constructs of *relational nurse leadership* and *team building tools and strategies* will now be discussed and presented within *Part Two of Phase Two* of this MN project.

Part Two: Creation of a Spider Map to Express the Alignment Discovered

For the second part of my *Phase Two*, I decided to explore an assertion made by All, Hucyke and Fisher (2003) that concept developers can create a *spider map* as a way to explicate the perceived relationship between concepts in a clear, concise, and visual manner. All, Huycke and Fisher (2003) claimed that there are various types of creative concept maps that help “represent the structure of knowledge and communicate it in a form that is psychologically compatible with an individual’s human experience and meaning” (p.312). These scholars assured readers that concept map developers can create a concept map using the Novak and Gowin (1984) method, or consider using other types of concept maps like “spider maps”, “system maps”, or “mandal/mandala maps” (p.313).

While considering these other types of concept maps, I recognized that the development of a “spider map” (p.313) would be beneficial for helping me to visually and succinctly explicate the alignment discovered between my concept maps on *relational nurse leadership* and *team building tools and strategies*. Thus, I decided to create a *spider map* for this next Phase of my MN project.

Steps needed for Spider Map development. All, Huycke and Fisher (2003)

claim that spider maps be created and “organized around...unifying factors with subthemes” that appear to the reader as “radiating outward” from a central idea (p.313). Whilst creating *spider maps*, these scholars suggest that developers’ strategically position a “central theme” in the middle of a page and then illustrate relating themes as branching off the main idea or “central theme” (p.313).

So for example, the concept of ‘the season of spring’ might be positioned within the middle of a page, while related or connecting concepts are illustrated as “radiating subthemes” that revolve or encircle the main idea (All, Huycke & Fisher, 2003, p. 313). Hence, related ideas or sub themes such as the ‘regeneration of plant life’, or ‘return of migrating birds’, ‘warmer temperatures’, ‘increased daylight hours’ and ‘increased rain’, would be illustrated and depicted as revolving around the central notion of ‘the season of spring’.

Moreover, as related subthemes are depicted as revolving around the central theme of ‘the season of spring’, this positioning allows readers to consider that these ideas not be considered as more important than others. Instead, a rotating illustration of how concepts connect to a main idea offers readers a way to conceptualize how some concepts do not need to be perceived within a hierarchal relationship to others (All, Huycke & Fisher, 2003). Because my Novak and Gowin (1984) inspired concept maps were created by ensuring hierarchy was established between skill sets, I considered that perhaps it might be advantageous to articulate the nine main aligning themes discovered, within a non-linear concept map like a spider map.

For instance, the hierarchal model that guided my thinking processes for the development of my Novak and Gowin (1984) inspired concept maps was achieved by carefully examining which skills or traits were the most promoted by scholars of the literature reviewed (see *Appendices C & G*). However, I posit that each of the nine final aligning skills and traits discovered could be argued as being equally significant and important to express to RN team leaders. Thus, I decided to depict my alignment findings within a *spider map* that did not specify the need for hierarchy between skill sets, so that RN team leaders readers would consider these skill sets as being equally beneficial for the enactment of safe, competent, ethical nurse leadership and bedside care team practice.

Steps taken for my Spider Map development. All, Huycke and Fisher (2003) asserted that concept map developers must first locate and choose the main “topic and related words” that they are exploring within their map (p.315). Because my *spider map* would specifically articulate the alignment discovered between *relational nurse leadership* and *team building tools and strategies*, I used the main topic sentence of ‘aligning skills, traits and abilities discovered between relational nurse leadership and team building tools and strategies’ and plotted this sentence centrally upon a page (see *Appendix J*).

Next, the scholars ask that developers consider “concept ranking”, “concept clustering”, and “linking of concepts with propositions” (p.315). Because these actions had already been undertaken during *Phase One* of this project, I continued onto their final step that asked that I “arrang[e] concepts into a diagrammatic representation” (p.315). Therefore, I listed my main topic phrase centrally upon a page and depicted all nine

aligning skill sets as “radiating” (p.313) or branching off my main topic phrase (see *Appendix J*).

Additionally, I indicated how my themes were reflective of the main topic phrase through the use of simple black connective lines between skill sets to the main topic phrase (see *Appendix J*). As well, I used broader, directional arrows between each of my nine skill sets as a way to illustrate to the readers how these skills not only connected to the main topic phrase, but to each other as well.

For example, I considered that in order for one to learn how to become more ‘respectful, ethical and moral, non-manipulative and non controlling’ with others, one also must also consider ‘developing trust’ or engaging in the skills of ‘reflection and awareness of self and others’, and so on (see *Appendix J*).

Moreover, I ensured that depiction of my themes included the related skills or traits found to be essential to its’ correlating main theme. For instance, I articulated how the main theme of ‘communicative’ was inherently connected to the skill sets of being more ‘open’ and ‘attentive, and thus, depicted this theme as ‘communicative (open and attentive)’” (see *Appendix J*). Similar actions were taken for the illustration of the theme of learning how to become more ‘respectful’ that included the skill sets of ‘ethical and moral’, and ‘non manipulative and non controlling’; and the articulation of main theme of ‘reflective’, which was previously noted as including the skill set ‘awareness of self and others’ (see *Appendix J*).

Lastly, I decided to demonstrate my nine aligning skill sets within boxes shaped like paper documents, with the main topic phrase situated within one large central core document-like box (see *Appendix J*). My decision to depict skill sets within document-

like boxes was crafted in such a way to articulate to readers how these skill sets could be considered as team leadership competencies, needed for the achievement of safe, competent, and ethical team leadership practice.

Discussion of Concept Mapping & Alignment Findings

In order to complete this concept mapping MN project, I decided to divide my work into two main sections or phases. I will now discuss the significant discoveries I made during the completion of these two phases in the following sections.

Discussion of Phase One Findings

During the completion of *Phase One*, I discovered that the scholars of the *relational nurse leadership* works described and promoted thirty-nine skills, traits, and abilities that these leaders employed in their practice (see *Appendix C*), while scholars of the *team building tools and strategies* expressed thirty-five skills, traits, and abilities that they believed led to the creation of communicative, collaborative and cohesive teams (see *Appendix E*). Moreover, during the construction of my concept maps, I was asked to establish and develop a level of hierarchy that would be used to base my conceptual thinking processes upon and illustrate connections or *cross linkages* proposed between separate skills or traits depicted within each map (Novak & Gowin, 1984), that were represented through the use of long and short red arrows (see *Appendices G & I*).

However, upon reflection of the established hierarchy and my proposed *cross linkages*, I noted that there was a significant difference between these Novak and Gowin (1984) two concept mapping steps. For instance, in my *relational nurse leadership* concept map, I proposed thirty nine *cross linkages* between the separate skills and traits.

The three top influential *relational nurse leadership* skill sets I perceived as being the most significant were: becoming a ‘relationship builder’; being ‘non manipulative/non controlling’; and becoming more ‘reflective’ (see *Appendix E*). Yet, upon examination, these three skill sets were not the *most* expressed skills, traits or abilities proclaimed by the scholars of the six resources reviewed on *relational nurse leadership* (see *Appendix C*). In contrast, the most declared skill sets were: being ‘collaborative’, ‘creative’, ‘communicative’, and ‘empowering’ (see *Appendix C*).

Thus, I needed to consider why there was such a disconnect between the skill sets I considered as being the most beneficial with the skill sets that scholars promoted and had expressed the most within the literature.

For example, I felt that the skill set of becoming a ‘relationship builder’ was a crucial skill set needed by relational nurse leaders because it would ensure that they further enacted many other skill sets such as being ‘inspiring’, ‘attentive’, ‘encouraging’, ‘supportive’, ‘non-manipulative/non controlling’, and ‘considerate of others’ (see *Appendix E*). I considered how becoming a ‘relationship builder’ was an integral capacity for nurse leaders to grasp and employ in practice because I felt it ensured that the interpersonal working relationships leaders forged with their staff were fundamentally based upon leaders being present, supportive, inspiring, considerate and encouraging of others.

For instance, I noted that several scholars of *relational nurse leadership* works described how valuable relationship building was for relational nurse leadership practice (MacPhee et al., 2008; Wong, Cummings & Ducharme, 2013). This skill set was perceived as assisting relational nurse leaders in becoming fully present and attentive of

their frontline staffs' needs, so that any actions or decisions made were done by deliberately considering staffers' context and views (Balasco Cathcart, 2014; Cummings et al., 2008; Wong, Cummings & Ducharme, 2013). Moreover, I felt that when meaningful relationships were intentionally and relationally fostered between leaders and staff, staff would be better supported and encouraged to become involved in unit-based or patient care decision making processes (Balasco Cathcart, 2014; Wong, Cummings & Ducharme, 2013). Thus, the skill of becoming a 'relationship builder' I felt, was a compulsory skill set needed for the enactment of several other relational nurse leadership skills, traits, and abilities.

Additionally, I determined that learning how to become 'non manipulative and non-controlling' was another vital capacity needed for the development of respectful, ethical nurse leadership practice. Indeed, I saw this skill as being inherently connected to five others including becoming a 'relationship builder', being more 'communicative', 'supportive', 'reflective', and 'honest' (see *Appendix E*). I reflected on how building respectful and non controlling interpersonal working relationships between leaders and staffers allowed leaders to become more respectful, supportive and inclusive of others.

For instance, I recognized that one *relational nurse leadership* scholar argued the need for leaders to become more consciously reflective of their own actions and their expectations of others (Balasco Cathcart, 2014). This scholar felt that in doing so, leaders would learn how to develop mutual respect between themselves and their staff, and that it would lead to increased support and inclusion of staff into policy or decision making processes (Balasco Cathcart, 2014). Moreover, I believed that once leaders became more reflective of their actions and expectations of others, they would recognize that they did

not need to control or manipulate others in order to entice them to achieve desired care goals. Therefore, I considered how the skill of becoming ‘non manipulative and non-controlling’ was indeed vital for the enactment of reflective, respectful, *relational nurse leadership* practice.

In taking this notion of reflective nurse leaders further, I noted how the *relational nurse leadership* skill set of becoming more ‘reflective’ was indeed another significant skill set that some suggested these leaders keenly employed in their practice (see *Appendix E*). Moreover, I perceived the skill of being ‘reflective’ as being related to six others including being ‘honest’, ‘competent’, ‘non manipulative and non-controlling’, ‘ethical and moral’, ‘innovative’, ‘culturally sensitive’, and ‘knowledgeable’ (see *Appendix E*).

For instance, I reflected how one *relational nurse leadership* scholar felt that the skill of ‘reflective’ practice was essential for nurse leaders to enlist, so that they would be able to consider present circumstances in the context of their own past actions, experience, and knowledge (Balasco Cathcart, 2014). Also, I noted from the literature that relational nurse leaders ensured that any present resolution made was done by ethically including others’ views into the discussion (Balasco Cathcart, 2014; Thompson et al., 2011). Additionally, I saw how reflective practice and mutual decision making allowed leaders and their staff to consider new and innovative ways to rectify care concerns (Balasco Cathcart, 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013). Thus, this example demonstrates why I linked the skill of reflective practice to the skill of becoming ‘innovative’ (see *Appendix E*).

Furthermore, I considered how some scholars of *relational nurse leadership* works, detailed that being ‘reflective’ was not only crucial for respectful *relational nurse leadership* practice, but was also essential for safe, ethical, and competent bedside nursing practice (Cummings et al., 2008). For example, Cummings et al. (2008) described how some relational nurse leaders used reflective practice as a way to help support the health and well being of their staffers. Because relational nurse leaders were argued as being moral practitioners by several of the scholars (Balasco Cathcart, 2014; Thompson et al., 2011; Wong, Cummings & Ducharme, 2013), I felt that the skill of reflective practice could be used to enhance one’s skill of being ‘ethical and moral’ as well. Hence, the ability of ‘reflective’ practice skill sets for the enactment of many other relational skill sets (see *Appendix E*) was perceived by me as being foundational for conscientious, respectful, and ethical *relational nurse leadership* practice.

Alternatively, within the twenty nine *cross linkages* proposed on my *team building tools and strategies* concept map (see *Appendix I*), the most influential skill sets I believed were crucial for *team building* appeared to be different than the most expressed skill sets promoted by the scholars of the works reviewed. For example, the most endorsed skill sets were that of developing ‘awareness of self and others’, becoming more ‘communicative’ and being more ‘supportive’ of others (see *Appendix G*). However, the top three *cross linkages* I proposed between separate skill sets were that of ‘honoring and valuing of others’, becoming more ‘ethical and moral’, and being more ‘attentive’ (see *Appendix I*). Once again, I needed to consider why there was such a difference between my perceptions of the most influential team building skill sets with the hierarchy of skill sets established on my *team building* concept map.

For example, I saw that the capacity of ‘honoring and valuing of others’ was an essential ability needed for the enactment of respectful, cohesive care teams. This skill set was only declared by one *team building* scholar (Chinn, 2013), yet *I* felt it was crucial for the enactment of becoming a ‘capacity builder’, being ‘appreciative’, ‘attentive’, ‘inclusive’, and ‘ethical and moral’ (see *Appendix I*).

Like Chinn (2013), I too believed that the creation of cohesive teams could only be accomplished when teammates learned to honor and respect “each individual’s viewpoint and abilities...equally” (Chinn, 2013, p.12). Because many other *team building* scholars described that team peers needed to learn to work more respectfully and collectively together for the achievement of a mutually desired goal (Andreatta, 2010; Chinn, 2013; Marshall & Manus, 2007), I realized that skill sets pertaining to the valuing and honoring others would ensure that team goals were indeed mutually met at the bedside. Thus, this skill set of ‘honoring and valuing of others’ I felt, was imperative for the enactment of other supportive and respectful team building skill sets depicted within my *team building* map (see *Appendix I*).

Moreover, I saw that the *team building* skill of being ‘ethical and moral’ was another influential skill set even though it was only promoted in two of the five *team building* resources reviewed (see *Appendix G*). Indeed, I saw this skill as being key for the enactment of being more ‘inclusive’, ‘non manipulative and non controlling’, ‘honoring and valuing of others’, ‘honest’ and ‘cooperative’ (see *Appendix I*). I made these linkages by reflecting upon assertions made by two *team building* scholars who argued that teammates must recognize their ethical and professional obligation as care providers to sustain “patient safety” at the bedside (Howe, 2014, p.133; Marshall &

Manus, 2007). Furthermore, I noted how these scholars claimed that frequent and enhanced communication opportunities between diverse care providers also promoted the elimination of negative *power* hierarchies within healthcare teams (Howe, 2014; Marshall & Manus, 2007). These scholars suggested that the promotion of professional and mandates for practice would lead team members in becoming equally respected, heard, and valued for their unique contributions and insights to care (Howe, 2014; Marshall & Manus, 2007). Thus, I considered and reflected that the prevention of some care providers' voices would lead poorer patient outcomes (Marshall and Manus, 2007), and then decided that the skill of being 'ethical and moral' was indeed crucial for the enactment of more respectful, inclusive, communicative, and cohesive healthcare teams.

Finally, I noted that the skill set of being 'attentive' was another essential *team building* capacity. However, I also recognized that this skill was endorsed within four of the five *team building* resourced reviewed (Andreatta, 2010; Chinn, 2013; Howe, 2014; Marshall & Manus, 2007), and felt that it was an influencing factor for the development of other skill sets such as becoming a 'relationship builder', becoming 'intuitive', 'empowering', 'open' and 'honoring and valuing of others' (see *Appendix I*).

For example, I noted how the skill of becoming more 'attentive' was repeatedly endorsed and explicated within the *team building* literature as being necessary for enactment of open and effective communication between teammates (Andreatta, 2010; Chinn, 2013; Howe, 2014; Marshall & Manus, 2007). I recognized how these scholars promoted the skill of being 'attentive' as a way to cultivate keen listening skills between teammates (Andreatta, 2010; Chinn, 2013), *and* for the promotion of open information sharing amongst diverse care providers (Howe, 2014; Johnson et al., 2011; Marshall &

Manus, 2007). Because I noted that the skill of becoming more ‘attentive’ was endorsed by so many of the scholars of the *team building* resources reviewed, the multiple *cross linkages* I proposed from this one skill may reflect its’ insistence and presence within the literature, or it may indicate that *I* also perceived it as being valuable and crucial for the enhancement of more respectful and communicative healthcare teams.

For example, I believed that health care teams can not promote and increase information sharing between individual members without each peer learning the need to become open, active listeners with one another. Moreover, I felt that if teammates became more ‘attentive’ of their peers, they would learn and hear each other’s unique insights, which would then lead to teammates becoming ‘appreciat[ed]’, ‘empower[ed]’, as well as enhancing the need to become ‘intuitive’ of each other’s needs, strengths and capacities. Thus, I asserted that the skill of being ‘attentive’ was absolutely fundamental for the development of more supportive and communicative healthcare teams.

Overall Reflection of Hierarchy versus Cross Linkages. Upon reflecting how my perceived *cross linkages* compared with the established hierarchy developed within each of concept map, I discovered that Novak and Gowin’s (1984) assertion that hierarchy be established within a concept map, does not deem that top level concepts be considered as the *most* significant or the *most* important concepts to note. Indeed, the establishment of hierarchy within my two concept maps did not appear to sufficiently reflect the skill sets *I* perceived as being the *most* influential for the enactment of effective *relational nurse leadership* or *team building*. Therefore, readers must recognize that although hierarchy was required within these maps-the importance or significance of these top level skill sets

must be carefully considered before adopting these for *relational nurse leadership* practice or for the enhancement of bedside *team building*.

Discussion of Phase Two Findings

During *Phase Two* of this MN project, *the theory of the relational work of nurses* by Terrizzi DeFrino (2009) was used as an analytical assistive tool for helping me uncover alignment between my two concept maps on *relational nurse leadership* and *team building tools and strategies*. Specifically, this theory helped me decide how each of the skills, traits, and abilities depicted within both maps aligned with one another in respective of Terrizzi DeFrino's (2009) three main theoretical assumptions.

However, as *the theory of the relational work of nurses* (Terrizzi DeFrino, 2009) was helpful for establishing nine main aligning skill sets between *relational nurse leadership* and *team building tools and strategies*, I also needed to consider how it insufficiently addressed or reflected many other beneficial skills, traits, and abilities that were expressed by scholars of each area. Additionally, I realized that Terrizzi DeFrino (2009) neglected to describe the ethical or moral underpinnings of her three theoretical assumptions. I will now discuss and debate these two issues, in the following sections.

Ways in which Terrizzi DeFrino's (2009) theory did not reflect the literature.

One meaningful way to decide how *the theory of the relational work of nurses* was insufficient in reflecting *all* of the skills, traits and abilities described by the scholars of the resources on reviewed on *relational nurse leadership* and *team building*, is to examine how some of these skills were not articulated within my *spider map* (see *Appendix J*).

Recall that the nine skill sets depicted within my *spider map* were the skill sets that aligned and reflected the three theoretical assertions posited by Terrizzi DeFrino (2009). Yet, upon further inspection, there were many other valuable skill sets depicted on my maps that are not found within my spider map because they did not explicitly align with one another or with Terrizzi DeFrino's (2009) three main theoretical contentions.

For example, whilst examining my *relational nurse leadership* concept map, I recognized that the skill sets of being 'innovative' or 'creative' were endorsed by *relational nurse leadership* scholars (see *Appendix E*). However, these skill sets were not promoted within any of the *team building tools* and *strategies* reviewed and were not specifically endorsed within Terrizzi DeFrino's (2009) three main theoretical assertions. Thus, both these skills are not articulated within my spider map (see *Appendix J*).

Moreover, the *team building* skill set of learning how to be 'assertive' was endorsed within the *team building* literature (Andreatta, 2010; Marshall & Manus, 2007), but was not articulated any of the *relational nurse leadership* resources examined, nor was it reflected within Terrizzi DeFrino's (2009) theory. Hence, as the skill of being 'assertive' was found not to align-it is not represented within my spider map (see *Appendix J*).

However, the argument that bedside care providers value creativity and innovation amongst each other has indeed been endorsed elsewhere. Pollard and Wild (2014) suggested that novice nurses learn how to become more creative and innovative with their care provider peers because "innovation and creativity naturally occurs among teams" (p.623). These scholars argued that valuing innovation would allow nurses to "creatively manag[e] change" in their respective healthcare settings (p.623).

Similarly, nurse leadership scholars Balasco Cathcart and Greenspan (2013) posited that creative visionaries are needed for the enhancement of higher quality practice settings. These scholars felt that nurse leaders honor the innovative ideas of their staffers because these ideas could be used to help “solve problems and find answers that lead to improvement and innovation” at the bedside (p.969). Hence, the need to promote and encourage creativity and innovation within care teams appears to be relevant, yet it was not promoted within any of the five *team building* resources reviewed. Moreover, as Terrizzi DeFrino’s (2009) theory did not even address or attend to the need for nurses to become creative or innovative with their care provider peers, the skill set of being ‘innovative’ could not be articulated or represented within my *spider map*.

Similarly, the *team building* skill of learning how to become ‘assertive’ was another expressed competency noted within many of the *team building* resources examined, but it was not articulated within any of the six *relational nurse leadership* resources, and was not described within any of the three theoretical assertions by Terrizzi DeFrino (2009).

Howe (2014) and Marshall and Manus (2007) stated that assertiveness training was a necessary skill set needed for bedside care workers so that they could become open and communicative with others in order to uphold quality patient care. Yet, none of the *relational nurse leadership* resources reviewed for this MN project appeared to promote the skill of being assertive, and this skill set was not detailed by Terrizzi DeFrino’s (2009) as being an essential capacity needed by nurses and their peers as a way to sustain and promote higher quality care at the bedside. However, Terrizzi DeFrino (2009) did mention that nurses and their peers “tak[e] action to prevent problems” and “do

‘whatever it takes’ to achieve goals” at the bedside (p.299), yet she does not specifically state that nurses and their peers employ the skill of being ‘assertive’ in order to achieve bedside goals.

Pollard and Wild (2014) argued that “a framework for teamwork” should include effective “communication” practices such as “collaboration, leadership, transparency” that included “open, honest, disclosure” (p.621). These scholars suggested that novice nurses be particularly trained in becoming more vocal, confident practitioners, as doing so, maintained that they became more influential and effective advocates for their patients and peers.

Although the need for care providers to becoming ‘assertive’ has been articulated by other nursing scholars, it was not explicated within any of the six *relational nurse leadership* resources reviewed and was not declared within Terrizzi DeFrino’s theory (2009). Thus, readers are urged to re-consider the use of this skill amongst care team providers, as it has been argued as being a necessary competency for the enactment of effective, ethical healthcare teams (Pollard & Wild, 2014).

The ethical implications of using Terrizzi DeFrino’s (2009) theory to uncover alignment. Another major disadvantage in using Terrizzi DeFrino’s (2009) theory to uncover and analyze alignment may rest in the way in which she failed to appropriately discuss and outline the ethical underpinning she used to promote moral comportment amongst nurses and their peers on healthcare teams. Terrizzi DeFrino (2009) does describe ethics in her theory in regards to the moral actions of nurses with their patients, but does not describe the ethical grounding of the moral actions of nurses and their bedside peers, as scholars of the *relational nurse leadership* and *team building* works did.

Thus, the absence of a clear, distinctive ethical grounding to underpin the relational and interpersonal skill sets used and enacted by nurses and their colleagues at the bedside, I felt needed to be further considered and examined.

For instance, Balasco Cathcart (2014), Thompson et al., (2011), and Wong, Cummings and Ducharme (2013) each described the need for relational nurse leaders to become strong moral practitioners who respectfully honored their staff and valued their contributions for enhancement of safe, quality patient care settings. Howe (2014) and Marshall and Manus (2007) believed that care teammates who promoted safer patient care initiatives at the bedside also contributed to the elimination of negative power hierarchies that unjustly silence some care providers during patient care discussions.

Indeed, Ewashen, McInnis-Perry and Murray (2013) outlined the need for healthcare teammates to learn how to become moral and ethical care practitioners with their bedside colleagues. These scholars believed that when teammates took notice of how they treated one another, they would recognize how they sustained negative power hierarchies within the team. They urged healthcare providers to adopt relevant ethical lenses such as relational ethics developed by ethicists like “Bergum” or “Gadow” (p.327), feeling that the adoption of such relational ethical lenses would help to adequately illuminate how the “relational process” between bedside care providers is one “of emotional and meaningful connectedness” and “mutual respect” (p.327).

As Terrizzi DeFrino’s (2009) theory described the interpersonal and supportive connections fostered between nurses and their care provider peers, her lack of attendance to fully articulate the ethical grounding that underpinned the need for these nurses to employ relational interpersonal working skills amongst their care provider peers, is I feel

unfortunate. For example, had Terrizzi DeFrino (2009) detailed a relational ethical lens as informing the three main theoretical assertions that outlined her theory on the relational work of nurses, readers might have been able to grasp how her three theoretical assumptions reflected “Bergum[s]...being-for-the-other” relational ethical assertion (Ewashen, McInnis-Perry & Murphy, 2013, p.327). I believe that had Terrizzi DeFrino (2009) done so, she would have been able to articulate how the *collective power* promoted between nurses and their peers was indicative of a *power with* or *power for*, which I believed is appropriately reflective of “Bergum[s]...being-for-the-other” assertion (Ewashen, McInnis-Perry & Murphy, 2013, p.327).

Concept Mapping Project: Implications for Nursing Practice

The utilization of concept mapping as a viable method to structure and organize concepts and connect separate concepts together with others has indeed been articulated within nursing literature (All & Havens, 1997; All, Huycke & Fisher, 2003; Irvine, 1995; Noonan, 2011). For example, concept mapping within nursing has been used as “an active teaching strategy” and as “an analytical tool” by hospital nurse leaders, clinicians, and educators “because it helps synthesize, organize, and prioritize data in a logical sequence” (Noonan, 2011, p. 470).

Hay and Kinchin (2006) have argued that the concept mapping method be used within the health sciences as a way to assist students to organize and plot out the rich data gained from patient “case studies” (p.173). As well, these scholars insisted that concept mapping can be enlisted by university educators for “the process of curriculum design” and development (p.175). Such assertions reflect other scholars’ suggestions that concept

mapping methods can be employed by nurse educators to develop workshops, programs, and nursing courses (All & Havens, 1997; Noonan, 2011).

Additionally, Novak and Canas (2007) believed that concept maps can be used by researchers as a means to help them carefully organize and categorize collected data. Therefore, the use of concept mapping within this MN project to uncover and articulate *alignment* between the skills, traits, and abilities expressed within the eleven literature resources reviewed on *relational nurse leadership* and *team building*, is indeed a relevant methodology that nurses can enlist for the advancement of nursing knowledge and practice.

For instance, each concept map created within this MN project could one day be taken up by nurse clinicians, leaders, or educators as a way to visualize and understand the intricate skills, abilities, or competencies needed for the instruction of relational nurse leaders *or* for the enhancement of more cohesive and collaborative healthcare teams. Thus, I posit that nurse clinicians, leaders, or educators could one day use my concept map on *relational nurse leadership* as a way to assist and inform newly positioned nurse leaders with some of the necessary skill sets they may need for practice.

Additionally, nurse clinicians, leaders, or educators could employ my concept map on *team building* as a way to train frontline care provider's with some of the competencies or skills needed for the enhancement and development of cohesive, collaborative, communicative, and ethical bedside care teams.

But more specifically, my *spider map*, which illustrates the skill alignment uncovered between *relational nurse leadership* and *team building tools and strategies* (see *Appendix J*) could one day be employed by nurse educators and clinicians as an

insightful guideline for the instruction and training of newly appointed RN team leaders. Moreover, this guideline could be taken up by nurse educators and embedded within undergraduate curricula for the instruction of novice nurses. Because some scholars have indicated that many bedside RNs may not be sufficiently equipped with the skills and abilities to become effective nurse leaders (Eddy et al., 2009; Heller et al., 2004), my concept maps *and* spider map could be deemed essential by scholars, educators and clinicians, to be employed into nursing education and practice.

Additionally, my maps might incite further exploration and research into the area of RN team leader practice. For example, nurse researchers could one day decide to examine my concept map findings and compare these to the actual skills, traits, and abilities deployed by working RN team leaders in clinical practice. As well, researchers might consider exploring how proper training of bedside RNs *before* these nurses assume their new team leadership roles, impacts patient outcomes and healthcare team dynamics. Thus, the potentialities inherent within this one MN concept mapping project as a meaningful and positive way to incite future nursing research or contribute to the education of nurses may indeed add to the enhancement of nursing knowledge and practice.

Limitations of this Concept Mapping MN Project

As the nine main aligning themes depicted within my spider map (see *Appendix J*) were developed by examining and exploring the skills, traits, and abilities noted within six *relational nurse leadership* and five *team building* resources, the resulting findings articulated within my *spider map* may not be completely representative of all of the skills or abilities deployed by relational nurse leaders or healthcare teammates.

For instance, it may be argued that reviewing six articles on *relational nurse leadership* was not sufficient in illuminating all of the intricate skills, traits, and abilities enacted by relational nurse leaders in their respective practices. Also, it may be contested that the skill sets recovered from the five *team building* resources were not fully representative of the vast amount of skills, traits and abilities employed by care team members with one another at the bedside. Hence, the exploration and alignment discovered in this MN project may be argued as not fully addressing or attending to of the essential capacities enacted by relational nurse leaders and bedside care teammates within clinical practice settings.

Moreover, as *the theory of the relational work of nurses* (Terrizzi DeFrino, 2009) has been debated as being slightly under-representative of all of the skills, traits, and abilities promoted by the scholars of *relational nurse leadership* and *team building*, some readers might assert that it was not sufficient in identifying the exact skill sets needed for safe, ethical, competent RN team leader practice. Therefore, I assert that further research and exploration in the area of RN team leader practice is greatly needed in order to detect and uncover the true skills, traits, and abilities enacted and employed by RN team leaders in their practice.

Summary & Conclusion

Canadian frontline RNs have recently been faced with care reform strategies that remove them from the bedside in order to fulfill the position of care team leader. However, as the majority of frontline RNs may not be fully equipped with the skills, traits, and abilities necessary to execute such a role (Eddy et al., 2009; Heller et al., 2004; Pate, 2013), I decided to explore the concept of *relational nurse leadership* and review

some select *team building tools* and *strategies* in order to discover what skills, traits and abilities RN team leaders might wish to consider and adopt for practice, as a way to help support their newly appointed roles.

By enlisting the systematic instructional steps inherent within the concept mapping methodology as outlined by Novak & Gowin (1984), I was able to closely examine the constructs of *relational nurse leadership* and *team building tools* and *strategies* to identify and articulate the skills, traits, and abilities promoted within each of these fields and develop two concept maps. Moreover, by carefully considering how the skills declared within each concept map aligned and reflected the three theoretical assumptions inherent to *the theory of the relational work of nurses* (Terrizzi DeFrino, 2009), I was able to uncover nine main aligning skill sets in order to depict these within a visual *spider map* (All, Huycke & Fisher, 2003). It is my hope that one day, my *spider map* could provide hospital clinicians, leaders, and educators with an insightful guideline that they can tailor or use in order to inform and empower newly positioned RN team leaders in acute care settings.

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Appendix A

The following is an example of a simple concept map on ‘the season of spring’ created by using the Novak and Gowin (1984) concept map methodology.

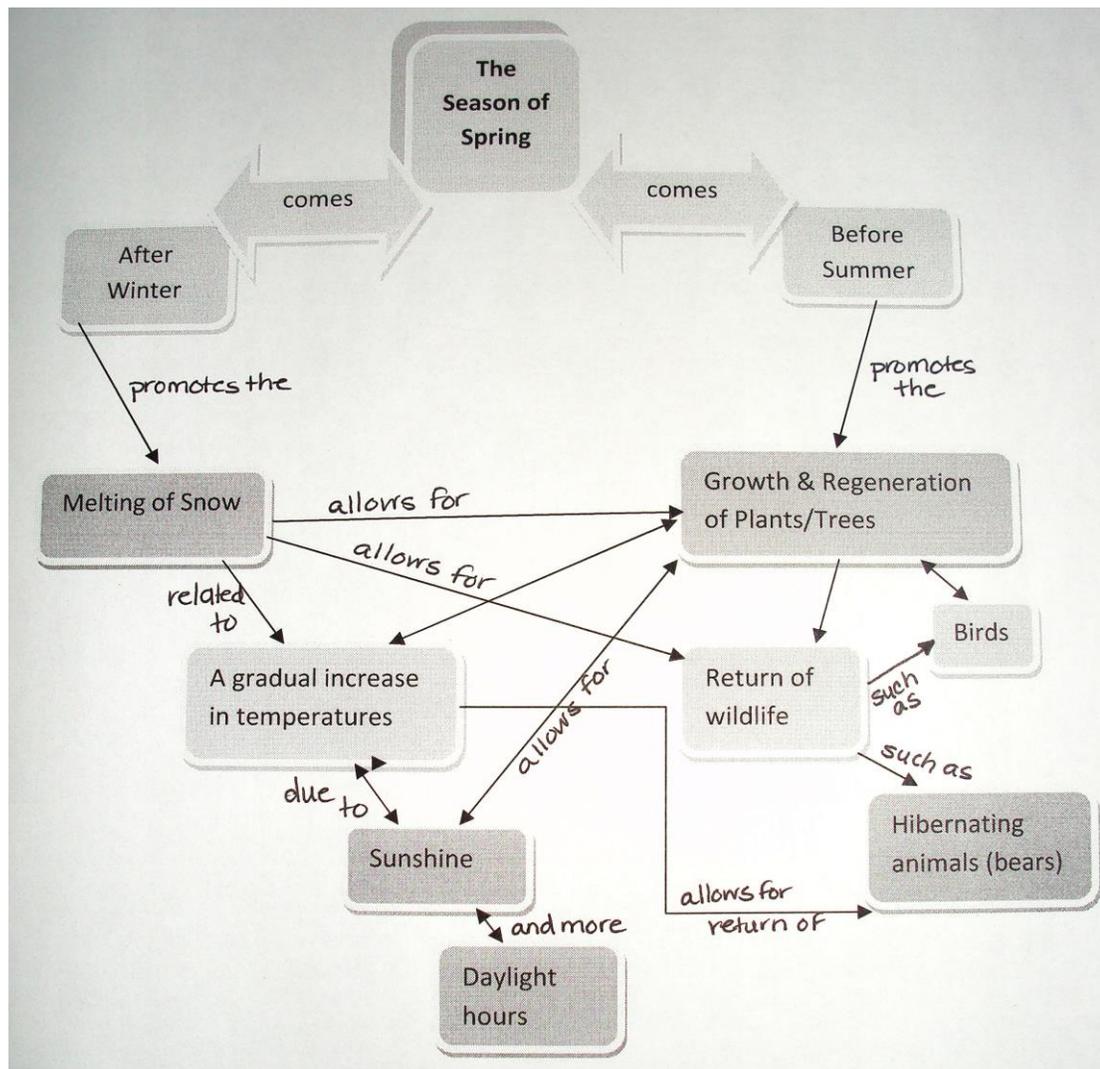


Figure A.1 The main phrase ‘the season of spring’ was used to guide and locate related and connecting ideas that became new themes, sub-themes, and propositions proposed underneath the main topic phrase. Additionally, the use of *linking words* is clearly depicted, such as ‘comes’, ‘allows for’, ‘related to’, and ‘due to’. These *linking words* indicate how themes and sub-themes are inter-related to the initial main phrase of ‘the season of spring’. Note how black arrows were used to demonstrate directional connections made between concepts.

Appendix B

Table B.1

The following is a complete list of skills, traits, and abilities proclaimed by scholars of the six resources reviewed on relational nurse leadership.

Resources Explored	Skills & traits proclaimed within the literature on relational nurse leadership
Balasco Cathcart (2014)	Authentic Creative & an Upstream thinker Capacity Builder Trusting Influential Motivational & Empowering Ethical & Moral Respectful Communicative Collaborative Inclusive, Attentive & Inviting ‘Situationally’ Aware Persistent Culturally Sensitive Open Reflective Ingenuous
Cummings et al. (2008)	Compassionate Caring Empathetic Supportive & Empowering A Relationship Builder Professionally Accountable Inclusive & Inviting Collaborative Innovative Communicative Role Model for Reflective Practices Self Aware & Aware of others
Dahinten et al. (2014)	A Relationship Builder Collaborative & Inclusive Motivational Self Determined Competent Supportive Trusting Appreciative & Affirmative

	Communicative Respectful & Fair
MacPhee et al. (2014)	Adaptable & Flexible Innovative & Creative Inspirational, Motivational & Influential Engaging & Participatory Self Aware Empowering & Supportive Inclusive Trusting Respectful
Thompson et al. (2011)	Non punitive, non-manipulative A Relationship Builder Respectful Trusting Motivational & Inspiring Inclusive & Collaborative Responsible & Accountable Communicative & Open Non punitive Innovative Supportive & Encouraging Inviting & Attentive Ethical & Moral
Wong, Cummings & Ducharme (2013)	A Relationship Builder Appreciative & Supportive Genuine, Honest, Transparent & Open Capacity Builder Trusting Respectful & Considerate of others Caring Empathetic Motivational Communicative Collaborative Ethical & Moral Innovative & Creative Competent Knowledgeable Supportive & Encouraging Reflective Inclusive & Attentive Situationally & Contextually Aware

Appendix C

Table C.1.

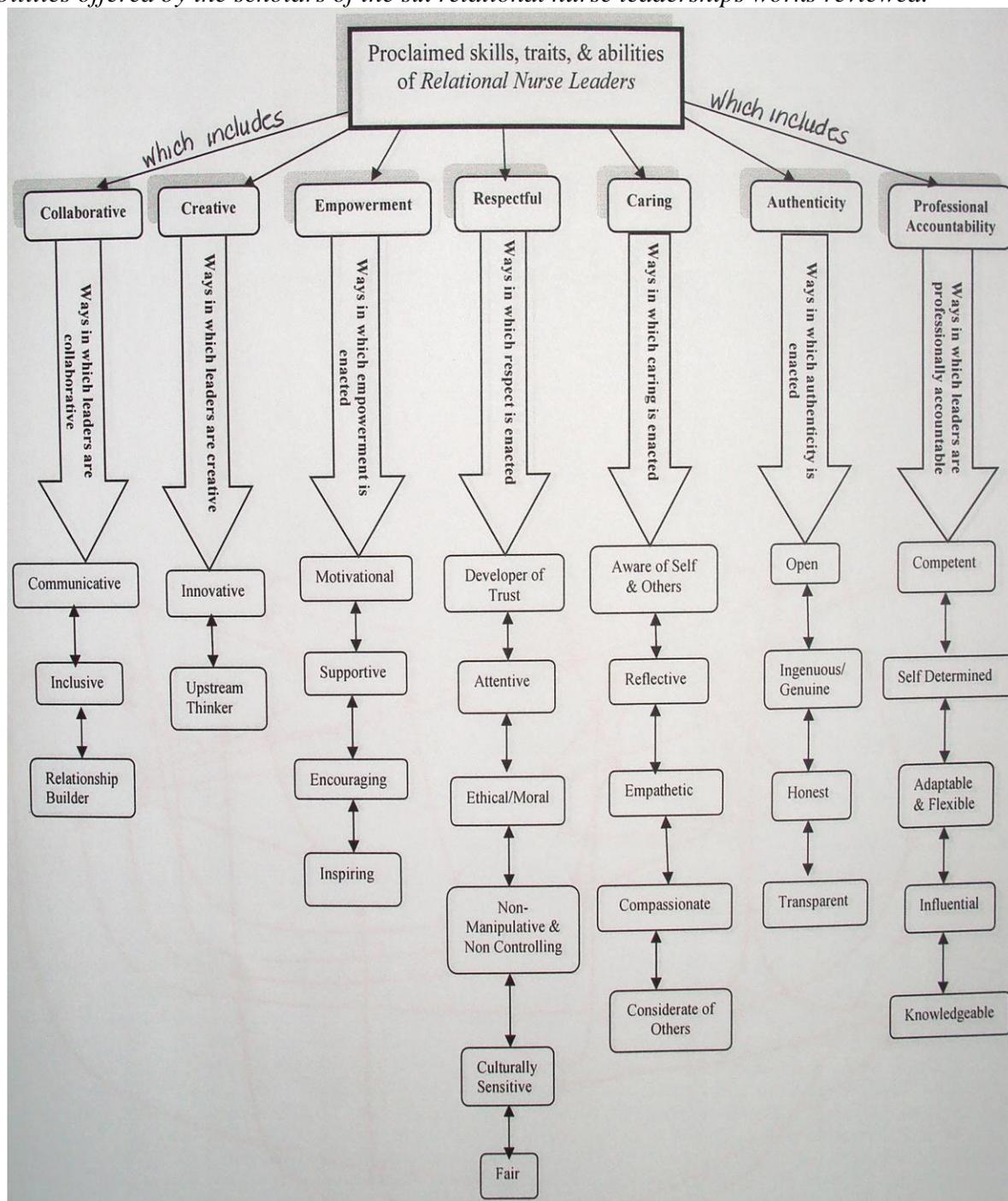
Phase One: Part One: Thirty nine specific skills, traits, and abilities found within the six literature resources reviewed on relational nurse leadership.

Skills & traits of relational nurse leaders proclaimed in the literature	Number of resources each skill & trait was found
Collaborative	6
Creative & Innovative	5
Communicative	5
Empowering	5
Inclusive	5
Motivational	5
Respectful	5
Supportive	5
Trust	5
Relationship Builders	4
Aware of Self & Others	4
Attentive	4
Ethical & Moral	4
Open	3
Reflective	3
Appreciative	3
Capacity Builder	3
Caring	2
Competent	2
Empathetic	2
Encouraging	2
Genuine	2
Influential	2
Inspiring	2
Non-Punitive	2
Professionally Accountable	2
Self Determined	2
Adaptable & Flexible	2
Affirmative	1
Authentic	1
Compassionate	1
Considerate of Others	1
Culturally Sensitive	1
Fair	1
Honest	1
Knowledgeable	1
Non-manipulative	1
Transparent	1
Upstream thinker	1

Appendix D

Figure D.1

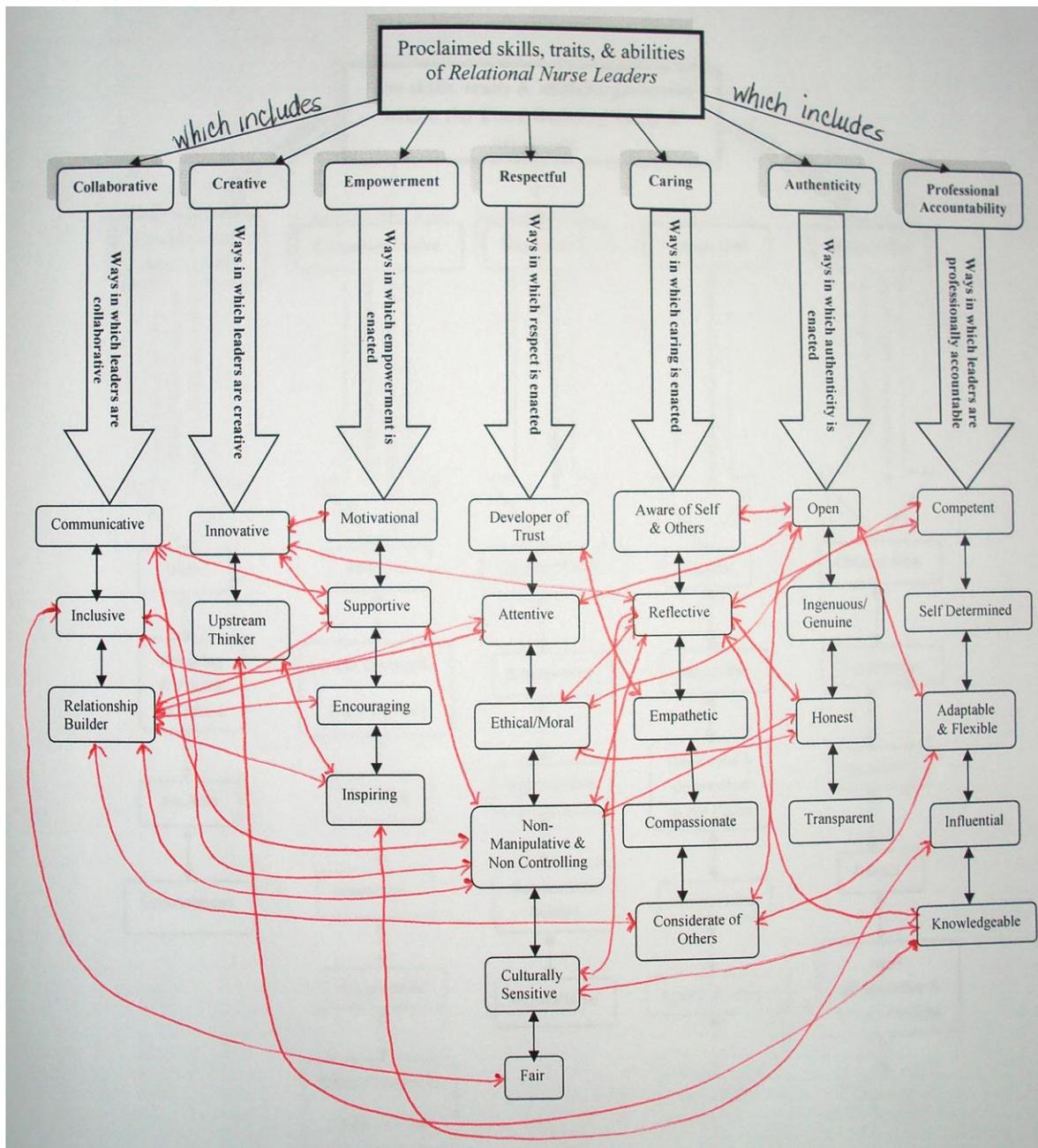
First concept map developed to express the most expressed or declared traits, skills and abilities offered by the scholars of the six relational nurse leadership works reviewed.



Appendix E

Figure E.1

Second concept map developed from the secondary analysis of the literature on relational nurse leadership to identify skills, traits and abilities declared within the literature. Note: thirty nine 'cross linkages' articulated in this map. These demonstrate how I perceived inter-relationships and connections between concepts located within one concept cluster with those located elsewhere.



Appendix F

Table F.1

Phase One, Part Two: exploring the five resources on team building tools and strategies to locate the skills, traits and abilities proclaimed by scholars as being beneficial for effective team work.

Resources Explored	Skills & traits promoted within the literature for Team Building
Andreatta (2010)	Situational Awareness Communicative Collaborative Competent Reliable Assertive Forth Coming & Sharing of Info Adaptable Open Trust Capacity Builder Supportive Dedicated & Committed to the cause Attentive
Chinn (2013)	Respect Honoring & Valuing of Others Interactive Communicative Forth Coming & Sharing of Info Reflective Dedicated & Committed to the cause Reverent Capacity Builder Attentive Open Honest Cooperative Empowering Supportive Appreciative Non Manipulative & Non Controlling Democratic Intuitive Conscientious Responsible Creative & Innovative

	Trust Inclusive
Howe (2014)	Empowering Competent Communicative Ethical & Moral Democratic Forth coming & Sharing of Info Attentive Supportive Heightened sense of Awareness of Self & Others Dedicated & Committed to the cause
Johnson et al. (2011)	Supportive Communicative Empowering Dedicated & Committed to the cause Awareness of Self & Others Collaborative Inclusive Relationship Builder Accountable Assertive Open Motivational Critical thinker & Problem Solver Adaptable
Marshall & Manus (2007)	Communicative Forth coming & Sharing of Info Critical thinker & Problem Solver Situationally Aware of Self & Others Dedicated & Committed to the cause Democratic Supportive Respectful Relationship Builder Trust Assertive Empowering Open Receptive Attentive

Appendix G

Table G.1

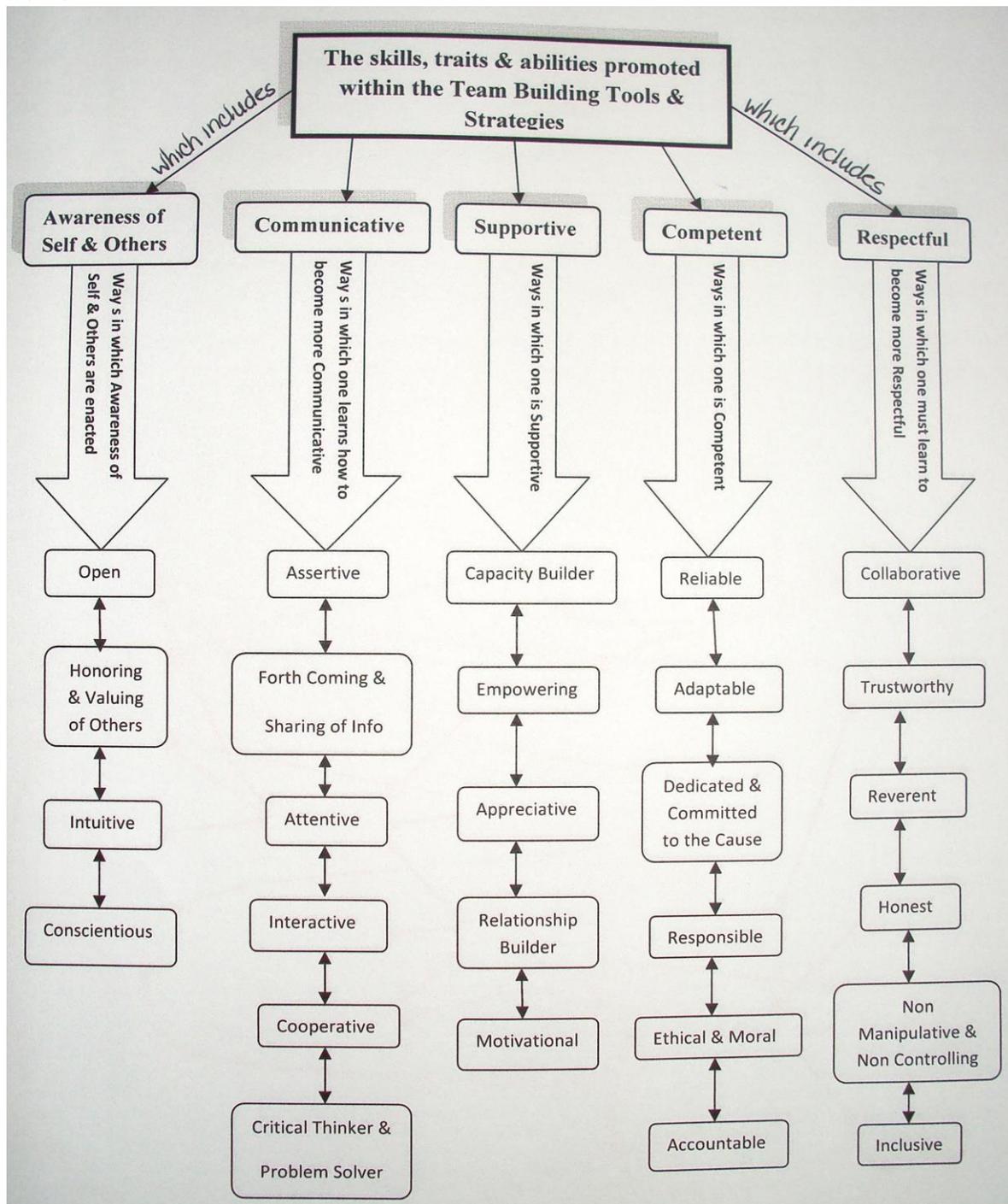
Part Two, Phase One: Thirty five skills, traits, abilities that were found to be encouraged and endorsed by the authors of five team building tools/strategies examined for this MN project.

Skills and traits endorsed within the literature on team building tools & strategies	Number of resources each skill & trait was located within
Awareness of Self & Others	5
Communicative	5
Dedicated & Committed to the Cause	5
Supportive	5
Attentive	4
Empowering	4
Forth Coming & Sharing of Info	4
Open	4
Assertive	3
Democratic	3
Trust	3
Adaptable	2
Capacity Builder	2
Collaborative	2
Competent	2
Critical Thinker & Problem Solver	2
Ethical & Moral	2
Non Manipulative & Non Controlling	2
Relationship Builder	2
Respectful	2
Appreciative	1
Reliable	1
Accountable	1
Responsible	1
Honoring & Valuing of others	1
Interactive	1
Reflective	1
Reverent	1
Honest	1
Cooperative	1
Intuitive	1
Conscientious	1
Inclusive	1
Motivational	1
Receptive	1

Appendix H

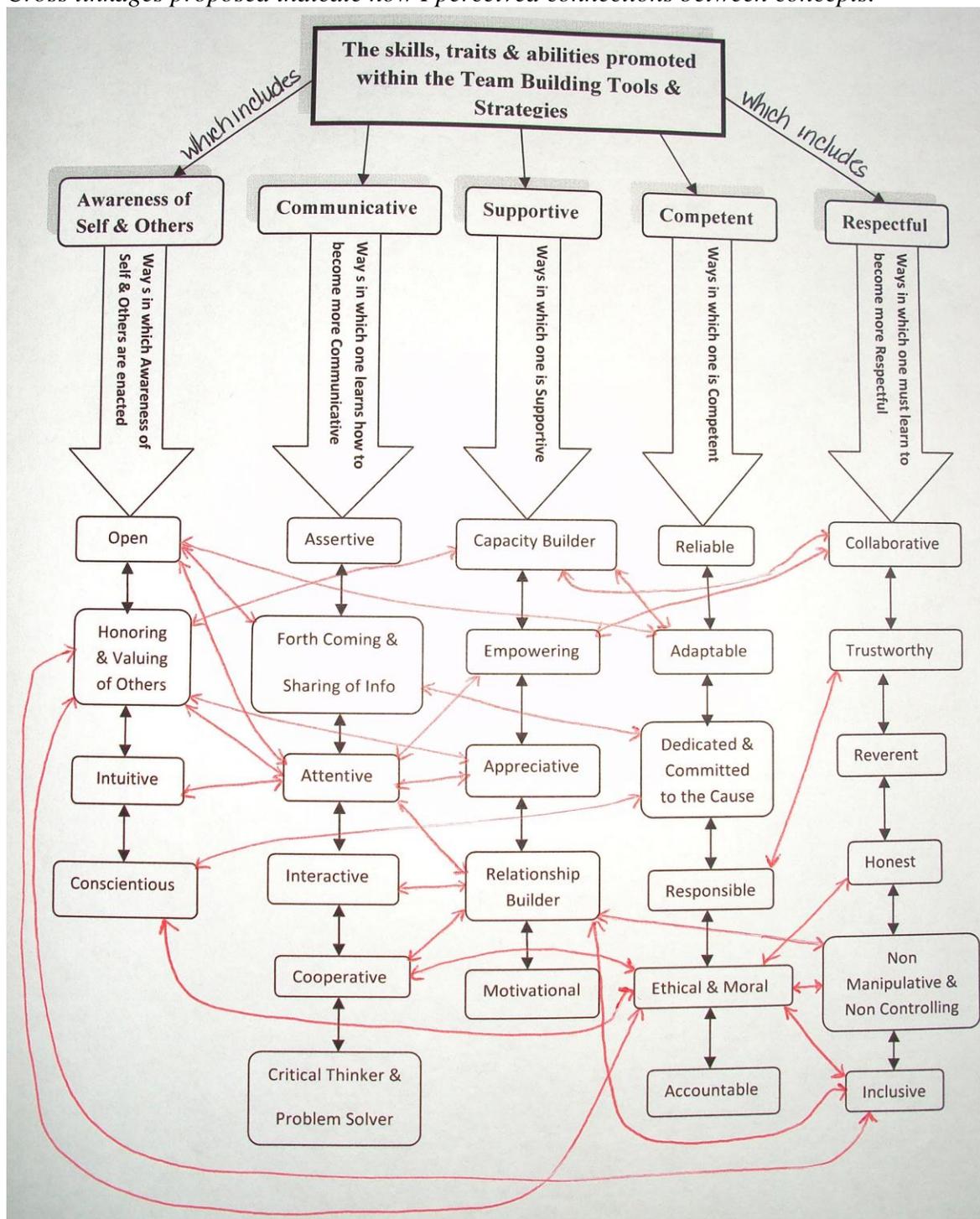
Figure H.1

First concept map developed to explicate the skills, traits, and abilities expressed by the scholars of the five team building tools & strategies resources reviewed. Hierarchy of skills in the map was developed by considering the importance given to the most expressed team building skills, traits and abilities endorsed by the scholars of these works.



Appendix I

Figure I.1
 Second concept map developed from the secondary analysis on team building tools and strategies. This map demonstrates how I developed thirty seven 'cross linkages' between concepts located under one concept cluster with others located elsewhere on the map. Cross linkages proposed indicate how I perceived connections between concepts.



Appendix J

Figure J.1.

Spider Map created to articulate the discovered alignment found between relational nurse leadership and team building tools/strategies. Each of the nine aligning skills/traits are represented inside a paper document that could be considered as core competencies needed for safe, competent, ethical RN team leadership practice.

