MASTERS THESIS

Experiences of Rebel Nurse Leadership in daily work: a qualitative study

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Abstract

Background Life expectancy and the demand of healthcare is increasing, as well as the shortage of nurses which creates risks for the safety and quality of patient care. This can be reversed by increasing nurse leadership, which contributes to better nursing outcomes and patient outcomes such as improved safety outcomes and patient satisfaction. A leadership practice which is mostly practiced 'under the radar' is rebel nurse leadership. This is an intentional and honourable behaviour, with elements of creativity, adaptability and innovation, and has a positive impact on the continuous improvement on the quality of patientcare. However, literature about rebel nurse leadership in daily work is still scarce.

Aim To gain insight in experiences of nurses with rebel nurse leadership practices in their daily work.

Methods Four focus group interviews were held in two hospitals and a long-term care organisation. A thematic analysis according to Braun & Clarke was carried out.

Results For all the participants, rebel nurse leadership was a new concept and few examples were mentioned. A wide variation of leadership practices appeared in nurses daily work. Four themes emerged from the data: (1) *On rebels, clinical leaders and wallflowers;* (2) *Improving quality of life*; (3) *Initiating continuous change;* and (4) *Influencing others.* Rebel nurses improve the quality of life of patients and the quality of care by deviating from protocols, going against existing structures and taking risks.

Conclusion and implication of key findings Rebel leadership practices are still unknown and scarce in daily work, but have a positive impact on the quality of life of patients and the continuous improvement of care. Stimulating rebel nurse leadership practices could be one of the answers to meet the needs of patients in the increasing demand of healthcare.

Key words Leadership (MeSH), nurse leadership, rebels, positive deviance

Samenvatting

Achtergrond De levensverwachting en de vraag naar gezondheidszorg neemt toe, alsook het tekort van verpleegkundigen. Dit creëert risico's voor de kwaliteit en veiligheid van patiëntenzorg, die voorkomen kunnen worden wanneer verpleegkundig leiderschap toeneemt. Dat draagt bij aan betere patiënt uitkomsten en verpleegkundige uitkomsten. Een leiderschapspraktijk die veelal 'onder de radar' plaatsvindt is rebels verpleegkundig leiderschap. Het is een doelbewuste en eervolle leiderschapspraktijk, met elementen van creativiteit, aanpassingsvermogen en innovatie, en heeft een positieve impact op de continue verbetering van de kwaliteit van de patiëntenzorg. Er is echter weinig literatuur over rebels verpleegkundig leiderschap in het dagelijks werk.

Doel Inzicht verkrijgen in ervaringen van verpleegkundigen met rebels verpleegkundige leiderschapspraktijken in hun dagelijks werk.

Methode Vier focusgroepen zijn gehouden in ziekenhuizen en een verpleeghuis. De thematische analyse volgens Braun & Clarke is toegepast.

Resultaten Voor alle deelnemers was rebels verpleegkundig leiderschap een nieuw begrip. Weinig voorbeelden werden genoemd. In één werkomgeving kan een variatie aan leiderschapspraktijken worden waargenomen. Vanuit de data ontstonden vier thema's: (1) *Over rebellen, klinisch leiders en muurbloempjes;* (2) *Verbeteren van kwaliteit van leven*; (3*) Initiëren van voortdurende verandering* en (4) *Beïnvloeden van anderen*. Rebellen verbeteren de kwaliteit van leven en de kwaliteit van zorg voor hun patiënten door af te wijken van protocollen, tegen bestaande structuren in te gaan en risico's te nemen.

Conclusie en implicatie van belangrijkste bevindingen Rebelse leiderschapspraktijken zijn nog onbekend en komen niet veel voor, maar hebben een positieve impact op de kwaliteit van leven van patiënten en het continu verbeteren van de zorg. Het stimuleren van rebelse leiderschapspraktijken kan één van de antwoorden zijn op de behoeften van de patiënt in de toenemende vraag naar gezondheidszorg.

1. Introduction

In the Netherlands, the demands of adequate healthcare are changing and increasing due to aging and comorbidity (1). An additional challenge, also faced in many European countries, is the shortage of nurses (2). In the Netherlands this shortage will rapidly rise to approximately 125.000 nurses if no action is taken (3) and result in an ever growing workload for staff nurses on the wards (4). Moreover, this towering shortage creates risks for quality and safety of care for patients (4,5). Reversing these developments is urged upon, so that the demands high quality care, in response to aging and comorbidity, can be sufficiently met.

One of the key factors in recruiting and retaining nurses is nurse leadership (6). Nurse leadership increases by empowering nurses, which in turn contributes to better patient outcomes such as lower mortality, improved patient safety outcomes, and higher patient satisfaction (7,8). Also nurse outcomes such as satisfaction, retention, recruitment, and a healthy work environment improves by stimulating nurse leadership (9).

Nurse leadership is thus seen as vital for both patients and nurses. In the last decade, many definitions of nurse leadership were drafted. Lalleman et al. (10), for example, described leadership as: *"the ability to influence all actors in and outside the healthcare organisation to act and enable clinical performance; provide support and motivation; play a role in enacting organisational strategic direction; challenge processes; and to possess the ability to drive and implement the vision of delivering safety in healthcare"*. Nurse leadership thinking is ever evolving. More classical views about leadership focus on heroic and hierarchical leadership based on position and belonging to management (11). In a novel and more critical approach to leadership, Carroll et al. (12) underline the importance of leadership as practice. The essence is that it evolves and unfolds in daily work through the collaboration of practitioners who achieve distinctive results, guided by their own rules (13). With the clinical leadership of nurses recognized (14,15), we as well turn to this new paradigm of leadership as practice (12,13) to fully comprehend nurses leadership in day-to-day quality improvement.

In analogy with Larsson and Lundholm (16) one could say that these nurses portray emergent and embedded, invisible leadership practices as 'under the radar'. In literature, they are referred to as healthcare radicals (17) or rebels (18). Gary (19) refers to this practices as positive deviant behaviour: *"the intentional and honourable behaviour that departs or differs from an established norm; contains elements of innovation, creativity, adaptability, or a combination thereof; and involves risk for the person deviating".* Essential for rebel nurses is, to make a difference which is tangible for their patients. They improve the

quality of care by learning and experimenting in their daily work, sometimes even for one patient (18).

Although there is increasing evidence about the positive impact of clinical nurse leadership (8,9,20), the evidence about a leadership as practice based approach, such as rebel nurse leadership, is scarce. In order to meet the current challenges such as the increasing demand of healthcare (1) and the shortage of nurses (2), it is important to further explore what the experiences of nurses with rebel nurse leadership are. It could be a small step to deeper understand what the meaning of rebel nurse leadership practices are in daily work for patients and nurses.

2. Objective

The aim of this research is to gain insight in experiences of nurses with rebel nurse leadership practices in their daily work.

3. Method

3.1 Design

This study has an exploratory qualitative design, and was carried out from February 2020 until June 2020. To gain more insight in experiences with rebel nurse leadership practices, focus groups were conducted. Focus group interviews are an appropriate method because the discussions can raise consciousness by participants and can lead to an individual change. Sharing of views of participants can also be experienced as empowering, because people realize that there are more professionals with a similar perspective (21). For reporting, the Consolidated criteria for reporting qualitative research (COREQ) checklist was used (22).

This study is part of the REBEL-V study, which consists of four phases. REBEL-V is a Dutch abbreviation for Rebel Excellent Passionate Energetic Leaders in Nursing. The current study is part of phase 2, and is a preparation on the action research which will be carried out in two hospitals, and one organisation which provide long-term care.

3.2 Participants

In total, 19 nurses and 3 nursing students participated in the study. Of them, 17 participants were working in a hospital, and 5 participants in a long-term care organisation. The inclusion criteria were: registered nurse, or third- or fourth year nursing student, and working in the direct patient care. Nurses who are detached from an employment agency were excluded. The demographic data of the participants is presented in Table 1.

[Insert Table 1 about here]

Convenience sampling was applied. The project leader of each organisation was asked to send an invitation by email to all nurses in their organisation. Nurses and nursing students who are interested in participating in a focus group about rebel nurse leadership were included after giving their consent.

3.3 Data collection

In each of the two participating hospitals from the REBEL-V study, one focus group interview was organised. In the long-term care organisation, three focus group interviews were planned. In one hospital, a test focus group interview was held, to test the interview guide and to optimize the collaboration of the researchers. Due to the COVID-19 pandemic, two focus group interviews in the long-term care were cancelled. The focus group interview which was initially planned as a test interview, is used as a formal focus group interview with permission of the participants. In total, four focus group interviews were held.

The focus groups lasted between 50 and 70 minutes. All focus group interviews were held in Dutch, audiotaped and transcribed. The focus group interviews were guided by two researchers with distinct roles. The role of the moderator (CR) was to interview, to create an open group climate, and to stimulate discussions and interactions. The facilitator (EK) assisted with practical issues in general and made observational notes (23). An semi-structured focus group guide was used, based on expert opinion and literature (17–19).

Every focus group interview started with a warm and friendly welcome to the participants, which helps to establish rapport (24). The moderator started the interview by showing six pictures from recent news items, to made clear what rebel leadership is. The focus group continued with discussing rebel nurse leadership practices in daily work. The moderator stimulated the discussion by asking questions, summarizing and submitting cases.

The following baseline data was collected: age (in years), sex (male/female), education level (bachelor/vocational), working experience as a nurse (in years), working experience in the current organisation (in years), and the work context (hospital/home care/long-term care).

3.4 Data analysis

In order to answer the research question, a thematic analysis according to Braun & Clarke (25) was carried out. The software program which was used for the analysis of the qualitative data is Atlas.ti 8 Windows (Atlas.ti, Berlin) (26). A logbook with choices made during the analysis is kept. For analysing the demographic data, SPSS (IBM Corp., New York) (27) was used.

The thematic analysis consists of six phases. The first step is to read and re-read the transcriptions of the focus group interviews and listening to the audio recordings. Second, codes are generated. Merging and clustering the codes into themes and sub-themes is the third step. Important is to explore the relationship within the themes, and to create one central theme. The fourth step is to review the developed themes in relation to the original data set and the codes. Then, in the fifth step, themes are named and defined. Finally, in the sixth step the report is written by describing the themes in the right order.

To increase the trustworthiness of the research, member check was done by sending the participants a summary of the focus group within two weeks. From each focus group interview, two or more participants confirmed the summary by email. Peer review was carried out during four video calls. The supervisor PBL and the PhD researcher EK gave feedback on the findings of the second, third, fourth and sixth phase of the analysis.

3.5 Ethical issues

This study was conducted according to the principles of the Declaration of Helsinki (28), and the Dutch Act on Implementation of the General Data Protection Regulation (29). For this study, as a part of the REBEL-V study, dispensation for the Medical Research Involving Human Subjects Act (30) is received. Informed consent was obtained from all respondents. In this report, aliases of the participants' names were used to protect their privacy.

4. Results

In the four focus group interviews, rebel nurse leadership was a new concept for almost all the participants. Most of them had difficulties describing this concept in relation to their day-to-day nursing practice on the ward, as Gytha said: *'I find this very difficult, what is rebellious*?'

The majority of the participants working in a hospital, demonstrated some knowledge about nurse leadership. Half of them gave examples showing that they are able to practice clinical leadership in daily work. They were open and curious about the topic and engaged each other critically. These participants had an active role in quality improvement on their ward, and were members of a hospital-wide working group or a Nurse Advisory Council. A few of these participants gave an example which implicate rebel nurse leadership. The participants described that they also have colleagues in their teams who do not want to change, do not have an active role in quality improvement, and do not show nurse leadership. In sum, a wide variation of leadership practices appeared or manifested themselves in nurses daily practice.

The participants working in the long-term care organisation found it difficult to speak of nurse leadership. They could not distinguish between managing and showing clinical nurse leadership. There were many silences during the focus group interview, and few examples from daily work were given. These participants experience low autonomy and lack of management support and no examples of rebel nurse leadership were given.

These above-mentioned descriptions of nurse leadership from our participants further guide the four themes of our findings. First, we elaborate on *On rebels, clinical leaders and wallflowers,* second, *Improving quality of life,* third, *Initiating continuous change,* and finally *Influencing others.*

On rebels, clinical leaders and wallflowers

The participants described that nurses who show rebellious practices have a clear opinion that differs from the group to which they belong. They have the courage to express their opinion and to deviate from existing norms. This can be both visible and invisible to others. They substantiate their opinion well and remain standing. Victoria summarizes a rebel as *"just someone who stands out (…) and goes against the flow."*

Where some nurses are able to openly show leadership practices, other nurses demonstrate them more in the background. Ann told about one of her colleagues: *"She does not have a*

big mouth, she stays very quiet, very calm." Although they are introverted, they also have an opinion and carry out clinical leadership practices.

Some participants dare not demonstrate leadership practices at all, as Tessa said:

> "I wouldn't dare do anything like that. (…) If everyone says it, they will probably be right. And they will probably convince me to follow their opinion, rather than providing my own well-founded arguments."

Some other participants support Tessa, and said that they can sometimes be convinced by others who have more knowledge, experience or authority than themselves. Most participants suggested that knowledge, work experience and self-confidence are necessary to demonstrate rebel leadership practices. In addition, Ann underlines the importance of role modelling in showing leadership practices: *"When you have a good buddy next to you, someone, sometimes the opposite of yourself, then you pull someone up."*

Improving quality of life

An example of improving the quality of life in a rebellious way is about Lucy:

> Lucy works in an oncology unit where patients can develop diarrhoea because of the treatment they receive. She does not always give the prescribed medicines Imodium®, but fibers, because in her experience this works much better as it is a natural remedy. When the diarrhoea was over the next day, she told the doctor that she had given fibers. "Then I say 'Listen, it works better, because the diarrhoea is gone.'"

As the fragment shows, the quality of life for their individual patient is the main motivation for rebel nurses to deviate well-founded from standards and protocols. When rebel nurses feel that they are taking risks, they choose to keep (temporarily) invisible that they deviate from regulations. Gathy says that rebels *"do things slightly differently, with the right intentions, without harming patients or their organisation".*

Many participants emphasize that making the difference for a patient is an important part of their job. Also for Emily:

> "When a young nurse comes to me today and she says, 'I called the Ambulance Wish Foundation today. And it is arranged! The gentleman can go home one more time.' And I said: 'And today, for the life that man has left, you made the difference.'"

For this nurses, the patient's wishes are the most important, not the fixed structure of the department or of other care providers. Deviating from protocols and taking risks is in these

situations often not necessary, which indicates one of the differences between clinical leadership practices and rebel leadership practices.

Initiating continuous change

Participants consider it important that the quality of care is continuously improved. Healthcare changes every day and they want to be part of it. Rebel nurses follow their own path, as Gytha makes clear:

> "When everyone turns left, I turn right. But in the hope, and then with full conviction, and if necessary with well-founded arguments, why they should also turn right. (…) I will first check, what are the rules, and who came up with them? And who had a say in this? And then I will do everything I can to make sure everything has to change."

Where rebels often act alone in improving the care for an individual patient, they seek out others when they want to initiate a continuous change. To change together, they establish connections with others who have the same drive and ambition, sometimes within their team, sometimes right across the organisation. When necessary, they go against existing structures. Resistance does not stop rebel nurses, but motivates them to persevere and to constantly propagate why a change is important. When Gytha get told no from a manager or department: *"I will just go to the next one. Until I succeed."*

Change can also be designed on a small scale in the department. Britt has adapted a protocol to reduce the frequency of blood glucose tests in patients with pancreatitis:

> "We used to do blood glucose tests for a longer time in pancreatitis, and now we do that for a shorter time. That also means that the workload for nurses decreases. So the patient is less affected by those injections, and we also."

Britt's example is one of many other examples from the focus group interviews. The small scale on which the improvement takes place, without the need to go against structures, testifies to a clinical leadership practice. However, also clinical leadership practices may face resistance from colleagues who do not want to change, as much participants experience. Sometimes, nurses get resistance from their manager as Patty experience:

> "So on the one hand, they [the team managers] let you determine things, and to take leadership on a particular project. On the other hand they say: no, back off. We determine, you perform."

Patty and her colleagues experience they get not enough support and autonomy from their manager to show leadership practices. These and other examples show that hierarchical leadership is still practiced in their work environment.

Influencing others

Rebel nurses stand up for good quality care for their patients and stand up for their profession. Helen told how she do that: *"I am going to influence a little, negotiate a little, then things sometimes change."* Rebel nurses negotiate with managers and influence organisational policy, which directly or indirectly concerns the quality of care for their patient. Positive experiences encourages them to do it again. Sometimes courage is needed, as the conversation of Emily shows:

> "I also recently had a conversation with a urologist about leadership. Then he said, and tapped my shoulder: 'If you all listen to me it will all go much better here.' It was a bit of a funny conversation, but I felt the underlying meaning. Then I thought okay... but I did it back. So I said, [and tapped the doctor's shoulder]: 'If you listen to me a little better, things are going much better here.'"

As Emily experienced, in a work environment in which multiple leadership practices are shown, nurse leadership practices sometimes lead to friction with others. This example also demonstrates that rebel nurses take control of their profession and take initiatives to increase their autonomy.

5. Discussion

In answering the research question of what nurses' experiences in daily work with rebel nurse leadership are, four themes were identified. (1) On rebels, clinical leaders and wallflowers; (2) Improving quality of life; (3) Initiating continuous change; and (4) Influencing others.

In the focus group interviews, few examples of rebel nurse leadership emerged. We think that there are at least three options here. First, a possibility is that rebel nurses have deliberately chosen not to accept the invitation of the focus group because then they come 'above the radar'. The second option is that rebel nurses participated in the focus group, but do not show themselves as rebel nurses, as invisibility is a characteristic of rebel nurses (17–19). The third option is that rebel nurse leadership in daily work is still scarce, which can be

explained by the fact that rebel nurse leadership was a new concept for most of the participants. This also applies to the literature in which little attention is paid to more critical leadership practices such as rebel nurse leadership. As Hutchinson reveals in her paper (11), more than 50% applies to more heroic leadership styles such as transformational leadership. Rebel nurse leadership can be seen as a 'family' of a more practice based approach to leadership, called leadership as a practice (13), which did not attract much attention in contemporary nursing leadership literature. The responses in the focus groups to rebel nursing leadership are in line with these scarce literature courses on the subject.

In literature, leaders are often described as heroic, charismatic (11), enthusiast and energetic, and able to take charge. This could suggest that persons who show leadership are extravert personalities (31). However, our findings show that there are nurses who display clinical leadership practices while remaining calm, quiet and doing their work in the background. Their leadership practices can also be referred to as quiet leadership (32). The similarities between quiet leadership and rebel nurse leadership are striking. Some characteristics, such as invisibility and creativity in devising solutions, occur in both leadership practices (17,18,31). These characteristics combined with strong analytical skills are important to provide solutions for complex situations in the care for patients (31). Leadership development however, is not about learning skills by an individual professional (12), but leadership is developed and embedded in day-to-day work through the collaboration and experiences of professionals (13). Our findings show that introverted nurses also contribute to this.

Another finding is that the main intention of rebels is to improve the quality of life of their patients, and to improve the quality of care. They do this by deviating well-founded from protocols, going against existing structures and taking risks. The example of Lucy, giving fibers on her own initiative, makes clear that rebel nurses chose to keep (temporarily) invisible that they deviate from protocols. An explanation can be that rebels consciously choose to stay under the radar so that they are not hindered in their actions (17,19,33). Rebels do not act unaccountable, as described by Wallenburg et al. (18), who speak about ‘walking the tightrope’. While rebels balance between being visible and invisible, they are accountable and try to create legitimacy and trust so that they can continue to improve the quality of care in their own way (18).

Strengths and limitations

A strength of the study is the presence and input of the facilitator (EK) during the focus group interviews. The observational notes contributed to the analysis. Another strength is the peer review of two experienced researchers (PBL and EK) in the preparation of the interview guide and in the analysis. The use of the focus group method is another strength, which is an suitable method for an under-researched topic as rebel nurse leadership is (24). A limitation of the method of focus group interviews could be that participants can choose to remain invisible as a rebel nurse, as mentioned above. This was attempted to lessen by asking the participants to treat the discussed matter confidentially, so that they feel safe to speak up (24).

Due to COVID-19 pandemic, no further data collection was allowed and two focus groups in the long-term care were cancelled. A limitation resulting from this is that the group of participants from long-term care is much smaller than the group of participants from the hospitals. As a result, it is not possible to make connections between any differences between the organisations. Since these are preliminary results, it cannot yet be stated that saturation has been achieved. Therefore, the two cancelled focus group interviews will be organised again in the autumn of 2020, provided that the measures surrounding the COVID-19 pandemic have been expanded.

Implications for research and practice

To increase the understanding of rebel nurse leadership practices, more qualitative research is needed. Shadowing is a more appropriate method, because rebel nurse leadership practices can be observed in their context (34).

In daily work, rebel nurse leadership is a practice which can unconsciously be present before attention is paid to it. As Carroll stated (12), leadership practices can be non-reflective and non-conscious. Important for nursing practice is to share stories and ideas of rebel leadership practices and to inspire nurses to learn together these practices in their daily work.

Conclusion

Although our findings show that rebel nurse leadership is still scarce and unknown in the daily work of nurses, our research has enabled us to provide more insight into nurses' experiences with rebel nurse leadership practices in daily work. Because rebel nurse leadership practices have a positive impact on the quality of life of patients and the continuous improvement of the quality of care, stimulating these leadership practices can respond to the increasing demand for health care.

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Appendix

Table 1. Baseline data

		N	%
Age	20 - 29	10	45.5
	30 - 39	6	27.3
	40 - 49	2	9.1
	50 - 59	4	18.2
Sex	Female	21	95.5
	Male	1	4.5
Education Base (highest initial education completed)	Higher General Secondary Education	2	9.1
	Vocational	10	45.5
	Bachelor	10	45.5
Education Further (further education completed)	No further education	17	77.3
	Specialization	3	13.6
	Otherwise**	2	9.1
Years Nurse (the number of years working as a nurse)	< 1 year	0	0
	1 - 5 year	9	40.9
	6 - 10 years	0	0
	> 10 years	10	45.5
	Nurse Student	3	13.6
Years Function (the number of years in the current function)	< 1 year	4	18.2
	1 - 5 year	11	50.0
	6 - 10 years	0	0
	> 10 years	7	31.8
Years Organisation (the number of years working in the current organisation)	< 1 year	4	18.2
	1 - 5 year	6	27.3
	6 - 10 years	2	9.1
	> 10 years	10	45.5
Setting	Nursing home	4	18.2

	Residential care home	1	4.5
	Hospital	17	77.3
**Otherwise: HBO Psychology; HBO Nursing Teacher*			