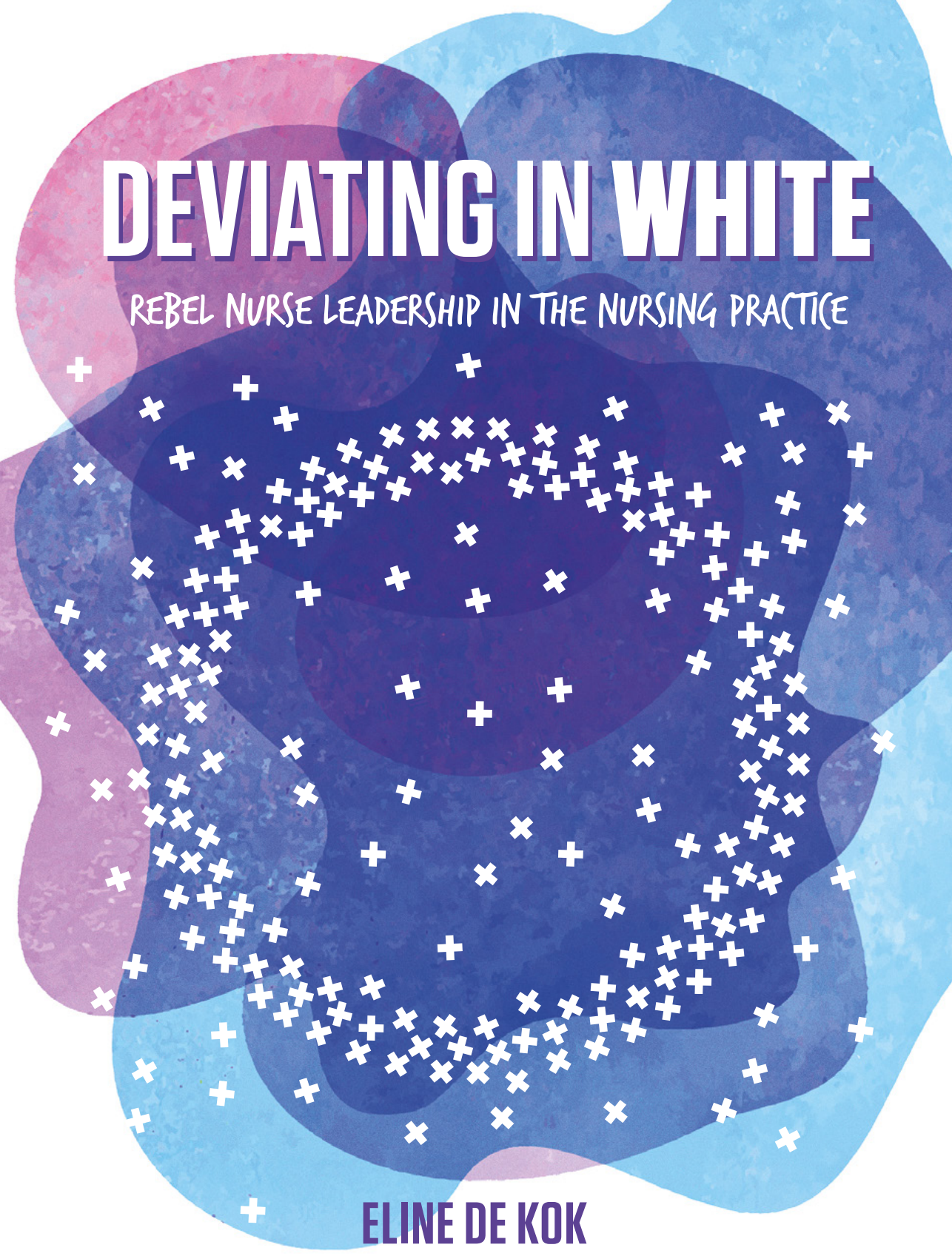
DEVIATING IN WHITE

REBEL NURSE LEADERSHIP IN THE NURSING PRACTICE



ELINE DE KOK

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REBEL NURSE LEADERSHIP IN THE NURSING PRACTICE

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Deviating in white

Rebel nurse leadership
in the nursing practice

Afwijken in het wit

Rebels verpleegkundig leiderschap
in de verpleegkundige praktijk

(met een samenvatting in het Nederlands)

Proefschrift

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1

GENERAL INTRODUCTION

> "Today I arranged that a patient she could return home from the hospital earlier. The patient was ready to be discharged, but because we do not provide tube feeding care at our nursing home (according to the admissions office), the transfer could not happen. I marveled at this because care around tube feeding should be something we are able to provide as nurses, right? If that is the only thing preventing this patient from going home, I want to be able to resolve this in another way. I noticed colleagues were holding off on taking over because they felt insufficiently competent to provide this care. But shouldn't we then make sure we feel competent again? I understand that knowledge has faded somewhat, but this is basic care that we should also be able to provide. I immediately set to work with the hospital to set up a clinical lesson and borrowed materials to make colleagues feel comfortable with tube feeding care again. I also made a quick call to a colleague from the nearest technical home care team and arranged that we could always contact their team for questions. The great thing is, tomorrow the patient can go home!"
>
> *Giny de Kok–de Cock*

The above excerpt is an example of nurse leadership—a topic I have been confronted with all my life: early on because of my mom was a nurse and often showed nurse leadership in daily practice, and later on because I became a nurse myself.

As a little girl, I often heard my mom talking about her experiences as a nurse, having to show nurse leadership to benefit her patients. At dinnertime, she regularly discussed patient cases and how she did her best to deliver the professional nursing care that matched their unique needs.

When I was older, I saw her in action when she took me with her to work. And what did I keep seeing? A nurse who stood up for her patients, who considered quality of care a high priority, who had an enormous network in which to gather and share knowledge, who critically reflected on her actions, and who constantly challenged the status quo and herself to do the right thing for her patients. Many of her colleagues also voiced this:

> "She stood up for her patients and the quality of care. She was always well prepared; if she didn't have the knowledge about something she searched for it, and you knew you could always rely on her. You also knew that if she reacted to something it came from a well-founded foundation, and she had thought a lot about it. She kept developing herself and took her colleagues along by sharing her knowledge and expertise. She always looked for possibilities instead of being held back. You could never disagree with her because it was never about her but about her patients and the quality of care. She was respected by her colleagues and doctors and was an authority within the organization. And not that she flaunted that; no, she was a silent engine that made a difference."
>
> *Former colleague of Giny de Kok-de Cock*

When I became a nurse and gained my own experience in healthcare and nurse leadership, my mother became my sparring partner. With her I gladly shared my experiences and astonishments at the healthcare system, the colleagues I worked with, and the difficult patient cases I encountered. I often felt an internal conflict between what I thought was the right thing to do as a nurse and what was allowed in my practice. And as benefits a good nursing role model, my mother listened to me, asked questions, encouraged me, coached me, and challenged me to become a nurse who stays close to her own norms and values in treating and caring for her patients. But also, a nurse who challenges the status quo and improves nursing practices. Therefore, it is not surprising that my interest in nurse leadership kept growing over the years and has led to this thesis on rebel nurse leadership practices.

In 2014, when I graduated as a nursing scientist, many healthcare professionals in the Netherlands began noting the importance of nurse leadership in daily practices. Within a short period of time, new books, websites, reports, and articles appeared about nurse leadership in the Netherlands (e.g. Lalleman, 2017; Vermeulen et al., 2017) and emerged more frequently as a topic of discussion at nursing conferences. Nurse leadership became an important topic at the Dutch Nurses Association where, at the time, I worked as an adviser in professional development. However, when I discussed the importance of nurse leadership during my nursing shifts at the University Medical Center in Utrecht, it became clear to me that my colleagues were struggling to find ways to do nurse leadership in their daily practices. And this was also the case for nurses from other healthcare organizations, whom I met during my work at the Dutch Nurses Association. Although nurse leadership was a hot topic, I noticed that nurses found it difficult to indicate how it occurred in their daily practice. Nurses often told me that they viewed nurse leadership as something that primarily took place in designated leadership roles, for example, nurse managers, nursing coordinators, and nurses on nursing advisory boards. Ward nurses found it hard to describe what nurse leadership looks like in direct patient care. This triggered my interest because, in my opinion, nurse leadership should be everywhere in patient care. Many questions arose about leadership in nursing practices. For example, why is it hard for nurses to see their nurse leadership actions in practice? How does nurse leadership occur in daily practice? How can we stimulate nurse leadership when nurses themselves do not see examples of nurse leadership in patient care? And which interventions help to stimulate nurse leadership in practice? The desire to help my nursing colleagues make their leadership practices more visible got stronger and stronger. I delved into the literature on nurse leadership and found out that this topic was extensively researched (e.g. Cummings et al., 2018, 2021; McCay et al., 2018; Stanley & Stanley, 2018; Wong et al., 2013) and continues to arouse the interest of many researchers. However, many of my above questions were not answered. After reading an abundance of nurse leadership literature, I learned about the 'positive deviants' and 'rebels,' in which I recognized my own experiences and opinions of nurse leadership practices. Now I was really curious about this topic, which was not well described in the nursing context. To address this, in 2018, I initiated the REBEL-V study (In Dutch: *Rebelse Excellente Bevlogen Energieke Leiders in de Verpleegkunde*, in English:

'Rebellious Excellence-Inspired Energetic Leaders in Nursing') and formed the research team, to investigate this remarkably interesting topic of in the context of nurse leadership practices.

This thesis describes and discusses the results of the REBEL-V study. In this general introduction, we first explain why focusing on nurse leadership in patient care is so important. In addition, we give an overview of the multitude of leadership styles in nursing literature, briefly describe the practices of nurse (leadership), introduce the concept of rebels, and describe the aim, study method, and outline of this thesis.

The importance of nurse leadership

Most nurse leadership research focuses on the importance of nurse leadership. These studies note that nurse leadership is needed to ensure a high-quality healthcare system that consistently provides safe and efficient care (Daly et al., 2014; Dempsey & Assi, 2018; Sfantou et al., 2017). Research has shown that both the engagement and leadership of nurses is critical in nursing practice (Allen, 2014; Wei et al., 2018) to give and improve the quality and safety of care (Dempsey & Assi, 2018). Several studies have also shown that when nurses can influence their practices, patient outcomes and the quality of care are improved, and the safety culture is enhanced (Aiken et al., 2014; Alilyyani et al., 2018; Boamah et al., 2018; Braithwaite et al., 2017; Lasater et al., 2019; McCaughey et al., 2020; Rodríguez-García et al., 2020; Stalpers et al., 2015; Stimpfel et al., 2014).

Nurses have a crucial role in healthcare organizations. Their work extends far beyond direct patient care (World Health Organization, 2020). In interprofessional collaborative practices with various professionals and patients (Morley & Cashell, 2017), nurses support and sustain the delivery and organization of high-quality health services (Allen, 2014). Besides direct patient care, the work of nurses includes coordinating complex systems and processes to ensure the translation of knowledge, people, and processes, as well as material resources into meaningful and person-centered care trajectories (Allen, 2014). Allen (2014) calls this the *'organizing work of nurses'*, which is vital to ensure that patients receive the right care, in the right place, and at the right time. Nurse leadership allows nurses to influence this coordinating and translating work within these complex systems and processes.

Nevertheless, the important work of nurses is under pressure worldwide because nursing shortages (International Council of Nurses, 2021; World Health Organization, 2020) adversely affect healthcare quality (Aiken et al., 2018; Ball et al., 2014; Rosenberg, 2019). The Netherlands saw a shortage of some 19,600 nurses in 2021 and this number is predicted to increase in the coming years (Prognose model Zorg en Welzijn, 2023). Nursing shortages are caused by the ongoing demand for nursing care due to the aging population and increasing comorbidity (Haddad et al., 2023; Leung et al., 2019). Furthermore, the number of available nurses has decreased as nurses leave the profession because of the many challenges they have to face (Fasbender et al., 2019; Goodare, 2017; Haddad et al., 2023; Li et al., 2018; Marć et al., 2019). These challenges include high workloads caused by nursing shortages, increased paperwork, and limited opportunities for professional leadership or innovation

(Goodare, 2017; Kox et al., 2020). It seems that nurse leadership is not only important for high-quality, efficient, and safe care but also for creating a professional work environment in which nurses' knowledge and experience are sufficiently used (Maassen et al., 2021; Mcclure et al., 1983; Rodríguez-García et al., 2020). When nurses work in a professional work environment, they deal with the shortages by critically reflecting on their working habits and offering alternative solutions and routines to organize their work differently. Research has shown that when nurses influence their work environment and organize their work differently, their job satisfaction and intention to stay increases (Kelly et al., 2012; Kim et al., 2020; Rodríguez-García et al., 2020). Therefore, nurse leadership not only improves the quality of care but also the work environment.

When one lists the contributions of the crucial role of nurse leadership, it becomes obvious that healthcare organizations focus more and more on developing a supportive and positive nursing work environment that stimulates nurse leadership. Investment in nurse leadership development has increased (McGowan et al., 2020) and programs have been developed worldwide to provide healthcare organizations with the supportive nurses' work environment that stimulates nurse leadership. These programs include 'Magnet Recognition' (American Nurses Credentialing Center, 2021) used in many countries (e.g., Australia, Belgium, Canada, China, Saudi Arabia, and the United States), 'Healthy Workplace, Healthy You' (Royal College of Nursing, 2022), and the 'Excellent Care Program' (Verpleegkundigen en Verzorgenden Nederland, 2022a). While any nurse can show leadership to improve the quality of care and work environment (Cardiff et al., 2018; Stanley & Stanley, 2018; Van Schothorst-Van Roekel et al., 2021), strikingly most leadership programs focus on individuals in designated leadership positions, e.g., nurse executives and nurse managers (Cope & Murray, 2017; Heuston et al., 2021; Pearson, 2020; Shaughnessy et al., 2018; Wei et al., 2018), and primarily approach nurse leadership from a transformational leadership perspective (Cummings et al., 2018, 2021; Page et al., 2021). However, nurses not in designated leadership positions (i.e., bedside nurses) also exhibit leadership in practice. This is often described as 'clinical nurse leadership' (Cardiff et al., 2018; Mianda & Voce, 2017; Stanley & Stanley, 2018; Van Schothorst-Van Roekel et al., 2021) and refers to nurses who are able to *"display their beliefs and values related to the quality of care and they interact with patients in a 'hands-on' fashion, living out their values in the delivery of clinical interventions"* (Stanley & Stanley, 2018, p. 1741).

To summarize, nurse leadership is approached and understood from various angles and perspectives. This variety is reflected by the multitude of research on nurse leadership (Cummings et al., 2018, 2021; McCay et al., 2018; Stanley & Stanley, 2018; Wong et al., 2013). Consequently, there are many interpretations, definitions, and descriptions of this topic. To elaborate further on nurse leadership practices, it is necessary to delve further into the nurse leadership literature to define the existing interpretations, definitions, and descriptions. In the next section, we will describe the various nurse leadership definitions and perspectives found in the nurse leadership literature.

An overview of nurse leadership

Leadership is an ever-growing field of research in literature (Fischer & Sitkin, 2022). There are many different descriptions of leadership styles (Cummings et al., 2018, 2021; Fischer & Sitkin, 2022). Two leadership styles are often studied: *'relationally focused leadership'* styles and *'task focused leadership'* styles (Cummings et al., 2018, 2021). **Relationally focused leadership styles** concentrate on the behavior and competencies of people in relation to others. These styles are *'transformational leadership'* (Bass & Avolio, 1994), in which a leader employs charisma and enthusiasm to inspire their followers, *'resonant leadership'* (Boyatzis & McKee, 2005; Goleman et al., 2003), in which leaders inspire followers through consistently positive relationships and emotions, and *'authentic leadership'* (Gardner, Avolio, & Walumbwa, 2005; Gardner, Avolio, Luthans, et al., 2005; Walumbwa et al., 2008), in which leaders are not only true to themselves but also lead others by helping them to achieve authenticity. **Task focused leadership styles** focus on the behavior and competencies of people to achieve results. These styles include *'transactional leadership'* (Bass & Avolio, 1994), in which the leader uses rewards in exchange for tasks completed to motivate their followers, *'dissonant leadership'* (Goleman et al., 2003), in which leaders focus on achieving goals and company growth rather than on the individuals, and *'instrumental leadership'* (Avolio et al., 1999), in which leaders ensure tasks are completed and provide feedback to employees to help them improve their performance; and *'laissez-faire leadership'* (Avolio et al., 1999), in which leaders delegate tasks, give their followers the autonomy to make their own decisions, and only step in when performance levels have already fallen.

All these styles approach leadership from the classical view, focused on heroic and hierarchical leadership (Hutchinson & Jackson, 2013). They concentrate on the leader's perspective and how this leader influences their followers. However, in recent years, some scholars have indicated that this perspective is too limited when it comes to nurse leadership. Nursing practices are inherently turbulent, interprofessional, distributed, shared, and collaborative in nature (Alvesson, 2019; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013; Morley & Cashell, 2017; Raelin, 2016a, 2016b). The heroic, classical leadership view does not take this distributed, shared, and collaborative nature into account. Despite Cummings et al. (2018, 2021) endorsing some styles as *'relationally focused leadership'*, these styles continue to describe how leadership should be and what the characteristics of leadership should be, and thus assume the image of the ideal leader (Carroll et al., 2008). Consequently, several scholars have argued that nurse leadership studies should focus more on the practices in which leadership emerges rather than on individuals (Alvesson, 2019; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013; Morley & Cashell, 2017; Raelin, 2016b). For that reason, when we want to do justice to the *'lived experience'* of leadership in mundane practices, nurse leadership must be seen as relational and collaborative (Fairhurst et al., 2020; Ospina et al., 2020). This is consistent with the literature on *'distributed leadership'* or *'shared leadership'* (Fairhurst et al., 2020; Gronn, 2002), which approaches leadership as the structuring influence of numerous individuals, or with other leadership perspectives, such

as *'complexity leadership'* (Uhl-Bien et al., 2020), which approaches leadership as networked interactions that enable new ideas to flow into the operational system, and *'leadership-as-practice'* (Raelin, 2016a), which approaches leadership as *"a cooperative effort among participants who choose through their own rules to achieve a distinctive outcome"* (Raelin, 2016a, p. 3). In sum, these leadership approaches zoom in on how different actors view, act, and talk about their interactions with each other, their relationships, and how they collectively construct reality. They focus on leadership practices instead of leaders.

However, according to Hutchinson & Jackson (2013), most nurse leadership studies still approach leadership from the classical, heroic, and individual point of view. To understand, learn, and stimulate leadership in nurses, we need another 'lens' through which to study leadership (Ospina et al., 2020). To start with this other lens, it is essential to have a comprehensive view of the practices in which nurse leadership is established and to understand how it occurs in the nursing practice. The next section briefly describes nurse (leadership) practices.

Nurse leadership practices

Morley & Cashell (2017) describe nursing as interprofessional and collaborative practices in which professionals must relate to their patients, their colleagues, and their organization. These practices consist of various activities and interactions in which *'interventions'* and *'relational work'* facilitate the delivery of care (Mol et al., 2010). In her extensive work on nursing practice, Allen (2014, 2018) says that nurses must mediate between direct patient care and the organizational context in which their patient care takes place. She argues that nurses are *'focal actors in health systems'* and that they *'sustain the networks'* through which care is organized (Allen, 2014). In addition, nurses operate *"as a powerful countervailing force to the centrifugal tendencies inherent in healthcare organisations, which, for all their gloss of order and rationality, are in reality very loose arrangements"* (Allen, 2018, p. 37). Consequently, nurses regularly confront the contradiction between how their work should be done to bring about the intended outcome and the way that their work is done in practice. Nurses are often challenged to do things (slightly) differently when organizational rules and regulations do not fit their (professional) norms and beliefs in what is best for their patients (Wallenburg et al., 2019). Therefore, if the system does not match their professional point of view they frequently generate workarounds, positively deviate, and take the responsibility to challenge practices to regulate patient care (Debono et al., 2013; Gary, 2013; Hollnagel & Clay-Williams, 2022; Meyerson, 2008; Wallenburg et al., 2019). Lalleman et al. (2016) find that nurses have a 'compensatory mode' (McNamara & Fealy, 2010) for everything that is poorly regulated in the system. Some researchers are critical of these workarounds because they are often quick fixes instead of sustainable change, time-consuming, and could lead to frustration and poor quality of care (Debono et al., 2013; Edmondson, 2004).

In addition to workarounds, nurses also deviate positively in their working practices. Positive deviance *"contains elements of innovation, creativity, adaptability, or a combination*

thereof, and involves risk for the person deviating" (Gary, 2013, p. 29). Other terms for nurses who show deviating behavior are *'tempered radicals'*, individuals who *"navigate the often murky organisational waters to pursue their ideals while fitting in enough to succeed"* (Meyerson, 2008, p. 8), and *'healthcare rebels'*, individuals committed to the patient-centered mission and values of their organization (Bevan, 2013a, 2013b). Both definitions show the healthcare professionals do their work slightly differently with their hearts in the right place, and look for a balance between creating spaces for other approaches and meeting the essential systems to ensure the organizations' function (Wallenburg et al., 2019). It is apparent that leadership is needed to deviate from rules, regulations, norms, standardizations, and control, and this leadership thus has a positive effect on the quality of care and the contributions in healthcare organizations (Clancy, 2010; Gary, 2013).

Wallenburg et al. (2019) further note that nurses who deviate tend to stay *'under the radar'* of management to achieve their goal of improved patient care. In agreement with the findings of Wallenburg et al. (2019), Allen (2014) observes that because much of the work of nurses is often invisible, it is not always valued in healthcare organizations (Allen, 2014). Mol et al. (2010) add that nurses deserve more credit for their crucial role in providing quality care. Rebels take responsibility for needed changes, but because organizations and other healthcare professionals do not notice the problems in rules and regulations that hinder nurses in their practices, the deviating work is frequently invisible. This means that organizations, nurses and other healthcare professionals cannot learn from the ways rebel nurses handle problems and the (smart) innovations they implement in practices. This also means that management cannot properly support nurses in their working environment to change the hindering rules and regulations. Finally, the unnoticed (smart) innovations could be deployed to benefit the whole organization. Acting 'under the radar' creates possibilities and a feeling of freedom to do things differently. However, it gives little insight into the nurses' working methods and the potential for sustainable innovation and change (Wallenburg et al., 2019).

Because rebel nurse leadership practices are important for sustainable innovation, which benefits the quality of care, and sustainable change, which benefits the work environment of nurses, it is crucial to learn more about rebel nurse leadership and how it is reflected in nursing practice.

Research aim and questions

The aim of this thesis is to explore and understand the concept of rebel nurse leadership and to describe how rebel nurse leadership is reflected in nursing practice. In addition, we want to give insights into the factors that stimulate and hinder the development of rebel nurse leadership.

The study addresses this central question:

- How is rebel nurse leadership reflected in nursing practices?

The following questions lead our research and analyses:

1. What characterizes rebel nurse leadership practices?
2. When and how do rebel nurse leadership practices occur?
3. Which factors stimulate rebel nurse leadership practices?
4. How do nurses collaborate with their colleagues and managers in rebel nurse leadership practices?
5. Which challenges do nurses and nurse managers face in rebel nurse leadership practices, and how do they deal with these?

Methodology: a mixed-methods approach

Rebel nurse leadership is a new concept. The diversity of the research questions makes it necessary to study the concept in several ways. We chose to use a mixed-methods approach that allows us to analyze in-depth how nurses—and other actors—actively practice and talk about rebel nurse leadership. Our mixed-methods approach involved conducting a scoping review, two descriptive qualitative studies, and an action-oriented, multiple-case study.

The scoping review (Peters et al., 2015) allowed us to identify and synthesize the current state of knowledge, identify themes that emerged across studies, and set the stage for further research about rebel nurse leadership. The aim was to give an overview of rebel nurse leadership by summarizing descriptions of positive deviance, tempered radicals, and healthcare rebels. In addition, we wanted to examine the competences related to rebel nurse leadership. Finally, we wanted to find and describe factors that stimulate or hinder the development of rebel nurse leadership.

Having gained information in the scoping review and made a preliminary description of rebel nurse leadership, we wanted to explore how nurses, nurse managers, and other professionals experience rebel nurse leadership in actual nursing practice. To investigate this, we conducted two descriptive qualitative studies (Bradshaw et al., 2017). The first aimed to reflect on how the contributions of the Dutch 'Excellent Care Program' contributes to nurse leadership development and rebel nurse leadership practices. This study gave us the opportunity to explore what happens when healthcare organizations help develop nurse leadership in the nursing environment, as this was a crucial element of the Excellent Care Program. The second descriptive qualitative study aimed to obtain insights into how nurses experienced rebel nurse leadership in their work. We wanted to know how rebel nurse leadership arises in practice and what happens when nurses show rebel nurse leadership.

Lastly, we also wanted to see what actually happens in the practices of rebel nurse leadership. Therefore, we conducted a multiple-case study (Stake, 2006) to observe rebel nurse leadership in various nursing practices. Through shadowing and interviews, we closely followed nurses and nurse managers and reflected on their practices. This final study

aimed to gain insights into the contemporary context of rebel nurse leadership, the 'lived experiences' of nurses and nurse managers, and the dilemmas they face in rebel leadership practices. This study method produced in-depth information on rebel nurse leadership practices and helped us to study the multiple cases together as a whole.

Outline of this thesis

This thesis addresses the aims and answers the research questions in five published academic articles (chapters 2–6) and a concluding chapter (chapter 7):

- **Chapter 2** *'Nurse leadership development: A qualitative study of the Dutch Excellent Care Program'* provides insights into the contributions of the 'Excellent Care Program' to nurse leadership development. We describe the processes that started in healthcare organizations when nurses got to work in a healthy, stimulating, and supportive working environment. We describe how these processes contribute to the development of nurse leadership as well as how the identified processes are interrelated.

- **Chapter 3** *'A scoping review of rebel nurse leadership: Descriptions, competences and stimulating/hindering factors'* summarizes 1) the descriptions of 'positive deviance', 'tempered radicals', and 'healthcare rebels', 2) the competences of rebel nurse leadership, and 3) the factors that stimulate or hinder the development of rebel nurse leadership. The chapter concludes with a preliminary definition and description of rebel nurse leadership, which we used in our further studies.

- **Chapter 4** *'Beyond transformational leadership in nursing: A qualitative study on rebel nurse leadership-as-practice'* provides insights into the nurses' experiences of rebel nurse leadership in their daily practices based on our talks with nurses from two hospitals and one long-term care organization about the concept of rebel nurse leadership and how it occurs in their practices. The chapter also deals with the complexity of studying nurse leadership in nursing practice.

- **Chapter 5** *'Exploring experiences that shaped change in the nurses' work environment during the COVID-19 pandemic: a qualitative study'* explores the experiences of nurses and hospital staff in the nurses' work environment during the COVID-19 pandemic. This pandemic gave us the chance to study rebel nurse leadership in the nurses' rapidly changing working environment. By interviewing nurses and (nurse) managers from a large teaching hospital (one of the first Dutch hospitals to be flooded with COVID-19 patients), we gained insights into how nurses showed leadership to shape their work environment, responding to the demands of COVID-19.

- **Chapter 6** *'Understanding rebel nurse leadership-as-practice: challenging and changing the status quo in hospitals'* gives insights into rebel nurse leadership practices based on a multiple-case study held in two Dutch hospitals. Our observations and interviews illustrate the context, dilemmas, and interactions in rebel nurse leadership practices. Using three characteristic rebel nurse leadership practices, we describe how rebel nurse leadership is reflected in practices and provide insights into the challenges nurses and nurse managers face in these practices.

- **Chapter 7** *'General discussion'* presents the main findings, reflects on the important outcomes of the work, provides recommendations for clinical practice, research and education. The thesis ends with an appeal to all actors in healthcare to regard creative rebel nurse leadership as having the potential to deal with nursing practice challenges that may arise in upcoming years.

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2

NURSE LEADERSHIP DEVELOPMENT: A QUALITATIVE STUDY OF THE DUTCH EXCELLENT CARE PROGRAM

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Abstract

Aims: To understand how nurses perceived the contributions of the Dutch Excellent Care Program the development of nurses' leadership and their ability to positively influence their work environment.

Background: Research shows that the nursing work environment influences job satisfaction, retention, and quality of care. Many countries have created programs such as the Excellent Care Program to improve nurses' leadership to facilitate a positive work environment.

Methods: Descriptive qualitative study based on 17 semi-structured group interviews (participants N=52) and directed content analysis using thematic coding.

Results: Four program processes contribute to leadership development: 1) nurses taking responsibility for their knowledge and skills development; 2) strengthening organizational structures to improve nursing governance; 3) challenging the status quo with quality-enhancing projects; and 4) enhancing awareness of the supportive role of the nurse manager.

Conclusions: The program supported nurses' leadership development for a positive work environment. The interrelatedness of the four processes enhanced the nurses' ability to solve day-to-day problems and challenge the status quo that influenced working practices.

Implications for Nursing Management: The findings support making improvements to healthcare organizational strategies to encourage nurses to show leadership in their work environment.

Introduction

Many countries face difficulties in attracting and retaining nurses (Bratt & Gautun, 2018; Brown et al., 2013; Devi et al., 2021; Lu et al., 2012). Previous studies have indicated the vital role of the work environment in retaining staff (Aiken et al., 2011; Mcclure et al., 1983; Ritter, 2011; Wei et al., 2018). The literature shows that improving the work environment results not only in higher job satisfaction, and nurse retention, but also in better quality of care and patient outcomes (Aiken et al., 2011; McCaughey et al., 2020; Rodríguez-García et al., 2020). In contrast, staff shortages negatively influence care quality (De Simone et al., 2017; Wei et al., 2018) and create a less healthy workforce suffering from psychological (e.g., emotional exhaustion) and physical problems (e.g., heart disease and diabetes) (Cicolini et al., 2014; Rodríguez-García et al., 2020).

Thus, it is imperative for healthcare organizations to have a positive work environment (e.g. healthy, supportive and stimulating). A positive work environment is defined as the inner setting of the organization, in which employees work and is the result of respect and trust between employees at all levels, getting recognition for good work, getting support from management, effective collaboration and communication, a safe climate, and a healthy workplace (Damschroder et al., 2009; Maassen et al., 2021). Although several studies have measured the nurses' work environment (Maassen et al., 2020), research is sparse on how nurses not in designated leadership positions can influence their environment.

Nurse leadership appears crucial to creating a positive work environment (Aiken et al., 2011; Maassen et al., 2021; Mcclure et al., 1983; Ritter, 2011; Wei et al., 2018). According to Wei et al. (2018) leadership and work environment are interdependent. Cummings et al. (2018) state that leadership helps nurses ameliorate their work environment. Several authors mention healthcare organizations putting emphasis on improving nurse leadership (Cummings et al., 2021; Mcdonald, 2014) and investing in leadership development (McGowan et al., 2020) to improve the work environment and nursing practices. Many countries have enhancement programs such as 'Magnet Recognition' (American Nurses Credentialing Center, 2021) used in many countries (e.g., Australia, Canada, China, Saudi Arabia, Belgium, and the United States) and 'Healthy Workplace, Healthy You' (Royal College of Nursing, 2022). Most programs focus on designated leadership positions, that is, nurse executives and managers (Cope & Murray, 2017; Heuston et al., 2021; Pearson, 2020; Shaughnessy et al., 2018; Wei et al., 2018). Often they focus on transformational leadership in management (Cummings et al., 2018, 2021; Page et al., 2021). However, nurses not in designated leadership positions (i.e., bedside nurses) also exhibit leadership in practice. This is often described as 'clinical nurse leadership' (Cardiff et al., 2018; Mianda & Voce, 2017; Stanley & Stanley, 2018; van Schothorst-van Roekel et al., 2021). Clinical nurse leaders are able to *"display their beliefs and values related to the quality of care and they interact with patients in a 'hands-on' fashion, living out their values in the delivery of clinical interventions"* (Stanley & Stanley, 2018, p. 1741). In their review, Mianda & Voce (2017) illustrate the qualities of clinical nurse

leaders and their impact on standards of care. The qualities include their ability to promote change, communicate effectively, and gain support to influence others, as well as their role modeling, approachability and availability to support, advise and guide. In addition, as Uhl-Bien et al. (2020) point out, *"leadership is a collective process flowing through networked interactions"*, instead of *"only a management function occurring in formal leadership roles and hierarchical structures"* (Uhl-Bien et al., 2020, p. 111). Therefore, supporting, developing, and stimulating leadership of nurses not in designated positions deserves attention both in practice and in science (Uhl-Bien et al., 2020).

The Excellent Care Program (ECP) focuses on nurses working directly in patient care, not in management positions (Verpleegkundigen en Verzorgenden Nederland, 2022a). Developed by the Dutch Nurses Association (V&VN) the ECP aims to help Dutch healthcare organizations create a positive work environment by developing nurses' leadership (Box 1). Between 2009 and 2020, 28 healthcare organizations participated in the ECP, beginning with baseline measurements of: 1) nurses' perception of their work environment; 2) organizational structures; and 3) nurse-sensitive patient outcomes (Verpleegkundigen & Verzorgenden Nederland, 2022b).

Following the baseline measurements, the organizations received the results of the measurements and recommendations to create a plan for improving the nurses' ability to develop their work environment (see e.g., Bloemhof et al., 2021). During this process, the Dutch Nurses Association supported the healthcare organization and facilitated an ECP-learning community.

Because ECP has never been studied in terms of nurse leadership, it is not clear if it contributes in any way to the development of nurse leadership. This study aims to fill the gap in the literature by describing how the ECP, according to nurses, contribute to the development of leadership and the ability to influence their work environment.

Box 1. Description of the Excellent Care Program

The Excellent Care Program is a model comprising three pillars (Figure 1). Each pillar addresses a number of aspects important to a positive nurses' work environment (Kramer & Schmalenberg, 2004; Maassen et al., 2021). All pillars can be measured by a validated questionnaire (de Brouwer et al., 2014; 2017a; 2017b; Stalpers et al., 2015).

The program starts with a baseline measurement of the healthcare organization. After receiving the outcome of the baseline measurements and recommendations, an organization develops an action plan for creating a positive nurses' work environment. The organizations could use workshops, lectures and interventions in various themes especially developed by the Dutch Nurses Association. In addition, healthcare organizations develop their own interventions based on the outcomes to start working on different themes themselves. After 2–3 years organizations often measure the effects on the developmental efforts. Bloemhof et al. (2021) provide a nice example of the way an organization that took the ECP approach went to work.

The Dutch Nurses Association facilitates a network for participating organizations. Conferences and meetings are organized to share experiences with interventions and post-baseline measurements. An online platform ensures that ECP organizations can ask each other questions and share solutions. ECP organizations can also rely on the support of employees of the Dutch Nurses Association throughout the program.

Figure 1. The Excellent Care Model

The Excellent Care Model		
Nurses pillar Nurses' perception of their work environment	**Organizational pillar** Conditions in an organization that enable nurses to deliver excellent care	**Patient pillar** Patients' perception of the quality of nursing care and nurse-sensitive indicators for patient outcomes
8 Essentials of Magnetism: • Working with clinically competent peers • Collaborative nurse-physician relationships • Clinical autonomy • Nurse manager support • Control over nursing practice • Perceived adequacy of staffing • Support for education • Culture in which concern for the patient is paramount	**5 themes:** • Nursing strategy • Leadership • Structures for shared governance • Research & development • Focus on results	**8 domains:** • Accessible care • Good communication and information • Respectful treatment • Competent employees • Healthcare organization that align with the needs of patients • Continuity of care • Effective and safe care
Measurement: • Perception of nurses on work environment (DEMOII) • Additional modules as: intention to leave, quality & safety	**Measurement:** • Survey on 5 themes	**Measurement:** • Patient experience • Nurse-sensitive indicators

Methods

Applying a descriptive qualitative study design (Bradshaw et al., 2017) we collected data in semi-structured group interviews. Group interviews are suitable for exploring a research area as they elicit similar types of information from each participant (Kallio et al., 2016) and give all the opportunity to respond to each other's statements and thus establish a shared opinion. Hence, engagement in the discussions is crucial (Krueger, 2002). We used the COREQ (Consolidated criteria for Reporting Qualitative research) checklist to report methods and findings in this study (Tong et al., 2007).

Setting

All organizations involved in the ECP were invited to participate (N=28). After four weeks, non-responding organizations received a reminder by e-mail and were contacted by phone. Organizations willing to participate (17/28) were included in the study (Table 1). Reasons for non-participation were: all members steering the local ECP were no longer employed (5); no time (2); an organizational merger or financial hardship that caused a stop to ECP (4).

Table 1. Demographics of healthcare organizations

Organization		Environment	Nurses	Start of Excellent Care Program (ECP)
1	Hospital 1	Urban	1349	2016
2	Hospital 2	Urban	1618	2015
3	Hospital 3	Urban	737	2010
4	Hospital 4	Urban	1043	2010
5	Hospital 5	Urban	763	2016
6	Hospital 6	Urban	1034	2010
7	Hospital 7	Urban	290	2011
8	Hospital 8	Urban	625	2010
9	Long-term care organization 1	Rural	2208	2009
10	Long-term care organization 2	Rural	958	2015
11	Long-term care organization 3	Rural	135	2010
12	Long-term care organization 4	Rural	452	2011
13	Long-term care organization 5	Rural	42	2010
14	Psychiatric organization 1	Urban	157	2016
15	Psychiatric organization 2	Rural	210	2013
16	Psychiatric organization 3	Urban	347	2010
17	Rehabilitation center	Urban	98	2016

Sample

Interview participants were selected through purposeful sampling, based on a predefined set of in- and exclusion criteria. Participants were included if they: 1) had an overview of the local ECP and implementation progress; 2) were familiar with nurses' views and experience of the local ECP; or 3) had close experience of the program. Participants were excluded if they were not involved in the ECP. The organizations invited participants in person or by e-mail, as they knew best who was involved. We asked them to select a heterogenous group of: 1) nurses responsible for the local ECP (ECP managers, assistants, expert panel members, and/or member of the nursing advisory board); 2) nurses with different levels of education (vocational degree, bachelor's degree, master's degree) working at the bedside (van Kraaij et al., 2023); 3) nurse managers or directors involved in ECP (unit managers, staff managers or nurse directors); and 4) nurses working in other functions (researchers, HR advisers, trainers or policy advisers) (Table 2).

Table 2. Demographics of participants

Participants (Position at start of the ECP)	N	Participants (Current position)	N	Responsibility during ECP			
				ECP manager / assistant / expert panel	N	Member nursing advisory board	N
Bedside nurse	23	Bedside nurse	14	ECP manager	15	Member	15
Nurse practitioner	4	Nurse practitioner	4	ECP assistant	4	Vice president	4
Nurse assistant	1	Nurse assistant	1	Member expert	5	President	8
Unit manager	8	Unit manager	8	panel			
Staff manager	7	Staff manager	8				
Policy adviser	6	Policy adviser	12				
HR adviser	1	HR adviser	1				
Trainer	1	Trainer	1				
Program manager	1	Nurse Director	1				
		Program manager	1				
		Researcher	1				
	52		52		24		27

Data collection

Referring to the literature, we developed with the whole research team an interview guide (Appendix 1) that included organizational factors (Mcclure et al., 1983), the 'Essentials of Magnetism' (Kramer & Schmalenberg, 2004), and various leadership styles (Cummings et al., 2018). Two researchers (EdK and KJ or PB) held the first three interviews, which allowed us to evaluate the interview process, the role of the interviewer, and the interview guide. The results provided guidance for further data collection and analysis. One researcher (EdK) held the other 14 interviews. All 17 group interviews consisting of 2–7 participants lasted 60–90 minutes and were held at each healthcare organization. The interviews were audio-recorded and transcribed verbatim. One participant from each organization did a member check of the transcripts. Field notes describing the setting, the observations and the thoughts of the researcher were also added to the transcripts to reflect and prevent biases and support memory recollection. Data saturation was reached after 15 interviews.

Data analysis

We used the thematic coding steps of Braun & Clark (2006) to conceptualize collected data, exposing every single sentence, and observation. We began familiarizing ourselves with the data by reading and re-reading the transcripts (EdK and KJ). Two researchers (EdK and KJ) independently generated initial codes from the transcripts and discussed these up to consensus with and between researchers (EdK, KJ, and AW). We aimed to formulate codes in the same context as the transcripts to stay closely linked to the data (an inductive

approach). Next, two researchers (EdK and KJ) refined the initial coding list by adding new codes or reconstructing existing codes. After this, three researchers (EdK, KJ, and AW) discussed and reconciled coding differences. Next, the codes were merged in clusters and defined in themes and sub-theme, still aiming to stay strongly linked to the data. Finally, the researchers (EdK, KJ, and AW) interrogated the themes in-depth, and reflected critically on their interrelationships (Thorne, 2020). To ensure rigor and enrich data interpretation, we analyzed the field notes in the same way. Data analysis was conducted in Dutch, using Atlas.ti version 8.2.0 software (ATLAS.ti Scientific Software Development GmbH, 2020).

Ethical considerations

Prior to the semi-structured group interviews participants were informed by letter about the research aim, the voluntary nature of the study, their right to withdraw at any moment and the confidentiality of the collected data. Before the semi-structured group interviews began, participants signed an informed consent form. The Medical Research Ethics Committee of University Medical Center Utrecht (number 19-183) approved the study. Data were stored according to the Dutch General Data Protection Regulation.

Results

The ECP baseline measurements gave organizations and nurses insight into perceived characteristics of a positive environment, such as clinically competent peers, clinical autonomy, control over nursing practice and nursing strategy. This information fed discussions between nurses and management about the baseline outcomes and subsequent recommendations that emphasized the need for ongoing development of a positive work environment. The ECP provided a framework for this. Each organization used their outcomes and recommendations to make an individual plan to enhance nurses' leadership skills to enable them to improve their work environment. Nurses worked on this plan with colleagues, including managers of policy departments (e.g., quality and safety, human resources). Despite individual differences in the plans, four common processes were perceived that, according to the participants, contributed to the development of nurse leadership. We describe these four processes in the following sections.

Taking on responsibility for continuous knowledge and skills development

Continuous knowledge and skills development was seen as the most important factor contributing to the leadership that would allow nurses to initiate change, make decisions and deploy strategies to improve their work environment. Nurses realized that if they wanted to have control over their work environment, they needed the necessary knowledge and skills. They also recognized that if they wanted to focus on gaining knowledge and skills they would have to take the ongoing development in their own hand. Basing their conclusions

on the outcomes of the baseline measurements, management often acknowledged that nursing education should receive more attention in their organizations. They also recognized they could support nurses in organizing this.

Most ECP organizations (11/17) began investing in continuous knowledge and skill development, establishing education and training programs. Team-level education mainly gave nurses information about occupational-specific topics related to nursing practices (e.g., nutritional deficiency risks or palliative care). Organizational-level programs, often conducted by inhouse training units or professional training institutes, were deployed to refresh and update nurses on clinical reasoning, guideline development and communication skills. Clinical leadership was observed in both nursing teams and multidisciplinary group meetings.

Our analysis showed that improving evidenced-based practice knowledge and clinical reasoning skills was regarded as the most essential component in developing nurse leadership. According to participants, better knowledge and skills enabled nurses to conduct better conversations on the balance between adhering to standardized procedures versus deviating from them to benefit care quality, for example. Gaining this competence taught nurses how to change practices by challenging the status quo to benefit the patient:

> "We'd agreed to enter the alarm score three times a day for all patients. Last week I heard from a doctor that a nurse had wondered if this was necessary for a certain patient category. The doctor thought so because it was the set rule. Pointing to the literature, the nurse backed up her claim that it wasn't needed for this patient category. She discussed it with her nursing colleagues and ultimately the protocol was adjusted."
> *(RN, researcher and ECP manager, hospital)*

Strengthen organizational structures to improve nursing governance

ECP baseline measurements enabled organizations to improve nursing governance. Also, the nurses' increased knowledge and skills helped them see their impact on relevant topics, such as e-health solutions, infection prevention, and on-the-job learning. In most organizations, participants felt that nurse involvement in nursing topics deserved more attention. One member of the ECP expert panel noted, "*Nurses were often talked about instead of with.*" These insights made nurses realize they had to show leadership and strengthen their governance to have a greater influence on their work environment. According to the nurses, improving their position increased their professional autonomy and influence:

> "If we want to say something about [patients' length of stay], we'll make sure that we have our say. We won't necessarily discuss it with the board of directors […]. We'll do it informally through our network or we'll find another way to ensure that we get our message across."
> *(RN, nursing policy adviser, hospital)*

Existing structures were reinforced and/or new ones were established in nursing governance, such as nursing advisory boards, platforms, and committees. The ECP framework helped nurses address relevant topics in the governance structures and monitor whether their organizations invested in these topics (e.g., time and money for training programs or nursing research). If the nurses felt that corporate investment could be improved, they spoke up or started projects themselves to realize these topics. Nurses felt it was their responsibility to act and had the professional discretionary space to do so.

As the active participation of nurses increased in the governance structures that influenced their work environment, their visibility also increased in organizations:

> "I've noticed that we're being taken more seriously. […] Far more nurses are interested in our work on the nursing [advisory] board because we're getting more and more people wanting to act as key figures. I think this is because of all of those projects on the wards. Nurses want to know more about what's going on at a higher level. So, you notice that people are really busy with professionalization and thinking about how they can improve their work. I think that's an incredibly good development".
> *(RN, clinical nurse specialist, psychiatric organization)*

Working on nursing governance structures was an incentive for nurses to build on their formal and informal networks to rally colleagues' involvement in nursing-related projects. These networks supported the exchange of knowledge, enabling nurses to share best practices and the outcomes of quality-enhancing projects, and discuss such issues as retaining nurses, patient-centered quality improvement, nursing research and education. According to the participants, nurses found these networks inspiring. They learned from each other how to show leadership in daily practice and felt supported collaborating on nursing-related improvements.

> "We achieved this through the nursing platform. It brings people together. Nurses know each other better now. You used to work only in your own department, and that was it. Now people from other departments work together on [improving the work environment and patient care]."
> *(RN, policy adviser and ECP manager, hospital)*

Challenging the status quo with quality-enhancing projects

The insights into the nursing environment, knowledge and skills, and governance structures stimulated the organizations' effort to develop nurses capable of challenging the status quo. Nurses began leading small improvements on the ward level and became involved in organization-wide projects. Nurses not only identified problems, they suggested how to solve them. For example, a nurse wanted to improve the patient handover process. Apparently, doctors were careless in completing the handover forms, which meant that nurses often had ask them to clarify post-surgery treatment. Discussing the issue with the doctors had no effect so this nurse took a different approach. She made a new form that required doctors to fill in more information. This caused an uproar and the new form was immediately abolished. But now the doctors filled in the old form properly. With this devious act, the nurse solved a longstanding problem that had caused extra work and distress for nurses unable to provide the best patient care:

> "A bit deviating, yes, but sometimes you have to encourage doctors differently."
> *(RN, unit manager and ECP assistant, hospital)*

Successful experiences with quality-enhancing projects gave nurses the confidence, motivation, and validation to continue:

> "Now nurses are more concerned with their further professionalization and think more about how they can improve care. That's nice because I feel like we're constantly reinforcing each other. As an organization, we've ended up in a positive flow."
> *(RN, staff manager and ECP manager, psychiatric institute)*

Moreover, organizations became more aware of their vital role in quality-enhancing projects. Now policy departments (e.g., quality and safety, HR) began collaborating more with nurses, offering more support for their quality-enhancing projects, such as developing formats to help nurses initiate a project or by organizing educational meetings about project management. Hence, they facilitated nurses to take responsibility for managing improvement projects on their work environment, instead of mere taking part in projects managed by the policy departments.

Becoming aware of the supportive role of the nurse manager

Through their participation in the ECP, all 17 organizations became more aware of the supportive role of the nurse manager in the development of nurse leadership. Participants noted that nurse managers substantially influenced the preconditions of a positive work environment. They could clear budget for quality improvements, create opportunities for continuous knowledge and skills development, and support nursing collaborations throughout the organization.

> "At the very least, the role of the manager is to facilitate so that their nurses can work on improving processes."
> *(RN, nurse and ECP manager, hospital)*

For example, managers stimulated nurses to reflect on their work routines, to improve work rosters, and enhanced capacity management.

According to the participants, the degree to which nurses felt supported depended on the manager's confidence-building behavior. For example, involving nurses actively in decision-making processes and standing up for them in hard conversations with colleagues had a positive effect. Some participants mentioned the importance of having a learning organization culture which allows nurses to make and learn from mistakes.

> "If you limit nurses and keep them on edge, it gets stressful for them. But if you give them space, you'll see them showing valuable qualities, which otherwise might not come up."
> *(Staff manager, long-term care organization)*

Overcontrolling managers who do not give nurses space hindered nurse leadership. However, nurses took alternate paths when they experienced managerial obstacles. The first path sought collaboration with colleagues across departments and/or other nurse managers willing to support their aims. The second path involved experimenting with new routines or interventions invisible to their managers. For example, a nurse on the nephrology ward introduced a smaller glass to help patients with their fluid restriction without first discussing the change with her manager. She knew she first had to collect evidence for why implementing the new size glass would make a difference, before financial constraints would stop the change (RN, manager and ECP assistant, hospital). Not being open gave nurses the space to experiment and avoided discouragement in their attempts to show leadership.

Discussion

In this study, we investigated how the ECP contributed to the development of nurses' leadership to improve their work environment. In the process we assessed whether the stated intention of ECP to stimulate leadership of nurses not in designated leadership positions was achieved (McGowan et al., 2020). In our assessment of the plans of the 17 healthcare organizations involved, we noticed that the ECP fosters four processes that influence how nurses, not in designated leadership positions, take on leadership on their work environment. The nurses began taking the lead on their knowledge and skill development, the nursing governance structures, and initiated nursing-related quality-enhancing projects. Besides this, the growing awareness of the supportive role of nurse

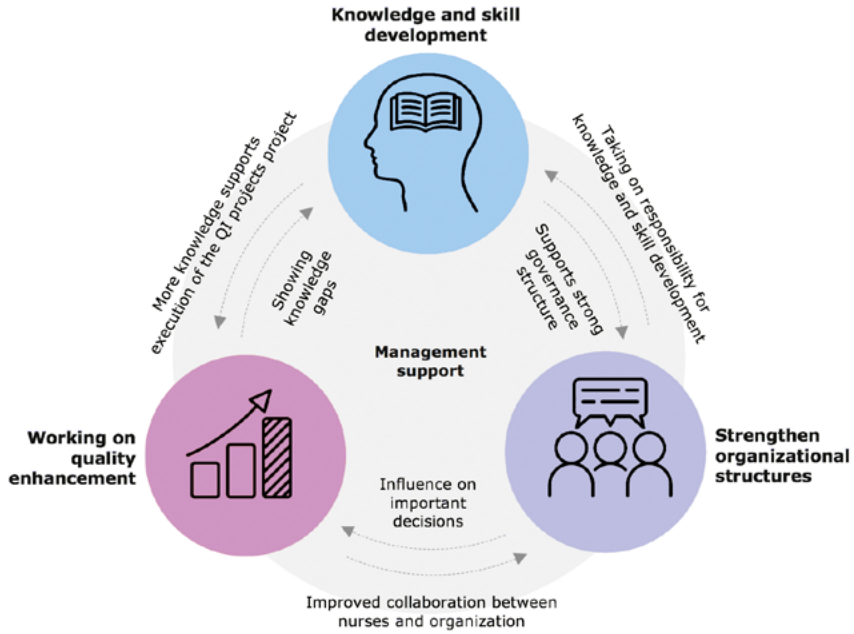
managers helped both organizations and nurses to understand the preconditions needed for undesignated nurses to demonstrate leadership.

Based on our qualitative data, we cautiously conclude that the ECP contributes to nurses' leadership development to facilitate a positive work environment. We cannot compare our findings to other programs on nurse leadership, such as Magnet Recognition (American Nurses Credentialing Center, 2021) or 'Healthy Workplace, Healthy You' (Royal College of Nursing, 2022), because these programs focus on developing leadership of nurses in designated leadership positions (Cope & Murray, 2017; Heuston et al., 2021; Pearson, 2020; Shaughnessy et al., 2018). However, we can compare our findings with a quasi-experimental, empirical study in one hospital that also found the ECP *"positively affects the nurse work environment, job satisfaction and quality of care"* (Bloemhof et al., 2021, p. 4919). In recent years leadership of nurses not in designated leadership positions has gained interest, especially after the review by Cummings et al. (2010) on nurse leadership styles, other stands on clinical leadership (e.g., Cardiff et al., 2018; Gauld, 2017; Martin & Waring, 2013; Stanley & Stanley, 2018) and leadership as practice (e.g., de Kok et al., 2022; Raelin, 2016; Silva et al., 2021).

Our study adds to the literature on how nurses develop leadership compentence with the ECP to benefit their work environment. Wei et al. (2018) also show the relation between nurse leadership and a positive work environment. Previous research confirm the importance of single elements in the development, such as continuous knowledge and skills development (Cummings et al., 2021; Page et al., 2021), the influence of nursing governance structures (Kutney-Lee et al., 2016; Porter-O'Grady & Clavelle, 2020), working on quality-enhancing projects (Laschinger et al., 2016), and the role of management (Lalleman et al., 2017; van Schothorst-van Roekel et al., 2021).

The four processes identified in this study probably strengthen each other. Figure 2 depicts their interrelatedness as a heuristic model that may need further study.

Figure 2. Interrelatedness of processes



As nurses gained knowledge and skills, their understanding of the extent to which they had governance over their work environment grew and that helped them develop stronger nursing governance structures. Nurses collaborating on quality-enhancing projects revealed the gaps in their knowledge and skills so that education strategies could be adapted on the organizational level, which in turn gave impetus to their leadership in the work environment. This causality between the findings of our study shows the importance of nurse leadership as it fosters processes directed at a positive work environment (Maassen et al., 2021) that are crucial for job satisfaction and retaining nurses. Keyko (2016) states that this leadership provides a higher autonomy which correlates positively with work engagement and ultimately improved patient outcomes.

Our study found the supportive role of nurse managers a precondition for nursing leadership. However, nurses were not discouraged if they did not get management support. Then they reflected on their work environment and the line between patient-centered care and organizational regulations. They took the initiative to find practical solutions, challenge set rules, and initiate quality-enhancing projects. They promoted discussion of nurse governance structures and built networks of like-minded nurses. This behavior aligns with the concepts of Gary (2013) about 'positive deviants' (2013), Meyerson (2008) about 'tempered radicals', and Bevan (2013) about 'healthcare rebels'. All three concepts describe nurses pursuing their nursing ideals to give the best quality of care and the need

for deviating behavior when organizational rules/regulations prevent this. The systematic review by de Kok et al. (2021) finds these interesting concepts for further study. Ethnographic studies would benefit especially since this behavior is invisible to the rest of the organization (Wallenburg et al., 2019). Learning from deviating practices is harder when it is invisible, even if this behavior could have positive effect on nurses' work environment and patient outcomes (Gary, 2013; Wallenburg et al., 2019).

Strengths and limitations

This is the first study to provide insights into the contribution of ECP on nurse leadership development and its constructive effect on the nurses' work environment in Dutch healthcare organizations. The study applied a precisely transparent qualitative method. However, two limitations must be noted. First, as we did not do an effect study, we do not know if the ECP alone contributed to the positive results. Other conditions could have been beneficial, such as changes in financial support or organizational strategies. We tried to overcome this limitation by interviewing ECP participants still working in the organization. However, an effect study on ECP outcomes could shed light on improvements to nurse leadership, retainment, job satisfaction, and care quality.

Second, at the time of the interview, some participating nurses had grown into ancillary functions or designated leadership positions, which can be seen as a result of the ECP. This may have biased the results on nurses not in designated leadership positions. These participants could have formed a different view of their organizations than their colleagues working only at the bedside. However, at the beginning of the ECP most participants worked primarily as bedside nurses. Through the ECP, they took on more responsibility and their leadership might have led to their gaining these ancillary or designated functions.

Conclusion

According to the experiences of nurses, the ECP contributed to developing the leadership qualities by which nurses influenced their work environment. Nurses took on responsibility for (1) continuous knowledge and skills development, (2) strengthening governance structures, (3) challenging the status quo with quality-enhancing projects, and (4) became aware of the supportive role of the nurse manager. The interrelatedness of these processes supported leadership development and its positive effect on the work environment. Nurse leadership development can be stimulated and enhanced diversely by applying several processes at once. This study shows the particular contribution of the ECP to develop nurses not in designated leadership positions.

Implications for Nursing Management

This study shows that a program like the ECP seems useful in helping nurses and organizations create a positive work environment, providing insights into crucial aspects and shedding light on areas of concern. It stimulates nurses not working in designated leadership positions to show leadership and enhances collaboration in the organization (Bloemhof et al., 2021). Therefore we recommend investing in developing the leadership of nurses not in designated leadership positions (Maassen et al., 2021), to create a positive nursing environment that will also benefit staff attraction and retention (Rodríguez-García et al., 2020; Wei et al., 2018).

This study reminds nurse managers of their influential position in creating a positive environment (Page et al., 2021; Pearson, 2020). They can ensure that nurses are involved in decision-making, break down the silos in the organization, and develop structures that influence mechanisms that affect patient outcomes (Pearson, 2020). Knowing their strong impact, nurse managers can help nurses develop their knowledge and skills, encourage nurses to cooperate throughout the organization, and engage them in quality-enhancing projects.

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Appendix

Appendix 1. Interview Guide

Start of the interview:

- Background questions on demographics including function and role in the Excellent Care Program.

Excellent Care Program experience:

- What did the Excellent Care Program bring to your institution?
- Why did your organization start the Excellent Care Program?
- What was the work environment of nurses like before the Excellent Care Program started?
- What did you do with your baseline measurement results in the Excellent Care Program?
- What interventions did you implement during the Excellent Care Program?
- What was the work environment of nurses like at the end Excellent Care Program, after the interventions were implemented?
- What do you think has helped your organization move toward excellent care?
- After the Excellent Care Program ended, did the quality of care and job satisfaction for nurses improve in any way?

Nurse leadership experience:

- What do you understand by nursing leadership?
- What are nurses doing when they show leadership?
- What do you see happening in the organization when nurses show leadership?
- What is your own role in promoting nurse leadership?
- What has the Excellent Care Program done in terms of nurse leadership?
- Has the Excellent Care Program helped the organization stimulate nurse leadership?
- Which factors do you think have contributed to the development of nurse leadership?
- Are any factors a barrier to the development of nurse leadership?
- What advice would you give to an organization if they want to start stimulating nurse leadership?

Closing questions:

- Have we missed asking any other questions that could help us better understand the outcome of the Excellent Care Program or the development of nurse leadership?
- What was it like for you taking part in this interview, and do you have any questions for us?

3

A SCOPING REVIEW OF REBEL NURSE LEADERSHIP: DESCRIPTIONS, COMPETENCES AND STIMULATING/HINDERING FACTORS

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Abstract

Aims: To 1) give an overview of rebel nurse leadership by summarising descriptions of positive deviance, tempered radicals and healthcare rebels; 2) examine the competences of nurse rebel leadership; and 3) describe factors that stimulate or hinder the development of rebel nurse leadership.

Background: Research shows nurses have lower intention to leave their jobs when they can control their work practices, show leadership and provide the best care. However, organisational rules and regulations do not always fit the provision of good care, which challenges nurses to show leadership and deviate from the rules and regulations to benefit the patient. Three concepts describe this practice: positive deviance, healthcare rebels and tempered radicals.

Design: Scoping review using the Joanna Briggs Institute method and PRISMA-ScR checklist.

Methods: Papers describing positive deviance, healthcare rebels and tempered radicals in nursing were identified by searching Scopus, CINAHL, Pubmed and PsycINFO. After data extraction, these three concepts were analysed to study the content of descriptions and definitions, competences and stimulating and hindering factors.

Results: Of 2705 identified papers, 25 were included. The concept descriptions yielded three aspects: 1) positive deviance approach, 2) unconventional and non-confirmative behaviour and 3) relevance of networks and relationships. The competences were the ability to: 1) collaborate in/outside the organisation, 2) gain and share expert (evidence-based) knowledge, 3) critically reflect on working habits/problems in daily care and dare to challenge the status quo, and 4) generate ideas to improve care. The factors that stimulate or hinder the development of rebel nurse leadership are: 1) dialogue and reflection, 2) networking conditions, and 3) the managers' role.

Conclusions: Based on our analysis, we summarise the descriptions given of rebel nurse leadership, the mentioned competences and provide an overview of the factors that stimulate or hinder rebel nurse leadership.

Relevance to clinical practice: The descriptions produced in this review of rebel nurse leadership and the stimulating or hindering factors listed should help nurses and managers encourage rebel leadership.

Introduction

The increasing demand for nurses (Marć, Bartosiewicz, Burzyńska, Chmiel, & Januszewicz, 2019) and their high turnover (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014; Fasbender, van der Heijden, & Grimshaw, 2019; Li et al., 2018) has resulted in a workforce shortage that has an adverse impact on healthcare quality (Aiken et al., 2018; Ball, Murrells, Rafferty, Morrow, & Griffiths, 2014). Research shows that reasons for nurses to resign include the high workload, job stress and little control over their own professional practice (Aiken, Clarke, & Sloane, 2002; Fasbender et al., 2019; Li et al., 2018). Several studies indicate that nurses have lower intentions to leave their profession if they can control their daily practice and show leadership (Blake, Leach, Robbins, Pike, & Needleman, 2013; Ducharme, Bernhardt, Padula, & Adams, 2017; Li et al., 2018). Fully understanding the role of nurse leadership in daily practice is crucial, especially with the current challenge of retaining nurses.

There are many studies on nurse leadership in the literature. These studies often highlight nurse leadership from a leader-follower perspective and resonate with the transformational leadership paradigm (Hutchinson & Jackson, 2013). Transformational leadership focuses on the cultural aspects of an organization and leaders establishing followers with their vision, norms and belief systems (Hutchinson & Jackson, 2013) that create meaning and motivation for the followers (Bass & Steidlmeier, 1999). Many transformational leadership studies in nursing focus on the hierarchical leader, a designated position of leadership of individuals (e.g. nurse manager, nurse executive) versus healthcare professionals (e.g. nurses) as followers (Reichenpfader, Carlfjord, & Nilsen, 2015; Sfantou et al., 2017; Wong, Cummings, & Ducharme, 2013). However, these papers direct *"little attention […] towards understanding how leadership may be enabled in those not in formally designated leadership positions or how organisational processes can be changed to liberate follower's potential to lead"* (Jackson & Parry, 2011 in Hutchinson & Jackson, 2013, p. 14). Many nurses do not have a designated position of leadership, but any nurse can exhibit leadership in their practices. Clark observes (2008, p. 30): *"Some nurses may not think of themselves as leaders because they equate leadership with authority or with specific job titles rather than as a way of thinking or behaving"* in daily work at the frontline. To understand more about leadership in everyday practices, Leadership-as-practice (LAP) theory provides insights into the moral, emotional, and relational aspects of leadership in daily working life (Raelin, 2011). Rather than envisioning leadership by its rational, objective, and technical aspects (Carroll, Levy, & Richmond, 2008), LAP helps us understand how leadership is enacted by those not in designated positions. It shines light on how the context influences leadership and the dynamics within organizations that foster leadership. The lens of LAP might provide valuable new insights into nurse leadership in daily practice, how it can be supported and how it could influence the retainment of nurses.

Nurses want to provide the best care for their patients, but they work in organizations with rules and regulations that might not always fit their norms and beliefs on what the best care

is. In terms of LAP theory, rules and regulations influence the moral, emotional and ultimately relational aspects of leadership in daily practice (Raelin, 2011). Wallenburg, Weggelaar and Bal (2019) found that nurses may find it challenging to comply with the organization's rules and regulations and sometimes also feel that the professional guidelines hinder the provision of best quality care for the individual patient. Gabbay & Le May (2016) state that if professionals want to make a good clinical decision for their patients' care the variability of the multifarious considerations becomes part of their clinical decisions. The authors stated that no theoretical, research-based knowledge or clinical guideline could ever be expected to cover all these considerations (Gabbay & Le May, 2016). Therefore, nurses sometimes deviate from the professional norms and organizational rules and regulations to generate better outcomes for their patients or to improve processes on their wards. However, hierarchical leaders do not always permit deviation, which requires individual nurses to show leadership as they must balance between conformity and compliance in order to be a 'good' employee and deviation to benefit their patients and the organization of their wards (Berwick, Loehrer, & Gunther-Murphy, 2017). The literature also describes 'bad rebelism' and 'wrong deviation' (Bevan, 2010); deviating in your own interest and breaking the rules out of anger only undermines the quality of care (NHS, 2016, slide 66).

Several studies describe professionals showing leadership in daily practice as 'positive deviance'. Gary defines positive deviance as *"an intentional and honorable behavior 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"* (Gary, 2013, p. 29). Bevan's description of deviating professionals in healthcare (2010) formed the basis of the online School for Health and Care Radicals, established in 2014, nowadays called the School for Change Agents. The purpose of the school was *"to develop effective change agents, ultimately contributing to fast, large-scale, sustainable improvement in health and social care, leading to better patient outcomes"* (Grifford et al., 2015, p.4). Bevan defines 'healthcare rebels' as *"committed to the patient-centred mission and values"* of their organization and see *"many possibilities for doing things in different ways"* (Bevan, 2013). The set-up of the school was inspired by Meyerson's book explaining her research on tempered radicals, individuals who *"navigate the often murky organisational waters to pursue their ideals while fitting in enough to succeed"* (Meyerson, 2008, p. 8). In addition, several other studies in healthcare describe professionals showing leadership in daily practice as 'positive deviants'. The concepts of positive deviance, healthcare rebels and tempered radicals describe nurses who deviate creatively from formal rules and regulations, not in their own interests, but for better healthcare (quality). Wallenburg et al. (2019) observe that deviating healthcare professionals – nurses – tend to 'stay under the radar' of management to achieve their goal of improved patient care. To deviate and find another, better way demands experimentation, trying things out and evaluating the results (Clancy, 2010; Meyerson, 2008; Wallenburg et al., 2019). Given that positive deviants, healthcare rebels and tempered radicals 'stay under the radar', it is not surprising that these concepts are seldom mentioned

in the nursing leadership literature. However, if rebel nurse leadership is better understood, it might be possible to study this more closely in nursing practice. Therefore, this scoping review provides an overview of perspectives on nurse rebel leadership based on the literature on positive deviance, healthcare rebels and tempered radicals.

Aims

In this study, we aim to 1) give an overview of the concepts and descriptions of positive deviants, tempered radicals and healthcare rebels in nursing, 2) examine the competences of rebel nurse leaders, 3) describe factors that stimulate or hinder the development of rebel nurse leadership, resulting in 4) a description of the concept of rebel nurse leadership.

Methods

Literature search

A scoping review is a method which provides a preliminary assessment of the potential size and scope of available research literature to identify the nature and extent of research evidence (Grant & Booth, 2009). In conducting our scoping review, we used the Joanna Briggs Institute (JBI) Reviewers' manual (Peters et al., 2017) and the PRISMA Extension for Scoping Reviews (PRISMA-ScR) checklist (Tricco et al., 2018) (Supplementary File 1).

First, we undertook a limited search to identify relevant keywords and synonyms to develop an *a priori* search protocol with a set of inclusion and exclusion criteria. We included three concepts: positive deviance, healthcare rebels and tempered radicals. Vigilantes and Mavericks were excluded, because the definitions and descriptions given in the papers did not match the positive deviating professionals we were aiming for, based on this limited search.

Second, we searched for all the identified keywords and index terms in four databases: Scopus, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Pubmed and PsycINFO. The keywords used in the search strings included: 'Rebel*', 'Tempered Radical*', 'Positive Deviance*' and 'Health*' (Appendix 1). One researcher (EdK) developed the search strings, and the whole research team checked and discussed them. The search period ranged from 1 January 1995 (first publication on tempered radicals by Meyerson & Scully (1995)) to 1 April 2020.

Third, we selected additional papers from the reference lists of the included papers. Relevant papers were checked to identify any research specifically on the three concepts (positive deviance, healthcare rebels and tempered radicals) that matched the eligibility criteria.

Review process and data extraction

One researcher (EdK) screened the titles and abstracts of the retrieved papers. Then two other researchers (PL or AMW) independently reviewed a randomly selected sample of ten titles and abstracts. The Fleiss Kappa measure of inter-rated reliability resulted in 1.0.

Inclusion criteria were primary research papers written in English, methodology papers, discussion papers, and reviews focusing on nurses or nursing practice in all healthcare sectors, including all patient or disease groups. Exclusion criteria were poster presentations, books, policy papers and interviews with researchers about their research.

Next, the three researchers independently read and assessed the full papers. Any disagreements on assessment were discussed by the research team up to consensus. Papers were excluded if their focus was on the related deviant behaviour or rebelism of patients and if healthcare professional teams or healthcare professionals were discussed in general. Papers focusing on organizational structures and not on the professionals were also excluded. Of the included papers, the literature references were checked, and additional papers were added.

Using a sheet developed by the research team to standardize the data extraction process, one researcher extracted details from the selected papers: author(s), year of publication, country, record type, research aim, study participants, methods, findings related to the aim of the scoping review (descriptions, competences and factors stimulating or hindering the development of rebel nurse leadership) and conclusions. Another researcher checked the extractions. Then, working together, all four researchers sorted the extracted data and accompanying narratives into a form that reflects the aims of this scoping review (Table 1).

Quality appraisal

To evaluate the quality of the included papers and the degree of evidence in a transparent and unbiased way, the research methodology (Appendix 2) involved using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). However, quality as such was not a criterion to exclude papers from the review. The quality appraisal was conducted independently by two researchers (EdK and AMW).

Results

The initial search strategy generated 2705 papers (Figure 1). After removing duplicates and screening the titles and abstracts in the first stage of screening, 66 papers were selected. In the second stage all 66 papers were read in full, and following assessment, 21 papers were agreed upon for inclusion. The references of these 21 papers were reviewed and four relevant papers were added. In total, 25 papers were analysed further. Table 1 presents the data from these papers. Because of the wide variety of methodological approaches, we present the content findings of our scoping review as narratives. Below we discuss the three concepts (positive deviance, healthcare rebels and tempered radicals) separately, and show their similarities.

Figure 1. Flow chart of inclusion process

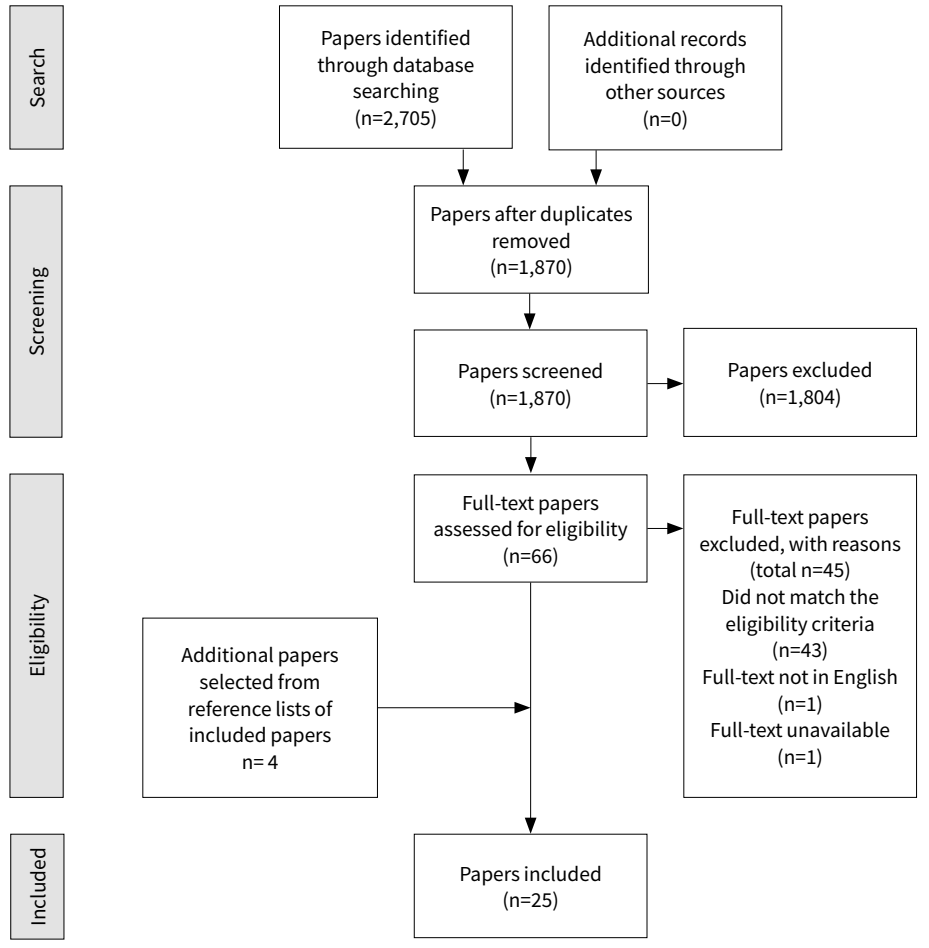

Table 1. Key competences of included papers

	Title paper, author(s), year	Country	Research aim	Study participants	Methods	Description	Competences	Stimulating/ hindering factors	Study conclusions
1	Combating infections at Maine Medical Center: Insights into complexity-informed leadership from positive deviance. (Lindberg & Schneider, 2013)	USA	To study organizational change process known as positive deviance (PD) which sheds light on leadership in a complex organizational context.	N=3 pilot inpatient nursing units (oncology, nephrology and dialysis service) at Maine Medical Center in Portland, and a tertiary care center for northern New England.	Exploratory case study. Open-ended, reflexive observation and a grounded theory approach.	•	•	•	Non-managerial employees now have a louder and stronger voice and management does listen to them. But there is an underlying acceptance that while managers might not dominate the conversation as much as they did in the past, their words might matter more than those who have only recently found their voice. All have a voice, but all voices are not equal.
2	Beyond the hospital infection control guidelines: A qualitative study using positive deviance to characterize gray areas and to achieve efficacy and clarity in the prevention of healthcare-associated infections. (Gesser-Edelsburg et al., 2018)	Israel	To study the gray areas in the care continuum in ICUs where systematic guidelines are adhered to only partially by the staff, and where there are no practices of PD individuals that address these gray areas as reported by the staff.	N=82 participants at Hadassah Hospital from the GICU and MICU (N=47 nurses, N=14 physicians, N=5 nursing aides, N=5 nursing students, N=2 social workers, N=2 physical therapists, N=1 respiratory technician, N=2 secretaries, N=1 national service volunteer, N=3 cleaning staff.	Qualitative constructivist research method. Interviews, observations, and video recordings of identified positive behavioral practices.	•	•	•	The study characterized the gray areas in the care continuum identified by staff, where solutions were found through PD practices. Instead of investing in producing additional, specific guidelines for different situations and developing training programs to implement them, it is important to encourage hospital personnel to create their own solutions for different situations on the care continuum, and to disseminate them in the units to achieve a bottom-to-top change.
3	Methicillin-resistant Staphylococcus aureus (MRSA) prevention through facility-wide culture change. (Bonuel et al., 2009)	USA	To study one hospital's fight against methicillin-resistant *Staphylococcus aureus* by implementing a facility-wide program aimed at changing and standardizing the hospital culture.	N.A.	N.A.	•		•	1 year after implementing our best practices and the MRSA bundle in all our 15-inpatient nursing units, we have 4 months of zero healthcare- acquired MRSA infection in all 3 intensive care units (36 beds). We reduced our MRSA-positive culture from a mean of 30 in 2005–2006 to a mean of 21 in 2007–2008. The Joint Commission has recognized our institution for best practices in infection prevention.

4	Nurses' Use of Positive Deviance When Encountering Electronic Health Records-Related Unintended Consequences. (Bristol et al., 2018)	USA	To study nurses' experiences with the unintended consequences of using an Electronic Health Record (EHR).	N=144 nurses working for various healthcare organizations.	Qualitative descriptive methods. Survey with quantitative questions and 5 open-ended qualitative questions.	•	•	•	Nurses' experiences with EHR systems offer insight into an organization's shift toward Resilience Engineering (RE). The ability to recognize the unique needs of nurses during design and implementation of an EHR system may support better resilience in nurses. EHR enhancements based on the results of this research could facilitate better patient care through improved nursing use of the EHR and improved patient safety applications.
5	Positive deviance and hand hygiene of nurses in a Quebec hospital: What can we learn from the best? (Létourneau et al., 2018)	USA	To study PD at the level of a care team, to shed light on dynamics within the group.	N=21 nurses (N=6 medical-surgery unit) (N=15 palliative care unit) at a Montreal university hospital.	Focused ethnography design. Systematic observations, individual interviews, field notes, and informal conversations.	•		•	It can be useful to apply the positive deviance approach to healthcare teams rather than individuals to better understand the ideologic and structural differences linked to better hand-hygiene performance by nurses.
6	How is success achieved by individuals innovating for patient safety and quality in the NHS? (Sheard et al., 2017)	UK	To study how individuals working in the NHS manage to implement innovations that benefit patient safety.	N=15 Health Services Journal (HSJ) innovators (selected from the awards list of 2014 and 2013 working in the area of patient safety and quality in the NHS).	Exploratory qualitative research design. Semi-structured in-depth interviews.	•	•	•	Main factors: i) personal determination of individuals, including their ability to challenge the status quo, ii) their capacity to connect people and teams and encourage collaborative working, iii) the ways in which some innovators used organizational culture to their advantage, and iv) using evidence to influence others. While innovation in healthcare seems hard to achieve, we have uncovered several key aspects which we believe may lead to successful innovation by individuals working in the NHS.
7	Positive deviance: a program for sustained improvement in hand-hygiene compliance. (Marra et al., 2011)	Brazil	To study the sustainability of a PD strategy for improving hand-hygiene compliance in two similar adult stepdown units (SDUs) using electronic handwashing counters.	All healthcare workers of two 20-bed adult SDUs with the same physical layout.	Observational study	•	•	•	Based on our findings, PD can be considered an intervention to sustain improved hand-hygiene compliance and can be associated with a decreased incidence of device-associated hospital acquired infections.
8	Improving the safety and quality of nursing care through standardized operating procedures in Bosnia and Herzegovina. (Ausserhofer et al., 2016)	Bosnia and Herzego-vina	To study if a consistent approach/ model was used for development, adaptation, implementation, monitoring and evaluation of nursing standard operating procedures (SOPs).	N=4 healthcare facilities: N=1 hospital and N=1 primary healthcare center in Republic of Srpska, and N=1 hospital and N=1 primary healthcare center in Fed. of Bosnia and Herzegovina.	Multiple-case study design, i.e. an in-depth empirical inquiry.	•		•	The certification/accreditation process is enabling necessary changes in institutions' organizational cultures, empowering nurses to take on advanced roles in improving the safety and quality of nursing care.

9	Positive deviance: Using a nurse call system to evaluate hand-hygiene practices. (de MacEdo et al., 2012)	Brazil	To study the application of PD in 2 stepdown units (SDUs), and evaluate the adherence of nursing staff to hand-hygiene practices based on the ratio between the number of uses of alcohol-based hand rub and the number of nurse visits to patient rooms.	N=2 SDUs in Albert Einstein Hospital in São Paulo, Brazil. East SDU is a 22-bed unit for patients with mixed clinical conditions; west SDU is a 22-bed unit for patients with cardiovascular conditions.	Quasi-experimental study.	•		•	The PD approach to hand hygiene produced positive results in terms of compliance to this practice, with increased consumption of alcohol hand rubs, improved ratio of alcohol rub use to nurse visits to patient rooms in the east SDU, and a >2 ratio in both the east and west SDUs. Using this approach led to a reduction in the rate of device-related infections in both units, with sustained results over 2 years.
10	Hospital Strategies for Reducing Emergency Department Crowding: A Mixed-Methods Study. (Chang et al., 2018)	USA	To study strategies among high-performing, low-performing, and high performance-improving hospitals to reduce ED crowding, using a PD methodology.	2,619 hospitals that reported both ED length of stay and boarding time metrics to CMS Hospital Compare in 2012. Interviews, N=60 staff members, including hospital executives, ED chairs and directors, nurse managers, and hospitalists.	Mixed-methods comparative case study.			•	Organizational characteristics are associated with ED decreased length of stay. Specific interventions targeted to reduce ED crowding were more likely to be successfully executed at hospitals with these characteristics. These organizational domains represent identifiable and actionable changes that other hospitals may incorporate to build awareness of ED crowding.
11	Creating a culture of innovation in nursing education through shared vision, leadership, interdisciplinary partnerships, and positive deviance. (Melnyk & Davidson, 2009)	USA	To study barriers and facilitators to innovation in colleges of nursing and healthcare professions along with recommendations for creating a culture of innovation in these academic settings.	N.A.	N.A.	•		•	A shared vision for innovation by faculty and staff in colleges of nursing and health sciences is essential to drive innovative cultures, programs, and initiatives. Aligning the vision to measurable goals and outcomes, role modeling innovation, facilitating interdisciplinary collaboration, and encouraging positive deviance and risk taking are key ingredients for success. Cultures take time to change. Patience and persistence in working through “character-building” times are needed to achieve the outcomes established as part of the vision.
12	Hospital nurse administrators in Japan: a feminist dimensional analysis. (Brandi & Naito, 2006)	Japan	To study key findings from a qualitative study that explored the views of 16 Japanese senior nurse administrators in hospitals to learn what was happening in their working situations and how they were managing.	N=16 female participants, including N=1 nursing vice president, N=14 nursing directors and N=1 assistant director, from middle or large-sized hospitals. Hospital types: private (N=11), public (N=5), general (N=14), specialty (N=2), and university (N=4).	Dimensional analysis strategies for data collection and analysis. Semi-structured interviews.	•		•	Nursing administration as a recognized specialty must rapidly develop to bring nursing and midwifery to the forefront of international health care delivery. Nurse administrators are in a position to challenge tradition, but they need advanced education, mentorship and the support of their organizations to enact a role that meets today’s goals of patient-centered care.

13	A qualitative positive deviance study to explore exceptionally safe care on medical wards for older people. (Baxter et al., 2019)	UK	To study how multidisciplinary teams deliver exceptionally safe care on medical wards for older people (i.e., perform best on a broad safety outcome).	N=70 multidisciplinary staff from 8 medical wards for older people clustered in 13 NHS Trusts in the Yorkshire and the Humber region of England.	Qualitative PD study. Focus groups and brief field notes.	•	•	•	There are no 'silver bullets' to achieving exceptionally safe patient care on medical wards for older people. Healthcare leaders should encourage truly integrated multidisciplinary ward teams where staff know each other and work well together. Focusing on underpinning characteristics may facilitate exceptional performances across a range of safety outcomes.
14	Reducing Infections "Together": A review of Socioadaptive Approaches. (Sreeramoju, 2019)	N.A.	To study modern-day physicians and physicians in training expected to participate in interventions to reduce hospital acquired infections and for those who serve as physician champions or lead these initiatives, to gain an understanding of socioadaptive approaches that help reduce these infections.	N.A.	N.A.	•		•	Socioadaptive interventions are necessary additions to technical interventions in an overall multicomponent strategy to reduce healthcare-associated infections. Assessment of local social and cultural context and needs is key to choosing the right socioadaptive approach for any improvement initiative.
15	People, systems and safety: resilience and excellence in healthcare practice. (Smith & Plunkett, 2019)	N.A.	To study the evolution of safety science, describing historical approaches, comparing them with recent concepts in safety, and describing how they affect staff working in the healthcare system.	N.A.	N.A.	•		•	The unspoken expectation is that healthcare practitioners should undertake three roles: 1) to take on the clinical function for which they are engaged, whatever that might be; 2) to not only maintain and enhance patient safety in their own work but also by intervening when needed in their organizational systems; and 3) to seek out opportunities for improving quality and make sure that positive changes are made.
16	Using a Positive Deviance Approach to Influence the Culture of Patient Safety Related to Infection Prevention. (Sreeramoju et al., 2018)	USA	To study the impact of PD on the patient safety culture related to infection prevention among healthcare personnel	N=6 wards in Parkland Memorial Hospital, an academic medical center in Dallas. All nurses, patient care technicians, ward managers, and clerks and all patients receiving care in the study wards were included.	Observational prospective study with a retrospective baseline period. Outcome of PD intervention was measured with the hospital survey of patient safety climate, adapted to infection prevention.	•		•	A positive deviance approach appeared to have a significant impact on patient safety culture among healthcare personnel who received the intervention. Social network analysis identified healthcare personnel who are likely to help disseminate infection prevention information. Systemwide interventions independent of PD resulted in hospital acquired infections reduction in both intervention and control wards.

17	Identifying positively deviant elderly medical wards using routinely collected NHS Safety Thermometer data: an observational study. (Baxter et al., 2018)	UK	To study a pragmatic method for identifying positively deviant wards using a routinely collected, broad measure of patient safety.	Phase 1: N=34 elderly medical wards clustered in N=13 NHS Trusts in the northern region of England, UK. Phase 2: Multidisciplinary staff (N=161) and patients (N=188) clustered in N=9 positively deviant and comparison wards.	Two-phased observational study. Phase 1, cross-sectional and temporal analyses of Safety Thermometer data. Phase 2, multidisciplinary staff and patient surveys	•	•	•	A distinct group of positively deviant wards that perform exceptionally well on a routinely collected, broad measure of safety can be identified using a robust yet pragmatic method. Staff and patient perceptions of safety mainly support their identification. The study highlights the challenges faced when selecting a source of routinely collected data that provides a valid and reliable measure at the appropriate level in order to facilitate performance comparisons across wards or units in several organizations.
18	Positive Deviance: A New Tool for Infection Prevention and Patient Safety. (Marra et al., 2013)	N.A	N.A.	N.A.	N.A.	•	•	•	The PD approach is particularly appropriate in situations where organizations can track the results with valid performance measures and where there is substantial natural variation in performance. This creates a good environment for discussion of practices and interventions to achieve improvements in patient safety.
19	Exploring the concept and use of positive deviance in nursing. (Gary, 2013)	N.A.	To study the essence of PD in the nursing practice environment, using the Walker and Avant procedure for concept analysis.	N.A.	Concept analysis of positive deviance	•	•	•	The goal was to provide an operational definition for the concept of positive deviance in nursing practice, which can offer nurses a basis for decision making when the normal or expected actions in a given situation collide with the nurse's view of the right thing to do. As nurses become more autonomous providers of primary health care services, the use of positive deviance must become a goal.
20	Positive deviance: An elegant solution to a complex problem. (Lindberg & Clancy, 2010)	USA	To study one example of how concepts taken from complex systems theory can be applied to real-world problems facing nurses today.	N.A.	N.A.	•	•		
21	Diamonds in the rough: positive deviance and complexity. (Clancy, 2010)	N.A.	To study the idea of PD and how it can be applied in developing elegant solutions to complex problems.	N.A.	N.A.	•	•		

22	Positive deviance: a different approach to achieving patient safety. (Lawton et al., 2014)	N.A.	N.A.	N.A.	N.A.	•	•		A myopic focus on errors, harm and near misses has long been sending negative messages. Politicians, bureaucrats, managers, the media and those leading enquiries as far back as Bristol Royal Infirmary and earlier, and more recently Mid-Staffordshire, have essentially indicated to clinicians: you are prone to making mistakes, and we must insist that you reduce the harm or potential harm you cause. If you do not, we will regulate your activities, tightening the rules over time. While no one would argue against the need to identify those people and organizations whose performance is consistently or deliberately negatively deviant, there is a clear obligation to recognize that healthcare is delivered in complex, uncertain settings, and although clinicians are time-pressured and resource-constrained, things go right very often, even in times of austerity.
23	Positive deviance: innovation from the inside out. (Jaramillo et al., 2008)	N.A.	To study PD theory and how it relates to innovation; an ever-present need for transformational leaders.	N.A.	N.A.		•	•	Positive deviance is a powerful strategy for nursing leaders to effect positive change. This is especially relevant for those on the Magnet journey. We present 7 strategies to assist leaders in recognizing positive deviants in the current environment and for optimizing innovation provide guidance for both experienced and emerging leaders. These strategies support a culture in which creativity, collaboration, and knowledge sharing are essential for optimal performance.
24	Walking the tightrope: how rebels "do" quality of care in healthcare organizations. (Wallenburg et al., 2019)	NL	To study how healthcare professionals and managers give shape to the increasing call for compassionate care as an alternative for system-based quality management systems.	3 Dutch hospitals, studying clinical groups identified as deviant: a ward for infectious diseases, a mother–child department and a dialysis department.	Ethnographic research. 120 h of observation, 41 semi-structured interviews and 2 focus groups.	•	•	•	Rebels' quality practices are an emerging set of collaborative activities to improve healthcare and meet (individual) patient needs. Rebels conduct "contexting work" to achieve their quality aims by expanding their normative work to outside domains. As rebels deviate from hospital policies, they are sometimes forced to act 'under the radar', risking 'groupthink' and may undermine the aim of public accounting.
25	Nurse managers: Being deviant to make a difference. (Crewe & Girardi, 2020)	Australia	To study how positive nurse-manager behaviors that deviate from 'business as usual' promote positive nursing outcomes.	N=7 nurse managers from a private hospital in Australia and N=17 from the public health sector in Seychelles.	An interpretivist methodology	•	•	•	Study addresses the call for the 'study of positive outcomes, processes, and attributes of organizations and their members' deemed valuable in healthcare. Interview data support that positive leadership strategies and practices that facilitate meaningful work, relationships, positive climates, and supportive communication, can impact organizational and individual outcomes. Importantly, positive leadership, not just interventions alone, leads to interventions that influence organizational outcomes.

N.A. = not available

Descriptions of the concepts

In the 25 selected papers, 'positive deviance' was mentioned 23 times and 'tempered radicals' (Brandi & Naito, 2006) and 'healthcare rebel' (Wallenburg et al., 2019) once each. Content analysis of the various descriptions showed that three aspects are often mentioned (Table 2).

Most of the studies identify positive deviant healthcare professionals, departments and/or organizations. Determining who the positive deviants are is done by researchers (Gesser-Edelsburg et al., 2018; Sheard, Jackson, & Lawton, 2017), by colleagues (Gesser-Edelsburg et al., 2018; Lawton, Taylor, Clay-Williams, & Braithwaite, 2014; Marra et al., 2011) and performance figures; for example, hospitals that are within the top and bottom 5% of Centers for Medicare and Medicaid services (Baxter, Taylor, Kellar, & Lawton, 2019; Baxter et al., 2018; Chang et al., 2018; Létourneau, Alderson, & Leibing, 2018). In the healthcare rebel study, performance figures and public opinion were used to select the healthcare organization while colleagues selected the rebel groups (Wallenburg et al., 2019). However, the methodology used to assess or determine positive deviants, healthcare rebels and tempered radicals by researchers and colleagues is seldom described. Only the study by Wallenburg et al. (2019) mentioned interviews with colleagues. Despite the unclear methodology, most papers define positive deviants, healthcare rebels, tempered radicals and their competences.

Table 2. Results: descriptions, competences and stimulating/hindering factors

			Descriptions			**Competences**			**Stimulating/ hindering factors**			
Paper		Concept	PD approach	Behavior	Networks/ Relationships	Collaborate	Expert (EB) knowledge	Courage/ Challenge status quo	Dialogues/ Reflection	Networking	Role of management	Hindering factors
1	Combating infections at Maine Medical Center: Insights into complexity-informed leadership from positive deviance. (Lindberg & Schneider, 2013)	PD	•	•	•	•			•	•	•	
2	Beyond the hospital infection control guidelines: A qualitative study using positive deviance to characterize gray areas and to achieve efficacy and clarity in the prevention of healthcare-associated infections. (Gesser-Edelsburg et al., 2018)	PD	•	•	•				•			
3	Methicillin-resistant Staphylococcus aureus (MRSA) prevention through facility-wide culture change. (Bonuel et al., 2009)	PD	•	•	•						•	
4	Nurses' Use of Positive Deviance When Encountering Electronic Health Records-Related Unintended Consequences. (Bristol et al., 2018)	PD	•	•	•	•	•	•				•
5	Positive deviance and hand hygiene of nurses in a Quebec hospital: What can we learn from the best? (Létourneau et al., 2018)	PD	•	•	•				•			
6	How is success achieved by individuals innovating for patient safety and quality in the NHS? (Sheard et al., 2017)	PD	•	•	•	•	•	•				•
7	Positive deviance: a program for sustained improvement in hand-hygiene compliance. (Marra et al., 2011)	PD	•		•	•	•		•			

8	Improving the safety and quality of nursing care through standardized operating procedures in Bosnia and Herzegovina. (Ausserhofer et al., 2016)	PD	•							•	
9	Positive deviance: Using a nurse call system to evaluate hand-hygiene practices. (de MacEdo et al., 2012)	PD	•						•		
10	Hospital Strategies for Reducing Emergency Department Crowding: A Mixed-Methods Study. (Chang et al., 2018)	PD								•	
11	Creating a culture of innovation in nursing education through shared vision, leadership, interdisciplinary partnerships, and positive deviance. (Melnyk & Davidson, 2009)	PD		•					•		
12	Hospital nurse administrators in Japan: a feminist dimensional analysis. (Brandi & Naito, 2006)	TR		•						•	•	•
13	A qualitative positive deviance study to explore exceptionally safe care on medical wards for older people. (Baxter et al., 2019)	PD	•						•	•		
14	Reducing Infections "Together": A review of Socioadaptive Approaches. (Sreeramoju, 2019)	PD	•		•				•			
15	People, systems and safety: resilience and excellence in healthcare practice. (Smith & Plunkett, 2019)	PD		•					•			
16	Using a Positive Deviance Approach to Influence the Culture of Patient Safety Related to Infection Prevention. (Sreeramoju et al., 2018)	PD	•		•				•		•	
17	Identifying positively deviant elderly medical wards using routinely collected NHS Safety Thermometer data: an observational study. (Baxter et al., 2018)	PD	•			•	•		•			
18	Positive Deviance: A New Tool for Infection Prevention and Patient Safety. (Marra et al., 2013)	PD	•		•	•	•	•	•	•		
19	Exploring the concept and use of positive deviance in nursing. (Gary, 2013)	PD	•	•	•	•	•	•				
20	Positive deviance: An elegant solution to a complex problem. (Lindberg & Clancy, 2010)	PD	•		•	•						
21	Diamonds in the rough: positive deviance and complexity. (Clancy, 2010)	PD	•	•	•	•	•	•				
22	Positive deviance: a different approach to achieving patient safety. (Lawton et al., 2014)	PD			•	•						
23	Positive deviance: innovation from the inside out. (Jaramillo et al., 2008)	PD						•			•	
24	Walking the tightrope: how rebels "do" quality of care in healthcare organizations. (Wallenburg et al., 2019)	HR		•	•	•	•	•	•	•	•	•
25	Nurse managers: Being deviant to make a difference. (Crewe & Girardi, 2020)	PD		•	•	•			•			

PD = Positive Deviance, TR = Tempered radicals, HR = Healthcare rebels

Concept descriptions

Most of the papers (17/25) describe using positive deviance as a method to initiate conscious and systematic (behavioral) change in an organization. The positive deviance method is based on the assumption that in each community, individuals or groups can find better solutions and achieve better results than their peers by executing unusual behaviour even though the circumstances and availability of materials and resources are the same for all (Ausserhofer et al., 2016; Baxter et al., 2018; Bonuel, Byers, & Gray-Becknell, 2009; Bristol, Nibbelink, Gephart, & Carrington, 2018; Clancy, 2010; de MacEdo et al., 2012; Gary, 2013; Gesser-Edelsburg et al., 2018; Létourneau et al., 2018; Lindberg & Clancy, 2010; Lindberg & Schneider, 2013; Marra, Pavão Dos Santos, Cendoroglo Neto, & Edmond, 2013; Marra et al., 2011; Sheard et al., 2017; Sreeramoju, 2019; Sreeramoju et al., 2018). These individuals or groups can be identified and pushed forward, and organizations can learn from their approaches (Baxter et al., 2019, 2018). Wallenburg et al. (2019) use the term rebels to describe the same deviant behaviour in healthcare professionals striving for the best quality. Rebels (groups) consciously deviate to accomplish change in organizations. Brandi and Naito (2006) complement this view by noting that tempered radicals pursue changes that go against the norms of dominant groups for better results.

To achieve better results under the same circumstances, positive deviants demonstrate behaviour and working methods that deviate from the norm (Clancy, 2010; Crewe & Girardi, 2020; Gary, 2013; Létourneau et al., 2018; Lindberg & Schneider, 2013; Melnyk & Davidson, 2009; Smith & Plunkett, 2019). The study on tempered radicals also mentions this (Brandi

& Naito, 2006). The behaviour of deviating healthcare professionals is often described in the literature as unconventional and non-confirmative behaviour (Bonuel et al., 2009; Gary, 2013; Gesser-Edelsburg et al., 2018; Lindberg & Schneider, 2013; Melnyk & Davidson, 2009; Sheard et al., 2017; Wallenburg et al., 2019). The study by Bristol et al. (2018) shows, for example, that nurses display positive abnormal behaviour when faced by system requirements of an electronic patient record that do not meet the needs of the patient. Nurses make various 'workarounds' to meet their patient's needs and do not comply with the restrictions of the electronic patient record (Bristol et al., 2018).

The literature on both positive deviants and healthcare rebels describes the relevance of social networks and personal relationships in and outside the organization (Bristol et al., 2018; Crewe & Girardi, 2020; Gary, 2013; Gesser-Edelsburg et al., 2018; Lawton et al., 2014; Létourneau et al., 2018; Lindberg & Clancy, 2010; Lindberg & Schneider, 2013; Sheard et al., 2017; Wallenburg et al., 2019). These networks and relationships spread successful practices, allowing nurses to share strategies and ideas (Bonuel et al., 2009; Gary, 2013; Létourneau et al., 2018; Lindberg & Clancy, 2010; Marra et al., 2013). Positive deviants and healthcare rebels often serve as influential role models who can exert peer pressure in these networks (Clancy, 2010; Gary, 2013; Marra et al., 2011; Sreeramoju, 2019; Sreeramoju et al., 2018).

Competences

Of the 25 papers, 15 describe the competences of healthcare rebels, positive deviants or tempered radicals (Table 1). The most frequently mentioned competence is the ability to collaborate and network (12/25 papers) (Table 2) (Baxter et al., 2018; Bristol et al., 2018; Clancy, 2010; Crewe & Girardi, 2020; Gary, 2013; Lawton et al., 2014; Lindberg & Clancy, 2010; Lindberg & Schneider, 2013; Marra et al., 2013, 2011; Sheard et al., 2017; Wallenburg et al., 2019). Deviating healthcare professionals collaborate with peers (i.e. nurse colleagues in the same position), colleagues from diverse disciplines or in management positions (Crewe & Girardi, 2020; Lindberg & Clancy, 2010; Sheard et al., 2017; Wallenburg et al., 2019) and colleagues from other departments and even other organizations (Bristol et al., 2018; Clancy, 2010; Lindberg & Schneider, 2013; Wallenburg et al., 2019). Deviating healthcare professionals know who to approach in their large network when help is needed (Wallenburg et al., 2019). Also mentioned are the competences to connect people and encourage others to take ownership of a problem (Clancy, 2010; Gary, 2013; Lawton et al., 2014; Marra et al., 2011; Sheard et al., 2017).

Other competences include using expert knowledge, scientific evidence, to improve care. Healthcare professionals who deviate actively seek evidence and spread this information. Therefore, colleagues regard them as experts and valuable, reliable sources of information (Bristol et al., 2018; Clancy, 2010; Gary, 2013; Marra et al., 2013; Wallenburg et al., 2019). If positive deviants want to convince others, they use collected data or scientific evidence (Baxter et al., 2018; Marra et al., 2011; Sheard et al., 2017).

Healthcare rebels characteristically have the courage to challenge the status quo (Wallenburg et al., 2019). Marra et al. (2013) describe this as an ability to reflect on working habits, organizational logistics and problems in daily care and generate ideas to improve care. Deviating healthcare professionals are determined to improve (Gary, 2013; Sheard et al., 2017) and dare to stretch the boundaries by for example breaking the rules (Gary, 2013). Wallenburg et al. (2019) describe how they make trade-offs between short-term improvements by breaking the rules and disobeying regulations while trying to achieve a more structural solution so that deviance is no longer needed.

The solutions to complex problems are often sold as elegant and efficient (Bristol et al., 2018). According to Gary (2013) and Wallenburg et al. (2019) deviating from the norm or breaking the rules is always done in the interests of the patient and the aim is to find better ways to get things done with the same or fewer resources (Jaramillo et al., 2008; Marra et al., 2013). Despite their deviant behaviour, rebels are committed to the mission and goals of the organization and want to provide the best care (Gary, 2013).

Research shows nurses do not always see themselves as a positive deviant, healthcare rebel and or tempered radical (Lindberg & Schneider, 2013). Sometimes, in talking about their work and what they do, they discover that they are deviant or rebellious. Thus, this kind of leadership is often unconscious and unintentional (Lindberg & Schneider, 2013).

In summary, based on the descriptions and competences described above, rebel nurse leaders can be characterized as networkers who collaborate with their peers, other disciplines and management in and outside the organization, using both formal and informal conversations. They are seen as experts based on their (evidence-based) knowledge. Their courage and competence in reflection help them to challenge the current status quo, deviating from the rules and regulations to achieve their goal of (solving problems which) improve daily care in both the short and longer term.

Factors stimulating and hindering the development of rebel nurse leadership

The included papers were also screened for factors that stimulate or hinder the development of rebel nurse leadership. 22 of the 25 papers describe three important factors (Table 2).

Dialogue and reflection

In the positive deviance literature, deviance is stimulated by organizing and conducting planned conversations such as meetings (Crewe & Girardi, 2020; de MacEdo et al., 2012; Létourneau et al., 2018; Lindberg & Schneider, 2013; Marra et al., 2013, 2011; Sreeramoju et al., 2018), structured reflective dialogue, and informal and spontaneous conversations (Sreeramoju, 2019). An example mentioned in the literature of a planned conversation is a Discovery and Action Dialogues (DAD) (Lindberg & Schneider, 2013). DAD are small-grouped facilitated conversations with healthcare professionals from different professional backgrounds to identify positive deviant practices on a specific topic. The aim of these DAD is to reveal positive deviance actions, and to discuss the obstacles for broader implementation.

Sharing experiences with professionals from different backgrounds supports personal relationships and understanding and respect for one another, resulting in improved

collaboration (Baxter et al., 2018; Lindberg & Schneider, 2013). Wallenburg et al. (2019) found that in planned conversations, healthcare rebels reveal their normativity and the normative work involved in what they consider is "good" care and how it should be organized. Papers mention that professionals feel heard in conversations, with an openness encourages them to talk about the problems they encounter and share new insights and solutions to improve the quality of care (Lindberg & Schneider, 2013; Melnyk & Davidson, 2009). Research by Sreeramoju et al. (2018) adds the importance of confidence in both formal reflective dialogue and informal conversations. Smith and Plunkett (2019) explain the relevance of a work environment in which professionals feel safe, so they dare to ask reflective questions, ask for help and take risks. An important effect of spreading new ideas and actions is an environment of eagerness to find even more constructive ideas (Gesser-Edelsburg et al., 2018).

Networking

In the positive deviance approach, networks are used to spread new ideas and deviant actions. These are the individuals' own networks and/or developed in conversations, both structured (as DAD) and informal (Brandi & Naito, 2006; Lindberg & Schneider, 2013; Marra et al., 2013). The paper on tempered radicals elaborates on networking and describes collaborations and alliances to change things by finding likeminded people and supportive relationships (Brandi & Naito, 2006).

Baxter et al. (2019) describe the nature of these networks: *"It helped them to support one another to deliver safe patient care. Friendly, personal connections between staff members were perceived to facilitate dialogue, influence their ability to contribute different perspectives, encourage them to work beyond silos and to be more broadly involved in patient care"* (p. 622). In the rebel paper, networking is a part of what they call *"contexting, [which] is about networking and encouraging others to act in line with rebels' practices of caring"* (Wallenburg et al., 2019, p. 877).

Role of management

Although the positive deviance approach seems to be a bottom-up movement, several papers show the importance of management involvement and support (Ausserhofer et al., 2016; Bonuel et al., 2009; Chang et al., 2018). This is also found in the literature on tempered radicals (Brandi & Naito, 2006) and healthcare rebels (Wallenburg et al., 2019). Managers play a role in stimulating dialogue among professionals, by asking critical questions, challenging the current status quo and stimulating rebel behaviour if they feel things can be improved (Wallenburg et al., 2019). Especially in the rebel paper (Wallenburg et al., 2019), managers show the same kind of behaviour as healthcare rebels.

The respect and endorsement of CEOs and support by middle managers prevents healthcare professionals from being penalized by powerful people in the organization who might view deviant behaviour as intrusive, threatening, or inappropriate (Lindberg & Schneider, 2013). Knowing management has your back allows healthcare professionals to

talk about their deviant actions to innovate and improve patient care (Jaramillo et al., 2008) without fearing negative consequences (Sreeramoju et al., 2018). Management can also play a pivotal role in promoting deviant action and to spread these good practices (Lindberg & Schneider, 2013).

Hindering factors

A few papers (4/25) describe the obstacles to being a positive deviant, healthcare rebel or tempered radical. First, a nurse who acts like a positive deviant, risks facing negative perceptions by management, punishment and the ultimate consequence of losing their job or license (Bristol et al., 2018). The fear of damage to their reputation or career keeps healthcare professionals from talking about deviating from organizational policy (Lindberg & Schneider, 2013). Wallenburg et al. (2019) observed the same; healthcare rebels 'stay under the radar' to avoid these negative consequences. However, keeping deviant actions hidden impedes the innovative spirit and ability to spread the innovation (Sheard et al., 2017; Wallenburg et al., 2019). The research by Brandi and Naito (2006) describes the harmful consequences for the organization and/or the individual tempered radical nurse who may feel 'trapped' in their position. *"Alternatives to tempered radicalism are to seek other jobs, surrender to silence and disempowerment, or assimilate to the conflicting dominant viewpoint or values of an organization"* (Brandi & Naito, 2006, p. 64).

Put together, the supporting factors are: 1) confidential conversations (both planned and spontaneous) and reflective dialogue in a safe work environment to reveal positive deviant behaviour of rebel leadership, support the exchange of normative points of view on the current situation and collectively find new solutions for points of improvement; 2) networking in and outside the organization to spread the deviant actions and ideas that help to encourage others; 3) management respect and support that stimulates professionals to deviate. Hindering factors are the negative consequences for personal reputation and/or career that urge professionals deviating from the rules and regulations to 'stay under the radar'.

Discussion

This scoping review provides an overview of 1) descriptions of positive deviance, healthcare rebels and tempered radicals in nursing; 2) the competences of rebel nurse leaders; and 3) factors that stimulate the development of rebel nurse leadership.

Most studies included in the review identify positive deviant healthcare professionals, departments and/or organizations. However, they seldom describe their exact selection criteria. Selection is methodologically challenging, as deviant or rebel behaviour requires a comparison with something regarded as 'normal' and is thus highly normative depending on the eye of the beholder. Besides, the methodology applied to 'organize' learning from

positive deviant behaviour and/or methods might not be all-encompassing as healthcare professionals prefer or even need to 'stay under the radar' to perform deviant behaviour (Wallenburg et al., 2019). Additionally, the selected papers make no mention of 'negative' deviation as all perspectives are highly appreciative on the topic. Numerous studies showed that deviating from clinical guidelines (without a proper reason) results in low quality of care (e.g. Rice, Morris, Tortella, Wheeler, & Christensen, 2012; Sargen & Kingsnorth, 2001).

Nevertheless, the findings of this scoping review demonstrate a variety of descriptions and definitions on positive deviance, healthcare rebels and tempered radicals. Analyzing these descriptions and definitions has made the overlap between these concepts apparent. All descriptions in the literature focus on deviant behaviour by healthcare rebels who, as a result, achieve better outcomes under the same circumstances than their peers, according to the authors. Only a few authors specify the better outcomes (by making a comparison) and no paper shows evidence that these better outcomes can be attributed to the positive deviant(s), healthcare rebel(s) or tempered radical(s) studied. Only the study by Wallenburg et al. (2019) used ethnographic methodology (observations, informal conversations and semi-structured interviews), to study more 'objectively' the results of rebel leadership.

Although the concepts of positive deviance, healthcare rebels and tempered radicals are similar, they also have important differences. The positive deviance approach purposefully identifies positive deviants, makes them visible and gives them an exemplary role with the aim of learning from them. Healthcare rebels or tempered radicals, on the other hand, are less visible in organizations as they prefer to 'stay under the radar' to avoid criticism (Wallenburg et al., 2019). Allen (2014) describes this as the invisible work of nurses to 'keep things on track' and serve as a 'Jack of all trades'. Our study focuses on rebel nurse leadership from the perspective of 'good rebels' who can 'rock the boat while staying in it', as Bevan (2010) and Meyerson (2008) put it. The 'bad rebels' who deviate and break the rules for personal gains or because of angry assertations and complaints were hardly mentioned in the included literature. There is a thin line between a 'good' and 'bad' rebel, and assessing the difference is a subjective matter. This matter fell outside the scope of our review; more empirical research in this direction would help enrich the literature on rebel (nurse) leadership.

LAP theory (Raelin, 2011) helps us to understand how leadership is enacted in the nursing workplace and how the context influences leadership and the dynamics within organizations that foster leadership (Raelin, 2011). However, the included papers do not describe the daily practices of nurses in terms of LAP and thus it is unclear what is actually enacted in the practices of positive deviants, healthcare rebels and tempered radicals. We regard this lack of transparency on the context and dynamics within the organizations concerned as a missed opportunity.

Further, we expected more papers to describe the practices of healthcare rebels, as the work of Helen Bevan and her colleagues has resonated in the healthcare sector worldwide. Bevan's educational program, School for Health and Care Radicals, was launched by the UK

National Health Service (NHS) in 2014. The purpose of this education program is to teach employees 'to rock the boat and stay in it' (Bevan & Fairman, 2016). The School for Health and Care Rebels *extended "beyond the NHS and across global healthcare networks. More than 1,500 people enrolled across 40 countries"* in its first year (Nesta, 2014). In the years following it was transformed into the School for Change Agents, offering free webinars and modules in a Massive Online Open Course (Bevan, 2018). Despite all the attention, there is a lack of scientific papers describing the practices of nurse rebel leaders and healthcare organizations that deliberately support the development of these healthcare rebels. This limits our knowledge about the program. Only Gifford, Houghton, Martorana, and Zheltoukhova (2015) has studied the results of the program and changes in work environments of nurses after the first year. Unfortunately, only one paper in our scoping review (Wallenburg et al., 2019) describes the practices of healthcare rebels. As mentioned earlier, one reason for this lack of information might be the difficulty of studying nurse rebel leadership and deviant behaviour because rebels tend to 'stay under the radar'. To capture actual practice is thus challenging.

Most included papers define the competences of positive deviants, healthcare rebels and tempered radicals. This review demonstrated four aspects of competence in rebel nurse leaders, of which two are interpersonal: 1) collaboration (networking); 2) communications (gain and share expertise knowledge and challenge the current status quo); and two are intrapersonal: 3) the ability to critically assess and reflect (on working habits, organization logistics, problems in daily care); and 4) come up with innovative ideas. Bevan (2013) and Meyerson (2008) also describe these four competences. Note that the competences listed by the included papers are not unique to rebel nurse leaders; they also arise in concepts of leadership both inside and outside healthcare.

Note that one relevant aspect influencing rebel nurse leaders previously described in literature was not found in the 25 papers. According to Meyerson (2008) *"they [tempered radicals] are treated as outsiders because they represent ideals or agendas that are somehow at odds with the dominant culture"* (p. 5). The included papers regard positive deviants, healthcare rebels and tempered radicals as role models for their peers and not as outsiders. Possibly, the 'outsider' was not found in the included paper because of their process-oriented approach to positive deviance methodology.

This scoping review might help researchers bind together the concepts of positive deviance, healthcare rebels and tempered radicals so that studies of nurse rebel leadership will enter the nursing (leadership) literature. Leadership in individual nurses is required when nurses need to balance between being a 'good' employee and 'deviating' for the benefit of patient care or the organization. Nurses must streamline processes aimed at better service provision, intertwining the professional and organizational logics as natural aspects of professional action (Noordegraaf, 2015). To gain an understanding of rebel nurse leaders in their daily practice of doing compassionate and good care, studying rebel nurse leadership would be a useful addition to the current nursing leadership literature, especially when blended with LAP.

Strengths and limitations

This scoping review used precise, transparent methods based on study and reporting guidelines (Peters et al., 2017; Tricco et al., 2018). However, it has three limitations. First, most of the included papers concerned positive deviance, describing a positive deviance methodology and the results it gained, without any focus on individual positive deviants. Our data extraction required close reading to understand the relevant competences of rebel nurse leaders and aspects that support or hinder their positive deviant behaviour. We might have put too much emphasis on this, as it was not the stated aim of most of the positive deviant papers. We found very few papers on the concepts of healthcare rebels and tempered radicals in nursing and this also influenced the validity of our findings.

The second limitation is the method of document selection. The selection criteria were designed to include relevant papers focusing on nurses. Hence, papers describing healthcare professional teams or healthcare professionals in general were excluded. However, nurses could have been members of such teams and as a result, selection bias may have occurred.

The third limitation is that papers not based on scientific research were excluded, which means we may have missed potentially relevant information. For instance, the work of Helen Bevan on healthcare rebels was not included, because she writes only blogs and white papers (Bevan, 2013; Bevan & Fairman, 2016).

Despite these limitations, this is the first scoping review based on a comprehensive literature search to assess the current state of what we call rebel nurse leadership. Our study provides a lens for studying rebel nurse leadership in that it describes what it entails and the competences that contribute to it.

Future research

The findings of this scoping review can be used in further studies on nurse rebel leadership in daily practice to gain more understanding of its influence on improving the quality of care. Shadowing could help accurately describe the practices of rebel nurse leaders and reveal more about their working context, strategies and behaviour (Lalleman et al., 2017).

Exploring the experiences of nurses seen as rebel leaders could be useful. Interviewing these nurses to study their perception and interpretation of rebel nurse leadership would help refine the description of the concept and apply the findings of this review in daily practice.

The stimulating and hindering factors this review describes could also be useful. For instance, studying interventions that foster communication among nurses – dialogue, reflection and networking competences – as well as interventions that change the role of the management could help us understand how these factors influence rebel nursing leadership.

Conclusion

Nurses' leadership plays a crucial role in daily practice, especially given the current challenge of retaining nurses and maintaining healthcare quality. This scoping literature review aimed to provide an overview of rebel nurse leadership, culled from the literature on positive deviance, healthcare rebels and tempered radicals. Our review gives insights into nurse rebel leadership, describes the competences of rebel nurse leaders and explains the factors that stimulate or hinder the development of rebel nurse leadership.

After synthesizing the descriptions and competences mentioned in the three concepts, we identified several common aspects. Rebel nurse leaders show unconventional nonconformist behaviour that varies or differs from norms, rules, codes of conduct, practices or strategies. They challenge the status quo with their ability to develop and use social networks (peers, other disciplines, and management) in- and outside their organization to obtain evidence-based knowledge. They share information and gain the engagement of others to provide better outcomes for patients and organizations. As a result, these nurse leaders consistently outperform their peers using the same resources.

Important competences are the ability to: 1) collaborate and network with diverse professionals and management in- and outside the organization, 2) obtain and share expert (evidence-based) knowledge, 3) critically reflect on working habits, organizational logistics and problems in daily care and dare to challenge the status quo, and 4) generate ideas to improve care. Factors supporting rebel nurse leadership are: 1) formal and informal communication – dialogues and reflection – to reveal positive deviant behaviour, to support the exchange of normative points of view on the current situation and collectively find new solutions to improve quality, 2) networking in- and outside the organization to share deviant activity and ideas that help to encourage others, and 3) management's willingness to stimulate professional deviation.

Relevance to clinical practice

This scoping review describes rebel nurse leaders, their competences, and provides an overview of factors that stimulate or hinder the development of rebel nurse leadership. This understanding will help management and nurses to support and develop rebel nurse leadership. More nurse leadership will influence and enhance the quality of care and help retain nurses.

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Appendix

Appendix 1. Search strings

Pubmed
(((Rebel*) OR Tempered Radical*) OR Positive deviance) AND Health* AND
((“1995/01/01”[PDat] : “2020/03/31”[PDat]))

CINAHL
Rebel* OR Tempered radical* OR Positive deviance AND Health* Limiters - Published Date: 19950101-20200331 Search modes - Boolean/Phrase

Scopus
(TITLE-ABS-KEY (rebel*) OR TITLE-ABS-KEY (tempered AND radical*) OR TITLE-ABS-KEY (positive AND deviance) AND TITLE-ABS-KEY (health*)) AND (EXCLUDE (PUBYEAR , 1994) OR EXCLUDE (PUBYEAR , 1993) OR EXCLUDE (PUBYEAR , 1992) OR EXCLUDE (PUBYEAR , 1991) OR EXCLUDE (PUBYEAR , 1990) OR EXCLUDE (PUBYEAR , 1989) OR EXCLUDE (PUBYEAR , 1988) OR EXCLUDE (PUBYEAR , 1987) OR EXCLUDE (PUBYEAR , 1986) OR EXCLUDE (PUBYEAR , 1985) OR EXCLUDE (PUBYEAR , 1984) OR EXCLUDE (PUBYEAR , 1983) OR EXCLUDE (PUBYEAR , 1982) OR EXCLUDE (PUBYEAR , 1981) OR EXCLUDE (PUBYEAR , 1980) OR EXCLUDE (PUBYEAR , 1979) OR EXCLUDE (PUBYEAR , 1978) OR EXCLUDE (PUBYEAR , 1977) OR EXCLUDE (PUBYEAR , 1976) OR EXCLUDE (PUBYEAR , 1975) OR EXCLUDE (PUBYEAR , 1974) OR EXCLUDE (PUBYEAR , 1973) OR EXCLUDE (PUBYEAR , 1972) OR EXCLUDE (PUBYEAR , 1971) OR EXCLUDE (PUBYEAR , 1970) OR EXCLUDE (PUBYEAR , 1969) OR EXCLUDE (PUBYEAR , 1968) OR EXCLUDE (PUBYEAR , 1966) OR EXCLUDE (PUBYEAR , 1965) OR EXCLUDE (PUBYEAR , 1964) OR EXCLUDE (PUBYEAR , 1961) OR EXCLUDE (PUBYEAR , 1955) OR EXCLUDE (PUBYEAR , 1954) OR EXCLUDE (PUBYEAR , 1933))

PsycInfo
((Rebel* or Tempered radical* or Positive deviance) and Health*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
limit 3 to yr=”1995 -Current”

Appendix 2. Quality Appraisal

Quality Appraisal of Qualitative studies

	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	1. Is the qualitative approach appropriate to answer the research question?	2. Are the qualitative data collection methods adequate to address the research question?	3. Are the findings adequately derived from the data?	4. Is the interpretation of results sufficiently substantiated by data?	5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
Beyond the hospital infection control guidelines: A qualitative study using positive deviance to characterize gray areas and to achieve efficacy and clarity in the prevention of healthcare-associated infections. (Gesser-Edelsburg et al., 2018)	Yes	Yes	Yes	Yes	No	Yes	Yes
Nurses’ Use of Positive Deviance When Encountering Electronic Health Records-Related Unintended Consequences. (Bristol et al., 2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Positive deviance and hand hygiene of nurses in a Quebec hospital: What can we learn from the best? (Létourneau et al., 2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How is success achieved by individuals innovating for patient safety and quality in the NHS? (Sheard et al., 2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Positive deviance: a program for sustained improvement in hand-hygiene compliance. (Marra et al., 2011)	Yes	No	No	No	No	No	No
Improving the safety and quality of nursing care through standardized operating procedures in Bosnia and Herzegovina. (Ausserhofer et al., 2016)	Yes	Yes	Yes	Yes	Yes	No	Yes
Hospital nurse administrators in Japan: a feminist dimensional analysis. (Brandi & Naito, 2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A qualitative positive deviance study to explore exceptionally safe care on medical wards for older people. (Baxter et al., 2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Using a Positive Deviance Approach to Influence the Culture of Patient Safety Related to Infection Prevention. (Sreeramoju et al., 2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Walking the tightrope: how rebels "do" quality of care in healthcare organizations. (Wallenburg et al., 2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nurse managers: Being deviant to make a difference. (Crewe & Girardi, 2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Quality Appraisal of Non-Randomized studies

	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	1. Are the participants representative of the target population?	2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3. Are there complete outcome data?	4. Are the confounders accounted for in the design and analysis?	5. During the study period, is the intervention administered (or exposure occurred) as intended?
Positive deviance: Using a nurse call system to evaluate hand-hygiene practices. (de MacEdo et al., 2012)	Yes	Yes	Yes	Yes	No	Yes	Yes
Identifying positively deviant elderly medical wards using routinely collected NHS Safety Thermometer data: an observational study. (Baxter et al., 2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Quality Appraisal of Mixed methods studies

	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	1. Is there an adequate rationale for using a mixed-methods design to address the research question?	2. Are the different components of the study effectively integrated to answer the research question?	3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Hospital Strategies for Reducing Emergency Department Crowding: A Mixed-Methods Study. (Chang et al., 2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Quality Appraisal N/A

Combating infections at Maine Medical Center: Insights into complexity-informed leadership from positive deviance. (Lindberg & Schneider, 2013)	No						
Methicillin-resistant Staphylococcus aureus (MRSA) prevention through facility-wide culture change. (Bonuel et al., 2009)	No						
Creating a culture of innovation in nursing education through shared vision, leadership, interdisciplinary partnerships, and positive deviance. (Melnyk & Davidson, 2009)	No						
Reducing Infections "Together": A review of Socioadaptive Approaches. (Sreeramoju, 2019)	No						
People, systems and safety: resilience and excellence in healthcare practice. (Smith & Plunkett, 2019)	No						
Positive Deviance: A New Tool for Infection Prevention and Patient Safety. (Marra et al., 2013)	No						

Exploring the concept and use of positive deviance in nursing. (Gary, 2013)	No						
Positive deviance: An elegant solution to a complex problem. (Lindberg & Clancy, 2010)	No						
Diamonds in the rough: positive deviance and complexity. (Clancy, 2010)	No						
Positive deviance: a different approach to achieving patient safety. (Lawton et al., 2014)	No						
Positive deviance: innovation from the inside out. (Jaramillo et al., 2008)	No						

Supplementary files

Supplementary file 1. Prisma Extension for Scoping Reviews (PRISMA-ScR) checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	1-2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	3-5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	6
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	6
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	7
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	6
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Appendix 1
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	7-8

Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	7-8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	7-8
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	8
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	7-8
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	8
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	8-16
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Appendix 2
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	8-16
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	8-16
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	16-19
Limitations	20	Discuss the limitations of the scoping review process.	19-20
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	21-22

FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	22

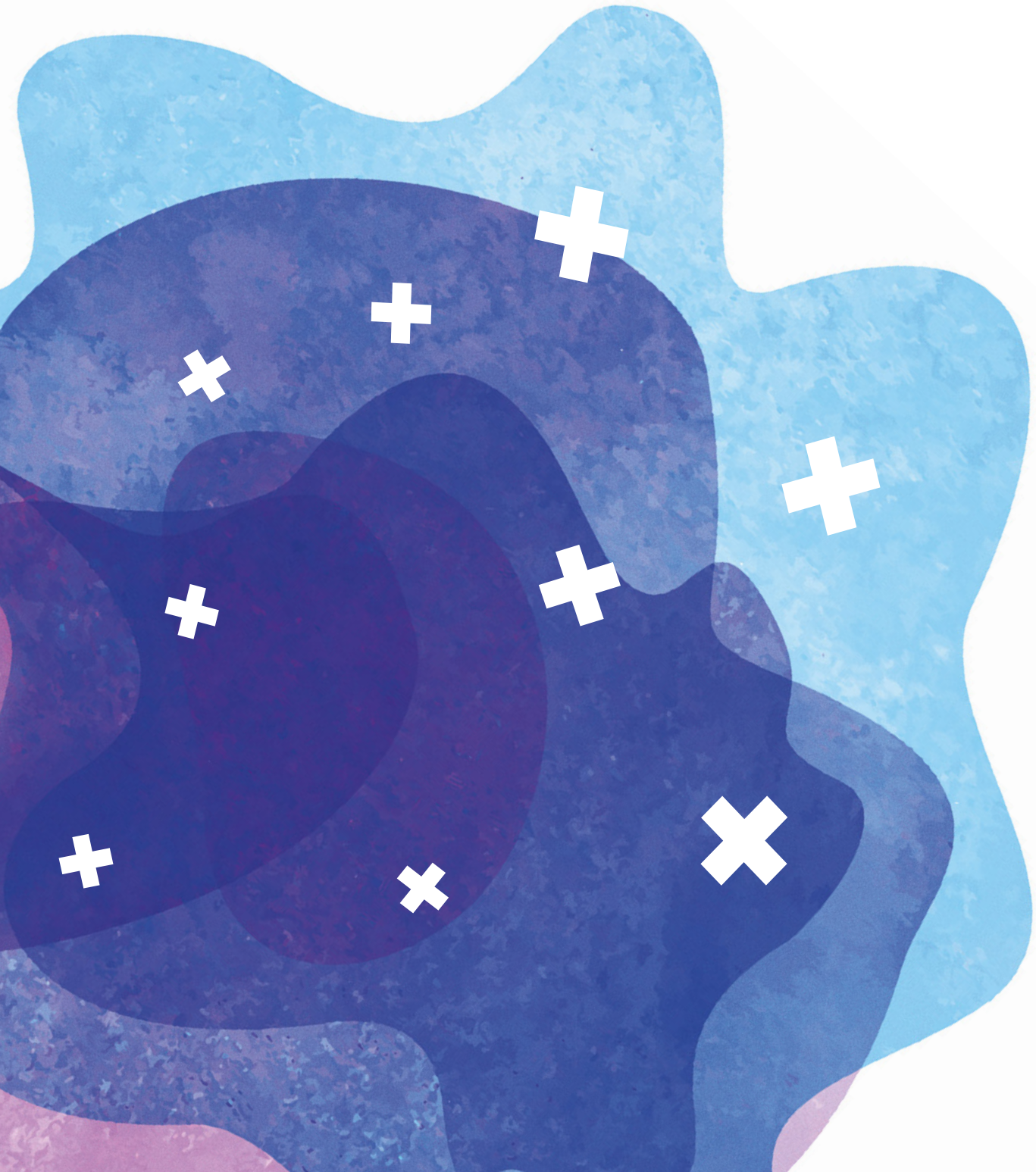
JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).



4

BEYOND TRANSFORMATIONAL LEADERSHIP IN NURSING: A QUALITATIVE STUDY ON REBEL NURSE LEADERSHIP-AS-PRACTICE

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Abstract

Most nurse leadership studies have concentrated on a classical, heroic, and hierarchical view of leadership. However, critical leadership studies have argued the need for more insight into leadership in daily nursing practices. Nurses must align their professional standards and opinions on quality of care with those of other professionals, management, and patients. They want to achieve better outcomes for their patients but also want to feel disciplined and controlled. To deal with this, nurses challenge the status quo by showing rebel nurse leadership. In this paper, we describe 47 nurses' experiences with rebel nurse leadership from a leadership-as-practice perspective. In eight focus groups, nurses from two hospitals and one long-term care organization shared their experiences of rebel nurse leadership practices. They illustrated the differences between 'bad' and 'good' rebels. Knowledge, work experience, and patient-driven motivation were considered necessary for 'good' rebel leadership. The participants also explained that continuous social influencing is important while exploring and challenging the boundaries set by colleagues and management. Credibility, trust, autonomy, freedom, and preserving relationships determined whether rebel nurses acted visibly or invisibly. Ultimately, this study refines the concept of rebel nurse leadership, gives a better understanding of how this occurs in nursing practice, and give insights into the challenges faced when studying nursing leadership practices.

Introduction

Besides Hutchinson and Jackson (2013), others have also criticized how nurse leadership has been studied for the last decade (Alvesson, 2019; Carroll et al., 2008; Cunliffe & Eriksen, 2011). For example, Cunliffe & Eriksen (2011) argued that we need to move away from classical 'tripod' or 'heroic' models of leadership, which seem to colonize the (nurse) leadership literature, towards more relational models and practices of nurse leadership. In addition, Alvesson (2019) argues the need to place leadership in a *"broader context of hierarchical and vertical divisions of work, labor processes and cultural and material pressures from various interest groups"* (p. 38). This view has been amplified by researchers of critical leadership studies, who are urging for less focus on the identities, capabilities, and skill-building of individuals in leadership studies and more emphasis on nurse leadership in daily nursing practices (Carroll et al., 2008; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013). In daily nursing practices, nurses work in interprofessional collaboration with different professionals and their patients (Morley & Cashell, 2017). Hence, leadership should be studied beyond individual capacity (Cope & Murray, 2017; Cummings et al., 2018) and in the context of team efforts and relational collaboration (Jackson & Parry, 2011). In this paper, we show how leadership is exhibited in daily nursing practice in collaboration with other nurses and healthcare professionals.

The relational leadership aspects are mentioned in the review of Cummings et al. (2018) and are classified under the classical leadership perspectives as transformational and authentic leadership.

In a more recent study, Cummings et al. (2021) pointed out that *"Leadership practices are intricately intertwined with the context in which they occur and do not simply depend on the characteristics of individuals"* (p. 10), which suggests research is needed on contexts too. Nurses do not only align their professional standards and opinions of best quality of care with those of other professionals, management, and patients but also align their standards with rules and regulations (Wallenburg et al., 2019) provided by the organization, national legislation, national policies, professional bodies, supervising authorities, and financial restrictions. In an editorial in this journal, Thorne (2021) described that nurses feel *"disciplined and controlled beyond the point of being able to make independent decisions on behalf of their patients to enact the intelligence and expertise that their profession stands for"* (p. 1). Furthermore, managers sometimes have little sympathy or understanding of the nursing perspective (Thorne, 2021). This editorial exposed two distinct worlds: the 'life world' of professionals' daily practice and the 'system world' of management, rules, and regulations (Stewart et al., 2012; Thorne, 2021).

Reconciling both worlds is not easy because nurses sometimes feel internally contested, for example if the organizational rules do not align with the patient's needs and wishes. Nurses deal with this by critically reflecting on their working habits, organizational logistics, and quality issues, and sometimes by deviating from the sub-optimal status quo (Bevan,

2013; Gary, 2013; Wallenburg et al., 2019). Deviating from the rules of the system world requires leadership in daily practices and the context of work. Several leadership theories and models include deviation of nurses (Boamah et al., 2018; Cummings et al., 2018; Posner, 2016; Stanley & Stanley, 2018). For instance, the Leadership Practices Inventory (LPI) model describes 'Challenge the Process' as a core element of leadership (Posner, 2016) whereas the transformational leadership theory highlights the importance of intellectual stimulation where leaders "Challenge the norm" (Boamah et al., 2018). Although these leadership models mention deviant elements, they mainly focus on the identities, capabilities, and skill-building of individuals. In contrast, deviating nurse leadership practices to improve patient outcomes or ward processes have been described as *"passionate enough to dissent against practices seen as stagnant, ineffective, or even dangerous to those around them"* (Dahling et al., 2017, p. 1167). In their review, de Kok et al. (2021) said "it is unclear what is actually enacted in the practices of positive deviants, healthcare rebels and tempered radicals", a statement that emphasize the need for more empirical studies. However, studying these practices in daily practice is not easy as nurse leadership often occurs 'under the radar' (de Kok et al., 2021) or 'invisibly' (Allen, 2014).

A suitable perspective for studying these leadership practices is leadership-as-practice (LAP) (Raelin, 2016). Carroll et al. (2008) stipulated and recognized how leadership is connected to a wider socio-cultural context and how leadership emerges through ongoing action and interaction (Raelin, 2016; Raelin et al., 2018; Vuojärvi & Korva, 2020). The LAP perspective is a promising way to bring the leadership practices of nurses, both visible and invisible, into view (Raelin, 2016). In this explorative study, by using the LAP perspective, we aim to respond to the complex, collective, and relational practice of nurses and to provide insights into the practice of nurses who show rebel nurse leadership. Our research questions were: 1) How do nurses experience rebel nurse leadership in their daily practices? and 2) How does rebel nurse leadership emerge in relation to others?

Methods

Design

In this explorative study, we used focus group interviews to collectively narrate nurses' understanding and experiences of rebel nurse leadership. Focus group interviews stimulate in-depth discussion among participants and are recognized as a useful technique for exploring values, beliefs, and systems (Barbour, 2018). We adhered to the Consolidated Criteria for Reporting Qualitative Research checklist (Tong et al., 2007).

Study setting and participants

The focus group interviews were part of a larger study design using action research to investigate rebel nurse leadership within three healthcare organizations: two hospitals and one long-term care organization. The healthcare organizations were selected based on convenience but are representative of Dutch healthcare organizations (Table 1) (Centraal Bureau voor de Statistiek, 2021). Nurses from these three organizations were invited to participate by the nurse advisory board. Inclusion criteria were registered nurses or vocational nurses in training for their bachelor's degree (third- or fourth-year students) and working in direct patient care. Nurses hired from an external employment agency were excluded. The nursing advisory boards sent an invitation email to all eligible nurses explaining the study aims. The first 50 nurses who gave written consent to participate in the study were included. The included participants were evenly spread from the three healthcare organizations. Data on participant demographics are presented in Table 2.

Table 1. Demographics of the organizations

Organization	
Hospital 1	This top clinical general hospital has more than 5,000 employees spread over eight locations in the middle of the Netherlands. Almost all specialties are represented in the hospital. The goal is to provide the best medical and nursing care, together with research and training. Work is based on the mission 'Together for quality of life' and the core values are together, involved, innovative, and continuous improvement. The management's philosophy is based on 'steering together', in which the board, management, and advisory councils are closely linked.
Hospital 2	This general hospital has more than 2,700 employees spread over three locations in the middle of the Netherlands. This hospital offers a wide range of outpatient and inpatient care. The goal is to provide people-oriented and high-quality care with a human focus and a connection inside and outside the organization. Work is based on the mission 'We provide great care, and we will always give you our full, undivided attention' and the core values are concerned, expert, open, and familiar. The management's philosophy is based on the idea that 'Responsibilities are as close as possible to colleagues in the care process'.
Long-term care	This long-term care organization has more than 2,500 employees spread over ten regions in the middle of the Netherlands. This organization offers home care, nursing home care, rehabilitation care, daycare centers, social care, services, welfare work, and private services. The goal is to make the lives of residents and clients and the work of its employees as pleasant as possible. Work is based on the mission 'Pleasant work, pleasant life care, pleasant living safe, and living together' and the core values are committed and professional. The management's philosophy is based on attention to cohesion and interaction.

Table 2. Demographics of the participants

		N	%
Age	20–29	12	25.5
	30–39	15	31.9
	40–49	6	12.8
	50–59	12	25.5
	60–69	2	4.3
Sex	Female	43	91.5
	Male	4	8.5
Base education (highest initial education completed)	Higher general secondary education	2	4.2
	Vocational	20	42.6
	Bachelor	25	53.2
Further education	No further education	34	72.3
	Specialization	9	19.2
	Otherwise*	4	8.5
Years working as a nurse	< 1 year	0	0
	1–5 year	14	29.8
	6–10 years	4	8.5
	> 10 years	26	55.3
	Nurse Student	3	6.4
Years in the current function	< 1 year	9	19.2
	1–5 year	27	57.4
	6–10 years	2	4.2
	> 10 years	9	19.2
Years working in the current organization	< 1 year	8	17.0
	1–5 year	15	31.9
	6–10 years	5	10.7
	> 10 years	19	40.4
Setting	Nursing home	16	34.0
	Residential care home	14	29.8
	Hospital	17	36.2

* Otherwise: Bachelor in Psychology; Education; Management

Data collection

Eight focus groups comprising 44 nurses and three nursing students were organized by two researchers (EdK and CR) between February 2020 and October 2020. Three nurses were unable to participate at the last minute because of illness or changes in their shift. In total, two focus groups were held in hospital 1, one focus group was held in hospital 2, and five focus groups were held in the long-term care organization. For the focus group, an interview guide was made in advance and included topics on rebel nurse leadership described in the scoping review de Kok et al. (2021) (Appendix 1). The focus group interviews were guided by two researchers – one moderator and one facilitator. The role of the moderator (CR) was to conduct the interview, create an open group climate, and stimulate discussion and interaction. The facilitator (EdK) assisted with practical issues and made field notes to maximize the verbal and non-verbal information obtained (Holloway & Galvin, 2017).

Two pilot focus group interviews were held (one in-person in a hospital and one online in the long-term care organization) to test the predesigned interview guide and to optimize collaboration between the researchers. These pilot focus group interviews yielded a lot of useful data, so were included in the analysis (with formal consent from the participants).

Every focus group interview started by welcoming the participants, which helped establish rapport (Braun & Clarke, 2006). In the focus group interview, participants discussed rebel nurse leadership practices in their daily work. The moderator stimulated the discussion by asking questions and summarizing the data.

The eight focus group interviews lasted approximately 70 minutes each. Four in-person focus group interviews took place in a private meeting room in the facility, outside of normal working hours. Because of the COVID-19 pandemic, four focus group interviews with participants from the long-term care organization were held online using Microsoft Teams. All focus group interviews were held in Dutch, audiotaped, and transcribed verbatim.

Data analysis

To capture nurses' experiences of rebel nurse leadership, a thematic analysis was performed in Dutch as described by Braun & Clarke (2006). **Atlas.ti** software was used to analyze the data (Scientific Software Development GmbH, 2020) and a logbook was kept of all choices made during data analysis.

The thematic analysis consisted of six phases (Braun & Clarke, 2006). First, the researchers (EdK and CR) read and re-read the transcriptions of the focus group interviews and listened to the audio recordings to familiarize themselves with the data. Then, each line of the transcripts was read and codes were derived. Field notes were used to interpret the data more carefully. After this initial coding phase, two researchers (EdK and CR) discussed and reconciled any differences in the coding, developed the definitive coding list, and recoded the transcripts based on this finalized list. Next, the codes were merged and clustered into themes and sub-themes to organize related codes into meaningful clusters. The themes were named, defined, and described in a document, which was discussed with the whole research team until consensus. Finally, three researchers (EdK, CR and PL) examined the data in-depth and critically reflected on the interrelationships to determine whether Thorne's view (2020) to go beyond thematic coding should be followed. The themes and quotations in the paper were translated into English and checked by a native English editor.

Ethical considerations

Before the focus group interviews started, all participants were informed of the study objectives. It was made clear that participation was voluntary and that they could withdraw at any time. All participants gave informed consent to participate. To increase trust in the study, participants were invited to check a summary of the focus group interview, which they received within two weeks of participating in the interview. The researchers gave each other feedback (peer review) during all phases of the study.

The Medical Research Ethics Committee of University Medical Center Utrecht (number 19-183) approved the study. Data were stored according to Dutch Data Protection Laws.

Results

Four themes emerged from the analysis: 1) talking about rebel nurse leadership, 2) defining good rebel leadership practices, 3) reasons for rebel leadership, and 4) rebels' relations and collaborations.

Talking about rebel nurse leadership

Rebel nurse leadership was a new concept for most focus group participants. At first, participants had difficulties describing the concept in relation to their day-to-day nursing practice. For example, one participant said:

> "I find this very difficult; what is rebellious?"
> *(P12, Hospital 2)*

Research focusing on deviant practices is normative, so we needed a shared understanding of rebel nurse leadership. This understanding was gained by sharing and discussing examples of rebel nurse leadership.

Most participants working in hospitals gave examples of how rebel nurse leadership was exhibited in their daily practice. Many examples were connected to quality improvement on their ward. In contrast, participants working in long-term care found it more challenging to discuss rebel nurse leadership in daily practice and could not give any examples. Long silences were noticed in three of the focus group interviews. This improved slightly after a fictional example of rebel nurse leadership was given. The examples given in these focus groups were related to problems being a coordinating nurse. Defining the difference

between leadership in designated and informal leadership roles was particularly hard for them. For example, one participant (P22, long-term care organization) talked about how she started a conversation with a healthcare assistant on how to guide a nurse student. She believed that starting this conversation showed leadership because she thought this was a management task.

> Interviewer: "So, do you now refer to leadership as managing; and you described you feel you take over the manager's seat?" Participant: "Yes, I do." Interviewer: "Is managing similar for you as showing leadership as a coordinating nurse?" Participant: "No, because you do not necessarily have to manage… you can also show leadership as coordinator by collaborating and discussing things among each other [red. other nurses]."
> *(P22, long-term care organization)*

This quote revealed a misunderstanding of what leadership in daily nursing practice is. It was striking that participants highlighted moments when they took on the role or task of a manager or hierarchical leader.

Defining 'good' rebel leadership practices

In all focus groups, participants described rebel leadership practices as deviating from organizational rules and regulations and professional guidelines. The participants also stressed that deviating from these rules is only acceptable under certain conditions, and distinguished between 'good' and 'bad' rebel practices.

The participants described nurses who showed 'good' rebel leadership as creative and capable of starting experiments:

> "… does things slightly differently, with the right intentions, without harming patients or the organization"
> *(P12, hospital 2)*

Many examples explained how nurses who showed 'good' rebel leadership have a clear fundamental belief and dare to express this to convince their colleagues to do things differently, especially when better quality of care is at stake:

> "she is just someone who stands out (…) and goes against the flow… for the benefit of patients"
> *(P10, hospital 1)*

Nurses who show 'good' rebel leadership substantiate their fundamental belief in professional knowledge and work experience and are hard to convince otherwise according to the participants. They also noted their energy and passion are contagious. They motivate their colleagues to reflect on working habits and to challenge the status quo and improve care. By motivating their colleagues, nurses who show rebel leadership create more critical thinkers who will challenge the status quo with them.

In contrast, participants described complaining and grumbling as examples of 'bad' leadership practices. They felt that focusing on self-interests, resisting changing practices, and having negative attitudes show lack of leadership and certainly do not reflect rebel leadership. One participant talked about a new routine in the handover between shifts. She described how some colleagues refused to do the handover at the patient's bedside but continued to do the handover without the patient present. These colleagues did not want practices to change. The participants said that this lack of patient-centeredness does not benefit the quality of care and does not comply with the organizational goals, and they labeled this behavior as 'bad' rebel leadership.

Another example of 'bad' rebel leadership concerned the reactions of some nurses on social media and national television:

> "Nurses were very negative and expressed their dissatisfaction in the media. When you hear what is being said! (…) I am hurt by nurses who are negative and grumble about what we try to accomplish."
> *(P5, hospital 1)*

This 'bad' leadership behavior and negative expressions reflected on the whole profession. These nurses try to get national support and want to create followers among fellow nurses too. Therefore, it becomes even more difficult to step up as a nurse leader (especially in multidisciplinary teams) when the profession is seen as rebellious in a negative way because a few colleagues gained (media) attention.

Reasons for rebel leadership

Participants agreed that the patient's quality of life was the main motivation to deviate from well-founded rules, regulations, and guidelines. Patient's wishes are more important than the fixed structures of the ward (such as getting washed in the morning or having breakfast at 8 a.m.). Nurses who show rebel leadership challenged these vested ideas by asking questions and starting discussions on ethics and values. One participant gave an example of a response to initiatives devised by the management that they deemed inappropriate:

> "I try to make it very clear: what is not appropriate or what is not workable. And simultaneously I try to find out what is the goal they [red. management] want to achieve? Next, if I feel it doesn't work, I will explain what will work and try to convince them to do otherwise."
> *(P46, long-term care organization)*

Nurses who show rebel leadership were also persistent and were the driving force for change. One participant explained this as:

> "We are trying to stick to our path and not get too distracted by different organizational aims. I think quite a lot is put on our plate, and I also feel free to disregard this or even put it back on the managers' plate. But always in dialogue with the other one (…) I would like to know why and what is the added value."
> *(P23, long-term care organization)*

This quote shows that 'good' rebel nurse leadership practice does not only concern a negative reaction on an assignment that does not fit how they want to take care of their patients. They always wanted to explain their refusal and present alternatives. Coming up with alternatives, especially alternatives that challenge or change the status quo, without formal consent is rebel leadership, according to our participants. The participants indicated that in this way, nurses who show rebel nurse leadership influence their work practices and justify their belief in giving good quality care to their patients.

When nurses challenge the vested ideas and status quo, they need the necessary social skills to 'rock the boat and stay in it' (conform Bevan (2013)). The participants mentioned that nurses who show rebel nurse leadership want to be seen as reliable and professional colleagues. Therefore, their image is carefully created by showing and sharing their knowledge and demonstrating their practical experience. They also set a good example and demonstrate with their actions that the change they want actually works. The adage 'the world changes by your example, not by your opinion' is the starting point for rebel nurse leadership voiced by the participants. One nurse (P17, hospital 2) with over ten years of work experience talked about how she did not give medication to one of her patients for a physical problem because she knew from experience that other solutions would work better. She discussed this with the physician several times, and when the physician still prescribed the medication without trying her suggestions, she simply did not administer it but went ahead and showed that her alternative approach worked. This kind of rebel nurse leadership shows responsible subversion – they know that they deviate, but can substantiate why they do this. Participants with less nursing experience said in the focus group that they would not dare to rebel in this way because they lack the knowledge and experience to do so with confidence:

> "You have to stand up for your professional values and express your opinion, but that is very difficult. Because you do not have your experience yet, your self-confidence in what you can do is lacking, so I do not feel comfortable to become a real rebel yet […] no, not yet."
> *(P16, hospital 2)*

This shows that having knowledge and experience offers space to act as a rebel nurse leader.

Rebels' relations and collaborations

Continuous social influences give rebel nurses the drive and courage to overcome obstacles and stir up their organizations. However, they do not want to violate trust in their professionalism, so continuously balance between freedom based on trust and credibility, and the chances of being whistled back. Our participants explained that nurses who show rebel leadership explore the boundaries from which they could deviate. "*After all, nobody wants to be laid off"* (participant 29, long-term care organization). Some participants, mainly from the long-term care organization gave examples of bounded autonomy:

> "So on the one hand, they [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 what you need to do, and you need to deliver this."
> *(P21, long-term care organization)*

However, resistance does not stop nurses from showing rebel nurse leadership. Instead, resistance motivates them to persevere and constantly propagate the value of the envisioned change. One participant (12, hospital 2) explained that, when she gets a 'no', *"I just go to the next one. Until I succeed".* Nurses who show rebel nurse leadership build relationships with colleagues to gain credibility, trust, autonomy, and freedom because this helps them to be seen as professionals. Moreover, they actively seek support from other disciplines, wards, or locations. They also discuss their ideas on a different 'stage' (e.g., at a quality meeting) or organizational level (e.g., board) and establish connections with others with the same drive and ambition.

> "Then I'm going to make a group of allies, to whom I say, 'can't we just take a look at how we can do that differently?'"
> *(P12, hospital 2)*

Nurses need connections for rebel nurse leadership, as described by a participant (12). Several participants mentioned that these connections support rebel nurses' fundamental beliefs and, as allies, give rebel nurses confidence. In addition, these individuals tell them when they have gone too far and what might damage their trustworthiness.

Participants also talked about how nurses who show rebel nurse leadership switch between acting 'above the radar' (visibly) and acting 'under the radar' (invisibly) in their organizations. They act 'above the radar' if they feel free to perform as a professional. If they are not sure how their actions will turn out, they experiment with their novel ideas invisibly. One participant gave an example of acting 'above' or 'under' the radar in nursing practice. He said that he had read about new wound materials and ordered these materials without asking his manager for approval. He explained how he weighed up the possible benefits for his patients against the risk of being punished for not complying to the rules.

> "… because you know, it's on the edge of what is accepted. (…) and often when you talk about it, they [the team managers] say 'these plasters are very expensive'. Yes, that's right, they are very expensive, but if you only use them once a week, overall the costs will decrease... (…) And often the team managers tell you upfront no. But if you just do it and if it turns out that it works better, then the team managers afterwards say 'yes, we trust you in it'."
> *(P29, long-term care organization)*

Participants emphasized that nurses who show rebel nurse leadership will never choose to do everything 'under the radar' because their invisible actions would damage their relationship of trust.

> "Because if you start doing things in secret, it can also backfire. (…) What are the risks of my choices? What are the limits? And will I still have support among colleagues after that?"
> *(P29, long-term care organization)*

By consciously choosing when to act 'under' and 'above' the radar, nurses who show rebel nurse leadership remain reliable and maintain the support of their colleagues. They do not want to risk being put aside and prevented from pursuing their fundamental belief. These nurses also find it vital that their colleagues participate of their own accord. Therefore, as the participants explained, nurses who show rebel nurse leadership do not go to extremes to make others agree with their beliefs. They do everything they can to be seen as a professional who only wants to improve care.

Discussion

In this study, we asked nurses who were not in designated leadership positions, about their experiences with rebel leadership in daily nursing practice using a Leadership-As-Practice (LAP) perspective (Raelin, 2016; Raelin et al., 2018). By studying nurses' leadership in mundane processes instead of formalized leadership (i.e. management positions), we moved beyond previous studies on nursing leadership that focused on the capabilities and

competencies of individuals with a charismatic leadership style (Hutchinson & Jackson, 2013). We also provided more in-depth insights than clinical leadership studies have into deviating practices.

All participants recognized rebel nurse leadership in their daily processes, although the concept/name was new for most participants. The participants found a shared understanding of rebel nurse leadership in the focus groups promoted by the LAP perspective (Raelin, 2016; Raelin et al., 2018) and during their discussions about examples of rebel leadership in daily nursing processes. Our analysis shows rebel nurse leadership practices are embedded in specific situations and circumstances, and are grounded in a normative assessment on 'good and 'bad' rebel behavior. The participants substantiated that deviating from rules and regulations was (not) appropriate, especially with regard to their motivation and intentions to deviate and how they deviated. In agreement with our findings, other studies have confirmed this need to clarify good and bad rebel practices; Kelly & Medina (2014) argued that 'rebel' is a normative term in itself.

Our participants' opinions and definitions on rebel nurse leadership were consistent with those described in previous studies on positive deviance (Gary, 2013) and rebel nurse leadership in healthcare (Bevan, 2013; Wallenburg et al., 2019). Our findings are also similar to those described in the scoping review of de Kok et al. (2021), who stated that rebel nurses show unconventional nonconformist behaviour that varies or differs from norms, rules, codes of conduct, practices or strategies to provide better outcomes for patients and organizations. Our participants complemented these findings by providing reasons for rebel leadership in daily nursing practice. Our findings show that nurses' intrinsic motivation to provide good care gives them the courage to challenge fixed structures and vested ideas by experimenting how things can be changed or by proposing new ideas. Previous studies have described deviating nurses as innovative, creative, and adaptable (Gary, 2013), and have shown that they come up with elegant and efficient solutions to complex problems (Bristol et al., 2018). Our study adds more detail on how aware rebel nurse leaders are of the need for continuous social influencing to change things. They are conscious of the professional boundaries of their colleagues and/or management and make balanced choices on whether to challenge these boundaries or not. Furthermore, they look for support and encouragement from likeminded critical thinkers within and beyond their organization to integrate their ideas into new practices. These collaborations and alliances help them to realize change, and if nobody agrees with their opinion then they stop pushing too hard, which stops them getting kicked out. Early work of Bevan & Fairman on health and care radicals (Nesta, 2014) (they later changed the name 'radicals' to 'change agents' to avoid negative connotations (NHS Horizons, 2022)) mentioned that there are *"hyperconnectors, building relationships with other change agents and innovators, utilizing open innovation principles to make social connections, pulling knowledge into the organization, making sense of it and sharing it to speed up change"* (Bevan & Fairman, 2017, p. 25). In our study we also learned how the strong ability of rebel nurse leaders to reflect on mundane practices, their

responsible subversion, their fundamental beliefs, and their profound evidence-based knowledge help to change things for the better. Also, their extensive experience supports deviation and stretches boundaries when needed.

We also found that experimenting within their own practices is key for rebel leadership in nursing. By showing how things can change in practice, nurses can substantiate their opinion. Rebel nurse leadership is not always 'above the radar' and therefore visible to colleagues and management. Our participants explained that having the space to deviate and experiment helps them to discover whether their ideas can improve patient care. Wallenburg et al. (2019) showed that deviating 'under the radar' allows nurses to test out their ideas, without being whistled back by their colleagues and management. Our study shows trust, autonomy, and credibility are important to nurses acting 'under the radar'. Acting 'above' or 'under' the radar is a constant balancing act between challenging the status quo to improve care and simultaneously maintaining the trust in their professionalism and profession. Van Schothorst-van Roekel, et al. (2021) made similar observations in their study on experimenting with new nursing roles in clinical practice. We add to their findings that nurses prefer to act 'above the radar' to remain reliable and professional. In addition, when nurses decide to act 'under the radar', they constantly consider if their invisible actions are ethical and can be justified, and constantly think about when they should reveal their invisible actions. This shows that within good rebel nurse leadership practices nurses do not want to act alone and be hazardous for their organization. This portrays a more positive image of rebel nurse leadership in practice. This should give healthcare organizations and professionals food for thought and should stimulate conversations with nurses about rebel nurse leadership in their own organizations.

The LAP perspective allowed us, to approach nursing leadership as more relational models of leadership (Carroll et al., 2008; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013). While the LAP perspective provided valuable new insights, it also presented challenges.

The first challenge was focusing on the social structures and interactions of deviating practices. In line with the findings of Schweiger et al. (2020), our participants struggled to abandon the individual 'heroic' image when talking about rebel nurse leadership at the start of the focus group interviews. This may support the hypothesis that competency thinking is dominant in nurse leadership (Carroll et al., 2008; Kennedy et al., 2013) and that programs to develop these competences (Boamah et al., 2018; Cummings et al., 2021; Posner, 2016), which are mainly based on transformational leadership survey data (Hutchinson & Jackson, 2013), prevent us from observing practices. Moreover, nurses are seldom exposed to the perspectives of complex, collective, and relational leadership (Kennedy et al., 2013; Uhl-Bien et al., 2020). Therefore, the participants were more encouraged to give examples of rebel nurse leadership practices rather than individual identities and capabilities.

Another challenge of the LAP perspective is that it is relatively new and is mainly described as a theory (Carroll et al., 2008; Raelin, 2016, 2019; Raelin et al., 2018) rather than an accepted method for studying nurse leadership (Vuojärvi & Korva, 2020). Only a few examples

exist where the LAP perspective was used to collect and analyze data. New approaches incorporating the LAP perspective into our study were carefully selected and used to collect data. This helped us to discover new insights into rebel nurse leadership practices that we could not have obtained using classical approaches. Therefore, this study contributes to the practical implementation of the LAP perspective to focus on relational leadership practices.

Limitations and future research

This study has a few limitations that warrant consideration. First, rebel nurse leadership sometimes takes place invisibly 'under the radar', so our participants may not have noticed all cases of rebel leadership in their daily nursing practice. This limitation could be addressed in future studies by shadowing nurses to closely observe their leadership practices (McDonald, 2005). This would help to fully understand the interactions, collaborations, and contexts surrounding rebel leadership (Husebø & Olsen, 2019; Lalleman et al., 2017). Shadowing would also overcome the challenges that hospital and long-term care nurses have describing rebel nurse leadership practices. Future research should observe rebel nurse leadership practices and further explore these practices in both the hospital and long-term care setting. Future research could also show how rebel nurse leadership influences care outcomes (Baxter et al., 2019).

Second, rebel nurse leadership practices might be influenced by social gender norms, and even by different cultural values. As shown above, the word 'rebel' is a normative term and could imply that nurses are behaving badly rather than as expected to promote quality of care for patients. More empirical research can be done on the deviant behavior of nurses, especially in daily practice in different countries. This will give more insight on the norms and values connected to the profession.

Third, because of the COVID-19 pandemic, we had to conduct some focus group interviews online instead of in person. This may have influenced the interaction between participants when responding to statements, asking questions, and entering into discussions. We tried to minimize these effects by allowing a maximum of five participants per meeting so that everyone could be seen on the screen (Barbour, 2018). Fortunately, the structure of the online focus group interviews was consistent, which meant data were collected and analyzed as planned.

Fourth, the generalizability of our findings is limited. Of the 47 participants, 18 worked in a hospital and 29 worked in a long-term care organization, which means we predominantly collected the experiences of long-term care nurses with rebel nurse leadership. Nevertheless, the long-term care organization is divided into separate care services across the middle of the Netherlands, so our results represented the diversity in the nursing profession. However, more research is needed on the differences between diverse sectors using the LAP perspective.

Conclusion

This study has provided insights into nurses' experiences with rebel leadership practices. The LAP perspective has given valuable insights into rebel nurse leadership. Interviewing nurses and analyzing their experiences helped to refine the concept of rebel nurse leadership in healthcare organizations. Differences between 'bad' and 'good' rebel leadership were explained and only nurses who showed 'good' rebel leadership were considered leaders by our participants. Good rebel leadership requires evidence-based knowledge, work experience, and motivation to change practices and vested ideas for the patients' benefit. In addition, the ability to continuously influence colleagues and management shows how nurses balance between challenging the status quo to improve care and maintaining trust in their professionalism. Aspects such as credibility, trust, autonomy, freedom, and preserving relationships let rebel nurses decide to act 'above' (visible) or 'under' (invisible) the radar. Nurses showing rebel nurse leadership are aware that collaborations are needed to improve their practices. Their responsible subversion makes them act to change their practices and shows that challenging the status quo improves patient care. By constantly exploring and stretching the boundaries of their colleagues and management, nurses could have a positive impact on their work environment and patient outcomes. This study helps nurses to recognize and acknowledge rebel nurse leadership practices more, stimulates nurses to show this rebel nurse leadership, helps organizations to understand the intentions of rebel nurse leadership, and gives insights into the mechanisms of rebel nurse leadership. Nurses do not want to be disloyal to their organizations, but always want to give the best care to their patients.

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Appendix

Appendix 1. Interview Guide

Start of the interview:

- Background questions including function, educational level, and work experience as a nurse and in the organization
- Explorative question: What does rebel nurse leadership mean to you?
- Short introduction about rebel nurse leadership (Rebel nurse leaders show unconventional behavior that varies or differs from norms, rules, codes of conduct, practices, or strategies. They challenge the status quo with their ability to develop and use social networks inside and outside their organization to obtain evidence-based knowledge. They share information and engage others to provide better outcomes for patients and organizations.)

Photo exercise:

Write in keywords on Post-its about each photo and discussing the photos with the participants:

- Is someone a rebel or not? And why?
- What characteristics make this person a rebel?
- What is happening when this person rebels?

Rebel nurse leadership experiences:

- Could you describe how rebel nurse leadership comes forward in your practice?
- Could you give examples of rebel nurse leadership in your practice?
- Could you describe why nurses rebel in their practices?
- How does the context of nursing practices influence rebel nurse leadership?
- Which preconditions are important when nurses want to show rebel nurse leadership?
- Could you describe what contributes to rebel nurse leadership?
- Could you describe what hinders rebel nurse leadership?
- Have you experiences with practicing rebel nurse leadership yourself?
- What happens in your practice when you show rebel nurse leadership?
- How do your colleagues react when you practice rebel nurse leadership?

Closing questions:

- Are there any questions that we have not asked that could help us better understand rebel nurse leadership practices?
- How has it been to participate in the interview, and do you have any questions for us?

5

EXPLORING EXPERIEN(ES THAT SHAPED (HANGE IN THE NURSES' WORK ENVIRONMENT DURING THE (OVID-19 PANDEMI(: A QUALITATIVE STUDY

Submitted as:
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Abstract

Aim: To gain insight into how nurses show leadership in shaping their work environment due to the changes COVID-19 required.

Design: A descriptive qualitative study

Method: 26 semi-structured interviews (between June and September 2020) in a large Dutch teaching hospital: one of the first hospitals to be flooded with COVID-19-infected patients. Participants were nurses, outpatient clinic assistants, nurse managers, and management (including one member of the Nurse Practice Council). Interviews were analyzed by open, axial, and selective coding.

Results: Five topics were identified related to the changed nurses' work environment and their leadership: 1) implementing a nursing staff deployment plan including shifting patients to other wards and setting up new micro-teams; 2) ensuring adequate staffing in micro-teams to take care of all patients by balancing their capacity for each shift; 3) ensuring competence in the different micro-teams by organizing professionalization activities and coaching for all involved; 4) increasing interprofessional collaboration and experienced solidarity resulting in more equal interdisciplinary relationships with mutual respect and autonomy; and 5) getting support by nurse managers.

Conclusion: Nurses took responsibility to reshape their work environment in a positive manner. Supported by their management, nurses showed leadership in their professionalization and innovating processes. This resulted in more respect for nurses' knowledge and competencies, which in turn led to nurses increasingly taking decisions regarding patient care autonomously.

Impact: The COVID-19 pandemic not only affected the nurses' work environment negatively, it also offered room for nurses to show leadership and reshape their work environment. This study offers lessons learned from this period allowing healthcare organizations, (nurse) managers, and nurses to develop strategies to stimulate leadership in nurses and support to reshape their work environment. This is particularly important given the shortages of nurses worldwide.

Reporting Method: The COnsolidated criteria for REporting Qualitative research.

Introduction

Nurses' work environment is crucial for ensuring high-quality patient care and retaining nurses for practice (Cicolini et al., 2014; De Simone et al., 2018; Kim et al., 2020; Wei et al., 2018). In a positive work environment nurses work autonomously, are in control over their practice, feel valued, respected and safe, and experience physical comfort, multidisciplinary collaboration, open communication, and career advancement (Maassen et al., 2021). However, due to the worldwide nursing shortages (World Health Organization, 2020), their work environment is strained. Nurses face a high workload, forced overtime, a lack of influence on their practices, insufficient use of their competencies, and a sentiment of being unable to provide high-quality care (Burmeister et al., 2019; Harris, 2019; Özgür & Tektaş, 2018). These are important factors for leaving the nursing profession (Brown et al., 2018; Gellasch, 2015).

More importantly, due to the COVID-19 pandemic nurses' work environment has changed even more drastically (Nagel et al., 2022). Nurses faced tremendous challenges to provide care during the pandemic, especially when the number of COVID-19-infected patients exceeded the available capacity and access to hospital care for patients was strained. Nurses also had to learn by trial and error how to take care of patients with a new life-threatening disease for which no guidelines or standardized procedures were available (Gómez-Ochoa et al., 2021; Islam et al., 2020; Kuijper et al., 2022). In addition to this, nurses had to deal with the constant threat of getting infected themselves (and infecting their family), the physical burden of working in protective clothing, and the pressure of social distancing in the workplace (Giusti et al., 2020; Nagel et al., 2022; Restubog et al., 2020). Nurses also had to be flexible as their roster continually changed, for example when colleagues became infected and were forced to isolate. Healthcare organizations had to make drastic changes to organizational structures to ensure care for all patients, for example setting up special wards with COVID-19-infected patients and consequently nurses were assigned to other teams or had to collaborate with new colleagues.

Despite these negative effects on the work environment (Falatah, 2021), the COVID-19 pandemic also gave nurses the opportunity to positively influence their daily practice (Blecher et al., 2020). Although the effects of COVID-19 on nurses' health and wellbeing have been well reported (Nagel et al., 2022; Pappa et al., 2020), less attention has been paid to how the work environment of nurses changed and the way nurses responded to these changes.

This study explored nurses' experiences in taking on the responsibility to reshape their work environment in response to the changed organizational structures due to the COVID-19 pandemic. We examined how nurses influenced the measures needed, took responsibility for the quality of care, and changed their practices. Our research question was: How did nurses in a large Dutch teaching hospital handle the changes in their work environment during the early stage of the COVID-19 pandemic?

Methods

Design

We conducted a descriptive qualitative study (Bradshaw et al., 2017) using semi-structured interviews. All interviews were undertaken between June and September 2020.

Setting

The study was conducted in a large Dutch teaching hospital (69,245 admissions and 93,221 outpatient visits per year; 4,385 employees). When the COVID-19 pandemic started in the Netherlands in March 2020, this hospital was one of the first to be flooded with COVID-19-infected patients. The hospital increased its intensive care unit (ICU) capacity from 22 to 46 beds and three hospital floors (96 beds) were allocated to COVID-19 patients to better manage the continuous stream of critically ill patients coming into the hospital. In March 2020, hospital policymakers developed the COVID-19 Nursing Staff Deployment Plan to provide nursing knowledge and skills, prevent capacity problems, and ensure sustainable nursing employment. This plan introduced three roles (A, B, and C), each with specific tasks on COVID-19 wards (see Box 1). Nurses from other wards complemented the permanent ICU nursing staff and outpatient clinic assistants were assigned to the COVID-19 wards.

Box 1. COVID-19 Nursing Staff Deployment Plan: roles, criteria, and tasks

The A-role will be performed by a registered nurse (vocational or bachelor trained), and will be ultimately responsible for nursing care.

Criteria:
- Known in the particular ward
- Experienced nurse
- Able to work as a senior nurse

Task:
- Coordinate nursing care (together with B-role)
- Manage C-role
- Attend ward rounds
- Administer medication
- Organize patient admission and discharge

The B-role will be performed by a registered nurse (vocational or bachelor trained), and will be responsible for providing nursing care to all patients.

Criteria:
- Preferably known in the particular ward
- Can resort to A-role
- Known in the hospital (e.g. psychiatry, geriatrics, pediatrics, nurse
- practitioner, day treatment)

Tasks:
- Collaborate with A-role
- Manage C-role
- Provide nursing care to assigned patients

The C-role will be performed by an outpatient clinic assistant or nursing student, and will be responsible for providing care activities of daily living (ADL) to patients with a low-complex care needs.

Criteria:
- Not known in the ward
- Accountable to A- and B-role

Tasks:
- Perform patient checks (e.g. Early Warning System score)
- Support patients with ADL
- Support patients with nutrition
- Assist A- and B-role in complex care situations

Sample

For the semi-structured interviews, we invited 245 nurses and outpatient clinic assistants (with the A-, B-, and C-roles outlined in the Nursing Staff Deployment Plan) who had worked on a COVID-19 ward. We also purposively invited ten healthcare professionals, seven of whom were either involved in the development and implementation of the Nursing Staff Deployment Plan or members of the Hospital Outbreak Management Team.

One researcher (AJBMdV) approached the potential participants by email, explaining the study aim, confidentiality, data storage, and ethics. Of the 255 potential participants, 26 agreed to an interview. We did not consider sample size or saturation but included everyone who wanted to participate after being approached. Sixteen were nurses, one was an outpatient clinic assistant, and three were nurse managers. All participants had cared for COVID-19 patients on a COVID-19 ward (N=10), in the ICU (N=10), or in the emergency department (N=1) during the study period. Additionally, we included four managers, one member of the Nurse Practice Council, and one member of the hospital board to gain more insight into the hospitals' policy and challenges of managers (see Table 1).

Table 1. Participant characteristics

n (N=26)	Profession	Usual work setting	Work setting during COVID-19 pandemic	Additional roles and tasks during COVID-19 pandemic
1	ICU nurse	ICU/ED	COVID-19 ICU/ED	
7	ICU nurse	ICU	COVID-19 ICU	
8	Registered nurse	Hospital ward	COVID-19 ward	
1	Outpatient clinic assistant	Outpatient clinic	COVID-19 ward	
1	Nurse manager	ICU	COVID-19 ICU	Member OMT
1	Nurse manager	Hospital ward	COVID-19 ward	
1	Nurse manager	Outpatient clinic	COVID-19 ICU	
1	Manager (healthcare & operations)	Management	Management	Member OMT
1	Manager (healthcare & operations)	Management	Management	Development and implementation of the NSDP
2	Manager (healthcare & operations)	Management	Management	Member OMT Development and implementation of the NSDP
1	Member Nurse Practice Council	Nurse Practice Council	COVID-19 ICU	Development and implementation of the NSDP
1	Member Hospital Board	Hospital Board	Hospital Board	Member OMT

ED = Emergency Department, ICU = Intensive Care Unit, NSDP = Nursing Staff Deployment Plan, OMT = Management Outbreak Team

Data collection and analysis

Two researchers (AJBMdV and MB) conducted private face-to-face semi-structured interviews using a pre-defined topic list based on the essentials of magnetism (Kramer et al., 2008) (see Appendix 1). Interviews were held at the workplace, lasted on average of 50 minutes, and no interviews were repeated.

The audio recordings were transcribed verbatim, summarized, and pseudo-anonymized by two researchers and accompanied by personal observational notes. The reliability and integrity of the transcripts were tested by a member check, in which transcripts were returned to five participants (Birt et al., 2016). Two experienced researchers (AJBMdV and EdK) started the data analysis by close reading each summary and multiple steps of coding (Williams & Moser, 2019). Open codes of the first 15 interviews were compared and the code labels were discussed until consensus was reached. The same researchers then relabeled their first 15 transcripts and labeled the rest. In the next phase, the labels were axial coded by one researcher (AJBMdV), and these were discussed with the whole research team until consensus was reached and situational findings were provided (Bowen, 2006). Next, selective coding was performed by the same researcher. To ensure dependability, all research steps, including data collection, data analysis, and manuscript preparation, were documented in a reflexive journal. Continuous reflections, particularly potential preconceptions, were crosschecked.

Research team

The research team comprised two female PhD-level researchers (AJBMdV and AMWJ) with extensive experience in qualitative research methods, two female PhD students (EdK and SMM), and one female MSc-level researcher (MB) with multiple experience in qualitative research methods.

Ethical considerations

All participants were informed of the study objectives and gave informed consent before the semi-structured interviews were conducted. Data were collected and stored following the Dutch General Data Protection Regulation. The study was approved by the Medical Research Ethics United (MEC-U) (Ref W20.095).

Results

When the COVID-19 outbreak first reached the Netherlands in March 2020, the hospital had to make decisions on capacity planning, operations management, and nurse deployment to fulfill the increasing demand for nursing care. Organizational changes, based on the Nursing Staff Deployment Plan (Box 1), were made on the ward and hospital level, which affected the nurses' work environment.

Because of the rising number of COVID-19-infected patients, the plan was implemented in the second week of March. In accordance with the plan, micro-teams of A-, B-, and C-role professionals were formed. The plan required the temporary transfer of nurses to the COVID-19 wards and the expanded ICU and other healthcare professionals to all the wards.

To accommodate all COVID-19-infected patients, patients had to be shifted around:

> "We moved the oncological patients to the vascular and trauma surgery ward, where we also had the neurological, orthopedics, and gastroenterology surgery patients. As a result, we worked with a different mix of nursing expertise resulting in a lack of routine and competencies. Although we tried to limit this as much as possible, we did not fully succeed."
> *(Manager)*

Analysis of the qualitative data identified five themes concerning the participants' experiences with the changing work environment caused by the implementation of the Nursing Staff Deployment Plan.

Nursing staff deployment plan

The Nursing Staff Deployment Plan described working with COVID-19-infected patients as a choice and called upon healthcare professionals' willingness to do so:

> "It has always been a voluntary choice whether or not to work on the COVID-19 ward. We cannot and must not force outpatient clinic assistants to do so. Every morning we had a meeting with all nurse managers to discuss the vacancies and deployment in the wards."
> (Manager)

> "In my view, nurses had control over practice and a say in whether they were willing to work on the COVID-19 ward, but I don't know what happened in daily practice. I think nurses were quite motivated by their managers to do it."
> *(Hospital board member)*

Most healthcare professionals were informed by their nurse manager via email about their roles and assigned ward. One manager expressed that the plan largely depended on the communication skills of the nurse managers, who know their staff best and could explain the shifts, tasks, and roles of the different teams and prevent stress and anxiety. However, most nurses expressed an intrinsic motivation to provide the care needed:

> "I have chosen this profession, and, in these times, you just have to do what is expected of you. If they expect me to work on the COVID-19 ward, then I should just do that. Because you just must be present for the patients."
> *(Registered nurse)*

Ensuring staffing in micro-teams

The implementation of the Nursing Staff Deployment Plan reshuffled the nursing staff. The new micro-teams were each assigned to a limited number of COVID-19-infected patients. Participants reported that more than enough staff were available on the COVID-19 wards and that the surplus of staff was needed in case there was a sudden influx of COVID-19-infected patients. This meant that fewer nurses were available for other wards:

> "There was enough staff on the COVID-19 ward. Sometimes I saw a lot of blue gowns (red: nurses) walking around. On the other hand, we had a shortage of staff on the other wards."
> *(Registered nurse)*

The department of process innovation and the nurse managers determined the nurse-patient ratio needed on the COVID-19 wards to guarantee safe and high-quality care. The ratio was based on the anticipated complexity of care and the task division proposed in the Nursing Staff Deployment Plan. Each COVID-19 micro-team was responsible for ten patients during the day shift and 15 patients during the evening and night shift. According to the participants, the nurse-patient ratio was based on trial and error rather than evidence. Predicting the optimal nurse-patient ratio was difficult because the level of nursing care constantly changed depending on the condition of COVID-19-infected patients, which could deteriorate quickly. The micro-teams were also not as consistent in their roles as intended because of staff changes due to illness or quarantine or assignment of staff to other wards. This undermined the agreed-upon mixed ratios:

> "I understood the justification of the A-, B-, and C-roles, but the daily practice was often different because of the unintended absence of the B- or C-role. Sometimes I felt responsible for ten patients, which was tough."
> *(Registered nurse)*

In response, nurses took the lead and balanced their capacity to ensure the best quality of care on each shift. They learned that composition of the micro-team roles could be adjusted on an hourly base depending on the situation. This required not only a flexible mindset, but also a central overview of the healthcare staff capacity, to gain a real-time overview of staff surplus and shortage. Nurses urged management to provide this overview:

> "So, I am working on a plan. How are we going to organize things even better? We can profit from the central overview on the plus and minus [red: of staffing], and centrally steering this and not organizing this in every ward."
> *(Manager)*

Ensuring competence in micro-teams

Participants stated that up-to-date knowledge of COVID-19 and how to take care of COVID-19-infected patients was important for optimal nursing care. As one manager said: *"Knowledge is the professional's power. If you don't know certain aspects… you can't observe them."* ICU nurses also explained that, because of the continuous stream of new evidence, even experienced ICU nurses could not rely on their knowledge and ventilation management, which were acquired previously: *"Protocols change in the blink of an eye" (ICU nurse)*. Participants stressed that their knowledge of COVID-19 and how to provide the best care changed as they learned more about the virus:

> "I thought I knew enough, but noticed that my knowledge was outdated, but that is what happens with a new disease."
> *(Registered nurse)*

The condition of COVID-19-infected patients could decline rapidly, so new competencies were needed to care for these patients. Knowledge of COVID-19-related symptoms and skilled provision of care to COVID-19-infected patients affected the quality of care. Hence, the pandemic prompted nurses to search the internet for the latest research and guidance on nursing and treating COVID-19-infected patients. Specialized nurses in A-roles started to provide on-the-job training to inform their colleagues about COVID-19. For example, nurses from the respiratory ward gave instructions on the COVID-19 ward.

> "And then you start reading papers again. What is happening? What are the newest insights? What are the current ventilation guidelines? What insights derive from these guidelines? So, you are constantly in the COVID-19 mode. And on top of that, you follow webinars and other things like that… You know nothing about it, and you want to provide good care... You have to be innovative and look in places where you normally do not search for information."
> *(ICU nurse)*

Nurses also called upon supporting departments to support their need for more knowledge. For example, the infection prevention department was invited to meetings to instruct healthcare staff on how to change into protective clothing. The hospital academy department also offered novel e-learning opportunities and online videos about how to care for COVID-19-infected patients.

Nurses took on the responsibility to acquire knowledge on COVID-19 and teach each other (on the job) and to adjust their mundane practices by making new guidelines, developing easier reporting templates, and developing new equipment/tooling: *"We started to package arterial blood gas materials together in kits for quick and easy use, as we use them many times a day." (outpatient clinic assistant).*

> "My colleagues developed specifically for the COVID-19-infected patient a round chart and standardized nursing report in our Electronic Patient Record. Nobody was expecting that."
> *(Registered nurse)*

Despite this, participants indicated that some team members, especially outpatient clinic assistants and nursing students with C-roles, were not competent enough to perform the assigned tasks. This was understandable since students or outpatient clinic assistants (C-roles) who were not trained as a nurse or had worked as a nurse for many years. One nurse mentioned:

> "Once a patient said he needed to go to the restroom, and the assistant [red: C-role] thought this is possible. But I know that a patient with a 15-liter non-rebreathing mask can't just walk to the toilet without the mask. Seems a simple thing; however, they should really ask. And that didn't happen, resulting in things go wrong."
> *(Registered nurse)*

While some B and C role professionals communicated their shortcomings to their colleagues in A-roles, others were reluctant to do so because of the hectic situation and others were not aware of their incompetence: *"People don't know what they don't know" (nurse manager)*. This had in the beginning a negative impact on the micro-team collaboration and patient care quality.

> "I found the new tasks with the A-, B-, and C-roles difficult. Some nurses and outpatient clinic assistants performed really well, but others thought it was scary… Sometimes I was busier with instructing and reassuring them because I couldn't do the half-hourly patient check-ups on my own."
> *(Registered nurse)*

The above excerpt shows how working with different colleagues with unknown competencies on a day-to-day basis required A-roles to have substantial communication and coaching skills, which they showed:

> "Which tasks can this buddy [red: the C-role] do independently and which ones not? This also depends on the individual person. You need people that are open in their communication and clear about their boundaries… So, I was actually explaining every day again and again what their tasks and responsibilities were. That took a lot of my time."
> *(ICU nurse)*

To prevent miscommunication, avoidable incidents, and reduced quality of care, nurses created new routines for task division. For example, the A-role instructed the C-role to take the blood pressure of all patients and to report back to the A-role. In addition, learning and reflection sessions were organized daily within micro-teams to establish trust in each other's competencies.

In sum, the work environment of all team members changed because of task assignments within the micro-teams, sometimes on a daily basis. This impacted the quality of patient care. We found that the success of the micro-teams depended on three things. First, the success depended on an appropriate balance between available competencies and the care workload, which could change quickly. Second, the success depended on knowledge about the competencies of the other healthcare staff, especially the B- and C-roles. And third, the success depended on open and respectful communication to exchange potential shortcomings of knowledge and skills. Working in these micro-teams also included collaboration with other healthcare professionals and management, as shown in the next two sections.

Interprofessional collaboration

Not only nurses but also physicians were shifted from their normal tasks to work in new COVID-19 micro-teams.

> "One day I worked with a pathologist, who had to listen to the patient's lungs. I think that he hadn't seen a living patient for 20 years. Or a psychiatrist who came to assess a lung patient… I thought this is special, but I get it, because it is an all hands-on-deck crisis."
> *(Registered nurse)*

Participants described this working environment as an increased interdisciplinary collaboration, characterized by frequent communication beyond the usual boundaries between disciplines. As explained before, healthcare staff were insecure about how to treat and care for COVID-19-infected patients because they lacked sufficient knowledge of the virus. Therefore, frequent interdisciplinary consultations were needed to discuss opinions and professionals' values on the best quality of care. Many participants were willing to collaborate when confronted with the COVID-19 crisis and developed equal interdisciplinary relationships with mutual respect that they did not have before.

> "I thought it was great! There were also plastic surgeons and gynecologists… They said: 'We do it all together!' I actually thought it was a very good atmosphere."
> *(Registered nurse)*

This illustrates the solidarity and positive atmosphere that our participants experienced. Some participants suggested that this equality between professionals was fostered by the fact that everyone wore the same protective clothing. Others believed it was fostered by a shared feeling of despair caused by the COVID-19 pandemic.

> "Everyone helped each other. So, turning ICU patients from back to belly and from belly to back was done by all of us. Normally, physicians would not perform this task, but now everyone chipped in."
> *(Nurse manager)*

Participants, particularly nurses, found they were able to gain more professional autonomy in the before mentioned work environment. For example, in the absence of physicians, nurses were forced to make decisions independently when a rapid intervention was needed. Also, the lack of scientific information on the virus meant that nurses were experts based on their experience taking care of many COVID-19-infected patients.

> "I decided independently about some actions, but only if I could substantiate them properly. And I always discussed it with a doctor afterward. COVID-19 was a new disease for all of us… This contributed to the fact that the doctors respected our decisions and actions."
> *(Registered nurse)*

Nurses participated more in discussions (such as rounds and multidisciplinary meetings) to enhance proactive treatment plans, including when to start palliative care. Participants indicated that physicians – to their surprise – respected the nurses' professional autonomy and valued their input on patient treatment.

This professional autonomy also involved independent decision-making by nurses regarding which tasks needed to be performed and by which role in the micro-team. This required close collaboration with management, as we will show in the next section.

Support by management

Temporary micro-teams were formed as part of the Nursing Staff Deployment Plan. Nurse managers had to manage these teams without team building or getting acquainted with each other. Despite this, many participants reported a strong sense of belonging in their new micro-teams. Nurses explained that this feeling spontaneously arose – once the crisis was upon them, they just buckled down, worked without complaining, and were proud of their achievements:

> "Everyone was willing to help and tried to make the best of it. I felt a true team spirit with everyone regardless of function or discipline."
> *(Registered nurse)*

Some participants explained that this sense of belonging to the team prevented them forming a relationship with the management though. However, others felt supported by their nurse managers, who listened to their concerns and advocated on their behalf. Participants emphasized the importance of their nurse managers being visible on the ward and available to share concerns, which supported their mental health and increased job satisfaction. Nurse managers also played an important role in relieving stress by improving work conditions, for example by adjusting work processes so that staff could take short breaks, or making sure that staff had sufficient equipment, medication, or bandages.

> "I worked in a team that functioned like a well-oiled machine. I saw the nurse manager regularly, and she always asked how I was doing. If I needed anything or if any adjustments needed to be made. She emphasized the need to tell her these things, so the team could learn from the situation. They were very open to learning."
> *(Registered nurse)*

> "I have seen nurse managers standing up for their team. For example, when personal protective measures were not in place, they moved heaven and earth to get them."
> *(Member of the Nurse Practice Council)*

Despite being preoccupied with deploying and rostering the nursing staff, most nurse managers made time for a daily chat with individual team members during breaks, shift evaluations, or other meetings. Nurse managers also paid attention to (ethical) concerns about patients and family as this weighed emotionally on the nurses. They organized (online) meetings for nurses to discuss their dilemmas, such as not being able to provide optimal care to patients or feeling obliged to come to work when they were afraid to do so.

> "Who else can do my job? That was the dilemma for a lot of nurses. I actually don't want to do it, but I can't just refuse… Patients depend on my care, and if I don't do my job, who would take care of those patients? I can't just tell my nurse manager that I'm not coming to work, because I find it scary and I am afraid, or because I have a vulnerable parent."
> *(Registered nurse)*

This shows that, although participants were stressed by their working conditions, the support from nurse managers was helpful and different to that in the normal work environment.

Discussion

This study explored how nurses handled changes in their work environment during the COVID-19 pandemic. We revealed how nurses coped with changes in tasks and team composition during the early stages of the COVID-19 pandemic. Without any knowledge of this new disease, nurses cared for COVID-19-infected patients in small teams with mixed roles and different backgrounds and competencies. In these micro-teams, they coordinated the assignment of work to different roles and started to innovate care processes and safeguard the quality of care. The nurses in our study found new ways to cope with existing rules and regulations and to reshape their work environment. Other studies also demonstrated how nurses all over the world were forced to continuously reshape their work environment and alter their work routines as new information about the virus became available (Eysenbach, 2020; Gómez-Ochoa et al., 2021; Islam et al., 2020; Mira et al., 2020).

Our findings illustrate how an unexpected crisis such as the COVID-19 pandemic directly affected the work environment of nurses and demanded immediate changes in their practices. The rigorous changes to the nurses' work environment - on top of existing shortages and work environment issues (Burmeister et al., 2019; Harris, 2019; World Health Organization, 2020) - could have reduced job satisfaction and increased attrition of nurses (Brown et al., 2018; Cicolini et al., 2014; Gellasch, 2015; Özgür & Tektaş, 2018). However, in our study most changes created a positive work environment (Maassen et al., 2021; Taylor et al., 2015) as a result of effective communication and collaboration. This resulted in feeling valued by other professionals and management. Studies show that nurses, as the largest proportion of healthcare professionals, played a key role in responding to the crisis and their hard work became visible and was respected by the public too (Aquila et al., 2020; Miawati et al., 2021).

Similar to our study, Wei et al. (2018) showed that exhibiting leadership in daily practice is linked to a positive work environment. The COVID-19 related practices motivated nurses to exhibit leadership to reshape their work environment. In our study we showed how reshaping their work environment increased nurses' professional autonomy in taking decisions and delivering good quality patient care. For example, nurses took the initiative to educate themselves and their team members about the virus and the skills needed to take care of patients. Thull-Freedman (2020) investigated the changing work environment during the early stages of the COVID-19 pandemic and also described the relevance of the expert knowledge and decision-making of frontline staff. Furthermore, in our study nurses developed equal interprofessional collaborations in which they were able to express their opinion about the best care for the patient as part of increasing professional autonomy and professionalization. Nurses took control over their own practices, assessed and decided independently whether a situation was urgent. Miawati et al. (2021) also found that nurses had to be creative and innovative and adapt their existing behavior, norms, and standards and - by doing so - gained room to reshape patient care. Nurses sharing their professional

expertise with physicians increased feelings of collaboration, equality, acceptance, and equivalence among nurses. Literature shows good communication and constructive collaboration improve the quality of patient care, because decision-making is more effective when taking everyone's view into account (Kvist et al., 2022). Additionally, several studies show how effective communication, teamwork, and personal leadership create a positive work environment, which in return can enhance nurse retention (Kramer et al., 2008; Rodríguez-García et al., 2020).

We found that nurse managers supported their team during the early stages of the COVID-19 pandemic by being more visible, advocating for optimal staffing and equipment, and discussing ethical concerns, all of which decreased the physical workload and mental stress. In line with the study of Raso et al. (2021) managers' leadership style positively affected the work environment of frontline nurses during the COVID-19 pandemic. Nurse managers were able to support the ability of nurses to exhibit leadership and shape their work environment (Stucky et al., 2022; Thull-Freedman et al., 2020; Wei et al., 2018). Furthermore, during the COVID-19 pandemic they were more conscious of their role and impact on the nurses' work environment.

Strengths, limitations and future research

This qualitative study has some limitations. First, the findings represent the opinions and insights of a purposeful sampled group from one Dutch hospital. Outpatient clinic assistants and nursing students (the C-role) were particularly under-represented. Moreover, only ten percent of potential participants were included; it could be possible that a group with specific opinions or feelings agreed to an interview. Therefore, our findings should be generalized with caution. Future studies should include a larger group of participants or interview participants from different hospitals (in different countries) to better understand how nurses reshape their work environment and show leadership in response to new circumstances. Secondly, the opinion of our participants on the nurses' work environment might have been affected by high levels of stress, adrenaline and relief just after the first wave of the pandemic. Participants might express different opinions and feelings on the situation over time after the second or latter wave. More long-term research is needed to examine this. Thirdly, the interviewers (AJBMdV and MB) worked in the hospital during the period of data collection. This helped our participants to be sensitive to relevant issues, but might have caused bias. However, both interviewers have extensive experience in interviewing. Moreover, the research team tested the credibility of the findings through in-depth discussion of the major themes and key points of all interviews. To maximize reliability, all research steps – including data collection, data analysis, and manuscript preparation – were well-documented and assessed by the researchers outside the hospital (AMWJ, EdK and SMM).

Conclusion

In sum, the COVID-19 pandemic substantially affected the nurses' work environment and the Nursing Staff Deployment Plan made huge changes to nurses' daily routines. However, nurses responded to these circumstances by exhibiting leadership for 1) their work environment in the micro-teams, 2) professionalization of their colleagues, 3) innovation of care processes. In doing so, nurses shaped their work environment in such a manner to be able to perform their job as well as possible well under the harsh conditions of the time. The nurse managers also supported nurses in exhibiting these alternative behaviors and supported the new work routines. Furthermore, interprofessional collaborations increased, especially with physicians. This resulted in a more positive work environment for nurses, as they gained professional autonomy from their experience-based knowledge and equality interprofessional collaboration.

Based on the findings from this study, healthcare organizations, nurse managers, and nurses should develop strategies to stimulate leadership in nurses, allowing them to reshape their work environment. This is particularly important given the shortages of nurses worldwide.

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Appendix

Appendix 1. Topic List for the Semi-structured Interviews

Literature synthesis on Essentials of Magnetism (adapted from de Brouwer (2019))	
Clinically competent peers	Nurses consider working with clinically competent fellow nurses important for delivering quality care. They regard specialty certification, educational degree, and both formal and informal peer review and reinforcement as proof of clinical competency. The absence of clinically competent peers inhibits quality patient care and is disadvantageous for nurse job satisfaction (Aiken et al., 2017; Kramer & Schmalenberg, 2004; Stalpers et al., 2017).
Collaborative nurse-physician relationships	In order to be collaborative, nurses and physicians should work together with mutual respect, trust, and equal power. Collaborative and collegial nurse-physician relationships increase retention of nurses and lower stress levels among nurses. More importantly, patients benefit from those relationships (Klipfel et al., 2014; Kramer & Schmalenberg, 2004; Tang et al., 2013).
Clinical autonomy	Clinical autonomy is defined as the freedom to independently make informed decisions that exceed standard nursing practice in the best interest of the patient (Kramer & Schmalenberg, 2008). Accountability of nurses in a positive and constructive manner is seen as an important element of the nursing work environment to enable high quality patient care (Mensik, 2007). Nurses' job satisfaction, levels of burnout, intention to leave the organization, as well as teamwork have been linked to nurses' autonomy (Rafferty et al., 2001).
Nurse manager support	Attracting and retaining nurses, and nurse job satisfaction, are affected by the support of nurse managers. Support means that nurse managers meet the expectations of nurses and provide them with means to deliver their job professionally, while also meeting the expectations of their superiors. Strong leadership is an important driver of adequate staffing, collaborative interdisciplinary relationships, and nursing participation in governance and policy development which positively affect nurse sensitive outcomes (Goedhart et al., 2017; Laschinger & Leiter, 2006).
Control over nursing practice	Control over nursing practice is a democratic process facilitated by a visible, organized, and supportive structure. The structure should give nurses input and involvement in decision making concerning clinical policies and problems and personnel issues which have an effect on nurses. Control over nursing practice, for instance in the form of a nurse practice council, will only lead to the desired outcomes if nurses have the authority to take control over their daily practice (Laschinger & Wong, 1999).
Support for education	Education includes continuing education and short courses, as well as on- and offsite degree programs. Educational support is valued highly with a view to attracting and retaining nurses, quality patient care, and job satisfaction (Aiken et al., 2013; Schmalenberg & Kramer, 2008; Stalpers et al., 2017). Support for education is considered essential for the autonomous practice of nurses and for positive nurse-physician relationships.

Adequacy of staffing	Adequate nurse staffing is associated with lower mortality rates in hospitals in the United States, Europe and other countries (Aiken et al., 2014; Griffiths et al., 2016; Twigg et al., 2010). Adequacy of staffing involves the number of nurses on a ward as well as the ability to deliver quality patient care. Nursing care left undone due to a lack of time is related to insufficient nurse staffing (Ausserhofer et al., 2014; Ball et al., 2014), mortality following common surgical procedures (Ball et al., 2018), lower nurse perceived patient safety (Ball et al., 2014).
Patient-centered cultural values	Organizational culture can be defined as a patterned, shared system of values guiding behavior in the work setting (Kramer et al., 2008). Shared values and norms are the two elements of which an organizations' culture is composed. Patient-centered culture is an important element of the nursing practice environment to enable high quality patient care delivery (Kramer et al., 2008; Stalpers et al., 2017).

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6

UNDERSTANDING REBEL NURSE LEADERSHIP-AS-PRACTICE: CHALLENGING AND CHANGING THE STATUS QUO IN HOSPITALS

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Abstract

Some nurses are responding rebelliously to the changing healthcare landscape by challenging the status quo and deviating from suboptimal practices, professional norms, and organizational rules. While some view rebel nurse leadership as challenging traditional structures to improve patient care, others see it as disruptive and harmful. These diverging opinions create dilemmas for nurses and nurse managers in daily practice. To understand the context, dilemmas, and interactions in rebel nurse leadership, we conducted a multiple case study in two Dutch hospitals. We delved into the mundane practices to expand the concept of leadership-as-practice. By shadowing rebel nurse practices, we identified three typical leadership practices which present the most common 'lived' experiences and dilemmas of nurses and nurse managers. Overall, we noticed that deviating acts were more often quick fixes rather than sustainable changes. Our research points to what is needed to change the status quo in a sustainable manner. To change unworkable practices, nurses need to share their experienced dilemmas with their managers. In addition, nurse managers must build relationships with other nurses, value different perspectives, and support experimenting to promote collective learning.

Introduction

The nursing profession is constantly evolving and nurses need to adapt and respond to the changing healthcare landscape (International Council of Nurses, 2022; World Health Organization, 2020). Some nurses are doing this by challenging the status quo and deviating from suboptimal professional norms and organizational rules and regulations to generate better outcomes for their patients or to improve unworkable processes (International Council of Nurses, 2022; World Health Organization, 2020). De Kok et al. (2021) call this 'rebel nurse leadership', in which the leadership exhibited in daily practice is aimed at providing the best care for patients by challenging the status quo in organizations. Based upon their scoping review, de Kok et al. (2021) define rebel nurse leadership as nurses who *"have unconventional and non-confirmative behavior that varies or differs from norms, rules, codes of conduct, practices, or strategies. They challenge the status quo with their ability to develop and use social networks (peers, other disciplines, and management) in- and outside their organization to obtain evidence-based knowledge, share information, and gain the engagement of others to provide better outcomes for patients and organizations"* (p. 2580). Rebel nurse leadership is grounded in the idea that nurses have a unique perspective of the needs of patients and play a pivotal role in the healthcare system to keep processes on track (Allen, 2014). Therefore, nurses' voices and actions can be powerful change agents. The rebel leadership concept empowers nurses and other healthcare workers to take an active role in shaping the healthcare system (Bevan, 2013). Rebel nurse leaders bring new ideas, advocate for patients and better processes and structures, and promote a more collaborative and participatory approach to decision-making within the organization (de Kok et al., 2021; 2022). However, rebel nurse leadership is not universally accepted or well understood in healthcare organizations as empirical evidence for this behavior is scarce.

While some view the behavior of rebel nurse leaders as a positive approach to promoting change and supporting patient care improvements, others view it as disruptive or even harmful to patient care and/or the organization (Banja, 2010; Petrou et al., 2020). For example, when deviance is normalized (Banja, 2010), that is when a deviant act is no longer regarded as one because everyone has adopted it, despite the presence of conflicting formal rules and regulations. Or when deviating creates tension between nurses and results in resistance among colleagues who do not want change. In the long term, this is not beneficial for changing the system. Studying deviating in daily practice is relevant as many of the issues that rebel nurse leaders address, such as person-centered care and better work practices, are complex, context specific, and multifaceted. Understanding more about these issues requires a deep understanding of the systemic issues and insight into nurses' ability to navigate these issues. This can be difficult to grasp but is crucial to fully understand the potential of rebel nurse leadership.

Healthcare organizations contain intricate systems, consisting of complex responsive processes (Davidson, 2020), and often have several levels of management and decision-

making (Uhl-Bien et al., 2020). Challenging the traditional (power) structures that exist in many layers and levels of decision-making is complicated in healthcare organizations. Besides the importance of understanding rebel nurse leadership practices from the perspective of nurses, it is also important to examine the role (nurse) managers play in these rebel nurse leadership practices. Research has shown that nurse managers can both stimulate and hinder nurses' leadership (Curtis & O'Connell, 2011; de Kok et al., 2021; 2022; 2023; García-Sierra & Fernández-Castro, 2018; Labrague, 2021; Labrague et al., 2020; Lalleman et al., 2016; van Schothorst-van Roekel et al., 2021), thus managers play a key role in giving rebel nurse leaders room to express their opinion (de Kok et al., 2021; 2022; Wallenburg et al., 2019). Managers and their management systems not only inspire nurses to exhibit rebel nurse leadership, aiming to innovate and improve quality of care (Labrague, 2021; Lalleman et al., 2016), but also play a pivotal role in spreading good rebel nurse leadership practices throughout the organization (de Kok et al., 2021; Wallenburg et al., 2019). However, several studies have described that nurse managers can have a negative influence on nursing practice (Labrague, 2021; Labrague et al., 2020), decreasing the involvement of nurses in their job and preventing nurses from influencing their practice. Nurse managers and their management systems often do not welcome input from nurses that interferes with their search for control and efficiency (Daly et al., 2014; Labrague, 2021; Labrague et al., 2020; van den Broek et al., 2014). As a result, nurse managers may hinder rebel nurse leadership practices by pushing nurses back, silencing their voices (de Kok et al., 2021), punishing them, or ultimately withdrawing their licenses (Bristol et al., 2018). This may cause nurses to feel 'trapped' and/or 'disciplined.' As a result, nurses may surrender to silence and disempowerment, assimilate with the dominant discourse or values of an organization even if these conflict with their personal opinions, or leave their jobs (Brandi & Naito, 2006). Observing these practices provides deeper insight into the difficulties rebel nurse leaders face to effect desired changes, and even to be heard. It is especially relevant because rebel nurses risk being marginalized or excluded from the decision-making processes of the organization.

Based on the findings of our previous study (de Kok et al., 2022), we show that in response to the risk of being marginalized, excluded, controlled, or disciplined, nurses sometimes choose to act 'under the radar' (i.e., in a way that is invisible to their colleagues) to influence their daily practices so that they match their professional judgments (Bevan & Fairman, 2017; de Kok et al., 2022; Wallenburg et al., 2019). Thorne (2021) describes this as *"to make independent decisions on behalf of their patients—to enact the intelligence and expertise that their profession stands for"* (p. 1). Acting under the radar, rebel nurse leaders focus on achieving their goals and avoiding opposition, resistance, and pushback from colleagues and management. This strategic move allows nurses to *"experiment with their novel ideas"* (de Kok et al., 2022, p. 7). Keeping the deviant actions of rebel nurse leaders hidden (under the radar) impedes the innovative spirit of a team and their ability to collectively learn from good practices. It also hinders the spread of innovations derived from their experiments as

these new practices are not noticed or shared (Sheard et al., 2017; Wallenburg et al., 2019). Although some empirical research has been done on rebel nurse leadership (de Kok et al., 2022; Wallenburg et al., 2019), under-the-radar behavior has not been studied fully. This is why it is interesting to observe how this mechanism influences rebel nurse leadership practices and whether nurses can change their practices by staying under the radar.

The leadership-as-practice perspective is convenient to use in studying rebel nurse leadership practices. This perspective assumes leadership is not only something done by specific individuals (in designated positions) or assigned roles but is also a joint practice influenced by interaction with others (Raelin, 2016a; Raelin et al., 2018). According to Uhl-Bien and colleagues (2016; 2017; 2020), leadership practices are rich in interconnectivity, meaning that *"when things interact, they change one another in unexpected and irreversible ways"* (Uhl-Bien & Arena, 2017, p. 9). The interaction between nurses and other healthcare professionals, managers, and patients determines whether and how nurse leadership occurs in practice. It involves relationship building, confrontation, and stabilization (Raelin, 2016a), and thus we included these factors in our study.

Our previous study on rebel nurse leadership practices described the leadership experiences of rebel nurses from an interview study. The aim of the current study to describe in more depth how rebel nurse leadership is reflected in the nursing practice, and thereby provide insight into the 'lived experiences' (Fairhurst et al., 2020) of nurses and nurse managers. Our aim is to understand the relationships by studying the contextual interactions and collaborations and thus gain insight into how nurses and nurse managers deal with the related dilemmas. Ultimately this will provide more insights into the difficulties rebel nurse leaders face to be heard and to effect the desired change within the organization. The key research question is: How do nurses and nurse managers deal with the dilemmas of rebel nurse leadership practices in daily hospital work?

Methods

We conducted a multiple case study (Stake, 2006) between January 2020 and December 2022 in two Dutch hospitals. We combined the data as both cases studied rebel nurse leadership practices and data collection was similar (Stake, 2006). We used several qualitative research methods to collect and analyze data, providing triangulation, and we used the checklist of Standards for Reporting Qualitative Research (O'Brien et al., 2014).

Setting and study participants

We built this study on two case studies on rebel nurse leadership practices in the Netherlands. We chose these two cases because since both organizations were already paying attention to developing nursing leadership, we assumed that studying rebel nurse leadership would be more accessible here than in organizations that paid little attention to

nurse leadership practices.

In hospital 1 (H1, three locations, 2,700 employees including 970 nurses) we chose to study rebel nurse leadership practices from the perspective of bedside nurses who were taking part in a nurse leadership program. All H1 bedside nurses, with various levels of education (vocational degree, bachelor's degree, master's degree) (van Kraaij et al., 2023), could apply to follow the program. Management held job interviews to select the most suitable candidates. We invited all included in the program to participate in this study and those who accepted (N=45) allowed us to shadow them at work and during relevant meetings (i.e., nursing advisory board meetings, leadership development program meetings, and/or management meetings) or to come to a focus group interview. We also invited several other stakeholders (N=16) involved in nurse leadership development to participate in the focus groups. We shadowed ten nurses (22%) and the focus groups included five nurses (11%) and eight stakeholders (50%) (see Table 1).

In hospital 2 (H2, eight locations, 5,000 employees, including 1,930 nurses) we chose to study rebel nurse leadership in context and therefore also included the perspective of nurse managers. H2 did not support the development of nurses' leadership with a dedicated program as in H1 but delegated the task of developing nurse leadership to nurse managers. All H2 nurse managers (N=50) were eligible and therefore invited to be shadowed or interviewed. Five nurse managers (10%) agreed to be shadowed and five (5%) agreed to participate in the interviews (two of whom were also willing to be shadowed). Additionally, through purposive sampling (Palinkas et al., 2015) we compiled a mix of participants with a maximum variation of knowledge and experience with the role of nurse managers in nurse leadership development (together with the nursing advisory board). These individuals were invited to participate in semi-structured (focus group) interviews. Nurses (N=10), managers (N=10), policy advisers (N=5), and one member of the board of directors (N=3) were then invited to participate, ten of whom agreed (see Table 1).

Table 1. Data collection hospitals

Hospital 1 (H1)								
Focus group interviews (F)			**Observations (O)**			**Observations (O)**		
C	**Function**	**H**	**C**	**Function**	**H**	**C**	**Meeting**	**H**
F1	Nurse 1	1.5	O1	Nurse Intensive Care Unit 1	4	O11	Nursing advisory board	2
F1	Nurse 2		O2	Nurse Neurology department	6	O12	Job-differentation meeting	1
F1	Nurse 3		O3	Nurse Short Stay Unit 1	4	O13	Nursing advisory board	4
F1	Nurse 4		O4	Nurse Cardiac Care Unit	4	O14	Nursing advisory board	2
F1	Nurse 5		O5	Nurse Short Stay Unit 2	4	O15	Nursing advisory board	2
F2	Nurse manager	2	O6	Nurse Children department	10	O16	Nursing advisory board	2
F2	Training advisor		O7	Nurse Geriatric department	4	O17	Management meeting	1
F2	Medical manager		O8	Nurse Oncology department	4	O18	Management meeting	1
F2	Coach Nurse Leadership Development Program		O9	Nurse Gastro-enterology department	4	O19	Nurse Leadership Development Program	2
F2	Business operations manager		O10	Nurse Intensive Care Unit 2	8			
F2	Trainer Nurse Leadership Development Program							
F2	Member board of directors							
F2	Member nursing advisory board							
		3.5			52			17

Hospital 2 (H2)								
Individual interviews (I)			**Observations (O)**			**Focus group interviews (F)**		
C	**Function**	**H**	**C**	**Function**	**H**	**C**	**Function**	**H**
I1	Nurse	1	O1	Nurse manager 1	9.5	F1	Nurse manager	0.75
I2	Nurse	1	O2	Nurse manager 2	10	F1	Nurse manager	
I3	Member board of directors	1	O3	Nurse manager 3	8.5	F1	Manager healthcare & operations	
I4	Physician	1	O4	Nurse manager 4	10	F2	Training advisor	0.75
I5	Nurse manager	1	O5	Nurse manager 5	8.5	F2	Nurse manager	
I6	Unit manager	1				F2	Nurse	
I7	Nurse	1				F3	Nurse	0.75
I8	Nurse manager	1				F3	Unit manager	
I9	Manager healthcare & operations	1				F3	Member board of directors	
I10	Nurse manager	1						
I11	Unit manager	1						
I12	Nurse manager	1						
I13	Nurse manager	1						
I14	Human resource advisor	1						
I15	Manager healthcare & operations	2						
		16			46.5			2.25

C = Code, H = Hours

Data collection

Shadowing

Shadowing (Czarniawska, 2007; McDonald, 2005) improves understanding of the interactions, collaborations, and contexts of rebel leadership development (Husebø & Olsen, 2019; Lalleman et al., 2017). In H1, nurses were shadowed in their daily practices between January 2020 and December 2021 by the lead researcher (EdK) to understand their experiences and the dilemmas they encountered in rebel nurse leadership practices. In total, 69 shadowing hours were captured in observational, thick description reports (52 hours of nursing practice and 17 hours of meetings). In H2, nurse managers were similarly shadowed

in their daily practices between December 2020 and July 2021 by three researchers. In total, 46.5 shadowing hours were captured in observational thick description reports.

(Focus group) interviews

After three researchers analyzed the shadowing phase data, we held semi-structured (focus group) interviews (Kallio et al., 2016) in both hospitals to gain a deeper understanding of our findings. All interviews were audio recorded and transcribed verbatim. Besides the interview transcripts, we made field notes to maximize the verbal and non-verbal information obtained (Holloway & Galvin, 2017). In H1 we held two online semi-structured focus group interviews (70 and 90 minutes; using Microsoft Teams). We used a predefined interview guide that included topics on rebel nurse leadership practices derived from our analysis of the shadowing data. In H2, we held 15 individual semi-structured interviews, both in person and online (using Microsoft Teams). Each interview lasted 60–120 minutes. We used the same predefined interview guide, complemented by topics on the work of the nurse manager observed during shadowing.

After analyzing the individual interviews and observational reports, three held three member-check group interviews to deepen our understanding of the retrieved data. Participants discussed the collected data in depth to explore their values, beliefs, and dilemmas about rebel nurse leadership practices and the role of nurse managers in these practices. Each interview lasted 45 minutes.

Both the semi-structured focus group interviews and individual interviews were led by two members of the research team—one acting as moderator, the other as facilitator. The moderator interviewed and the facilitator assisted with practical issues and made field notes.

Data analysis

Following Stake (2006) and Abma & Stake (2014) data was analyzed in two phases: first the individual hospital cases and then comparing and contrasting the findings from both cases (Creswell, 2021). For both cases (H1 and H2), the first phase involved condensing and triangulating the shadowing and (focus group) interview data to understand the particular activities and observed practices. For each case, we paid attention to the contextual elements and interactions that emerged in rebel nurse leadership practices and how these influenced the practices (Abma & Stake, 2014). The observational reports, transcripts, and field notes were analyzed using the six steps of thematic analysis described by Braun & Clarke (2006). EdK familiarized herself with the data, derived codes from the qualitative data, and then discussed the coding with two members of the research team. Then EdK developed the final coding lists for each case and merged and clustered the codes into the themes and sub-themes of each case. The descriptions of the themes were discussed with the whole research team until consensus was reached.

After the individual case analysis, both cases were examined together to identify their similarities and differences in rebel nurse leadership practices (Abma & Stake, 2014;

Creswell, 2021). After comparing both coding lists, looking for corresponding themes in the data, we developed an overarching coding list with terms for how rebel nurse leadership is reflected in nursing practices and the dilemmas nurses and nurse managers encounter. The overarching coding list and all data were included in the final three steps of thematic analysis (Braun & Clarke, 2006). Then, going beyond theming (Thorne, 2020), EdK examined the combined data and critically reflected on the interrelationships between the two cases. She discussed her findings with the other researchers and the whole team agreed on the most characteristic rebel leadership practices.

Ethical considerations

All participants were informed of the study objectives before data collection began. Participants were informed that participation was voluntary and that they could withdraw at any time. All participants signed the informed consent form. All data was anonymized before the analysis. The Medical Research Ethics Committee of University Medical Center Utrecht (number 19-183) approved the study. Data was stored according to the Dutch Data Protection Laws.

Results

Rebel nurse leadership is expressed in diverse ways, from invisible (under the radar) unsustainable changes to visible acts that set improvement to practice in motion. We focus on three characteristics of rebel leadership that portray the contextual and relational richness of their practices. They illustrate how nurses and nurse managers deal with rebel nurse leadership and the common dilemmas they encounter in practice, as we saw happening during our observations and focus group interviews.

High fives for climbing onto air mattress carts

Prologue

Nurses are responsible for determining the risk of pressure ulcers and for starting interventions (e.g., arrange for an air mattress) to prevent pressure ulcers forming during the patient's hospital stay. In H1, nurses must contact the mattress supplier each time they need to arrange for an air mattress. Because patients regularly need air mattresses in the observed department, the supplier delivers three mattresses at a time on one cart. To ensure the supplier gets paid for each mattress, the cart is locked with a combination code (that often changes). To get the code, nurses have to call the supplier to confirm they want to use the mattress for a particular patient. The nurses also have to report the risk-reducing intervention in the electronic patient record.

Characteristic rebel practice

> "Kim[1] saw that her patient needed an air mattress as indicated by the standard risk-scoring method. She collected a few nurses and together they went to the department storeroom without telling me [Ed: the shadower] what they were going to do. I saw the nurses kick off their clogs and climb onto a locked cart, which was open at the top. They pushed the mattresses out, got down off the cart, and gave each other a high five. Then they left the storeroom with big smiles, going back to work as if nothing had happened. Kim explained to me later that this is not the first time they have done this as the code of the combination lock often does not open the cart and they have to wait too long to get an air mattress. Although Kim had several opportunities to talk to her nurse manager about this unworkable practice during her shift, she did not. Kim kept her action quiet."
> *(Nurse, H1, O9)*

Epilogue

This first observed rebel practice reflects how nurses dealt with an unworkable process. In this case, they were losing a lot of time arranging a mattress for their patient because they needed to get a code from the supplier to unlock the cart, and the code was often incorrect. Kim knew the air mattress was important and found a way to bypass the unworkable system to get one quickly. This was not an exception. In both H1 and H2 we regularly saw nurses working around the system to ensure their patients' needs were met. Nurses often had creative solutions for systemic problems. They challenged the status quo by finding workarounds like 'elephant paths' (meaning they establish a more efficient alternative to counter an outdated or inflexible routine; think of how people—and elephants—cut corners on winding paths to take a more direct route).

We also observed that, overall, nurses felt positive about their deviating actions. Kim and her colleagues celebrated their success with a high five, having solved their acute problem in that moment (the ad hoc need for an air mattress). However, the deviating action did not solve the real problem—the time-wasting administrative process and malfunctioning combination lock. Still, the nurses felt satisfied with their deviating action. In their eyes, they had improved an unworkable practice, and this encouraged them to continue their deviating actions. In other instances, we saw that rebel practices were often quick fixes or applied local ingenuity, which made us wonder if rebel nurse leadership practices ever lead to sustainable solutions. In fact, we noticed that the nurses did not discuss changing these unworkable practices to turn them into sustainable, long-lasting solutions. Instead, they continued to compensate for their unworkable practices on a daily basis.

We also noticed that some nurses no longer recognized that their actions were deviating from their daily work because they had become part of their normal routine. They only became aware of their workarounds after the researchers shared their reflections on

[1] Names of the participants are fictional

shadowing and during the interviews. Nurses are adept at arranging patient care but could be more aware of how they compensate for poor arrangements and achieve desirable outcomes by deviating. However, even when nurses were aware of their workarounds, they were still not always willing to discuss them with their nurse manager. A good example is Kim's case. She had many opportunities to discuss the unworkable practice with her nurse manager but chose not to do so. In the next example, the nurse did raise the unworkable practice with others, but still concealed her rebel action.

Crumbling suppositories sparking internal conflict

Prologue
When outpatients are scheduled for minor surgery, pre-admission and pre-operative assessments are done in advance. They also get the prescriptions for the medicine needed after the operation, which they can collect from their own pharmacy. This means that patients arrive well-prepared on the day of surgery and can be discharged quickly because everything they need at home has been arranged. H1 has agreements in place with pharmacies to ensure sufficient medicine is in stock to cover different doses of frequently prescribed medicines.

Characteristic rebel practice

> "When Janet asked the mother if her son was ready to be discharged, the mother said that her pharmacy had given her the regular suppository for adults instead of the one designed for children and told her to cut them in half. Janet thought for a moment. Then she went to the drugs cabinet, grabbed five suppositories with the correct dosage for children and gave these to the mother. She knew that the hospital wouldn't be reimbursed for the cost, so she asked the mother for the name of her pharmacy. Later, at the nurse station, Janet explained to me (Ed: shadower) that she is not allowed to do this, but she knows that a suppository will crumble if it is cut in half. Janet didn't like that. So she sent an email to the attending physician and pharmacy to make new arrangements without revealing that she had given the mother suppositories from the hospital's stock."
> *(Nurse, H1, O6)*

Epilogue
In many cases we observed, nurses experienced an internal conflict. In this example, Janet expressed this internal conflict. On the one hand, she wanted to be a good employee and adhere to the essential healthcare system requirements. The hospital outsources the dispensing of medicines. She wanted to adhere to protocol, which the hospital expects of her, requiring her not to dispense the hospital's stock of medication for patients to use at home. On the other hand, she allowed herself to be guided by her professional knowledge

and experience to meet this patient's care needs. Feeling responsible for providing good care, she gave the mother the proper suppositories, fully aware that she was deviating from the rule against giving patients the hospital's medication for home use. She told the shadower that she did not feel like a bad employee because she was convinced that this was the only way she could give good quality care.

In contrast to Kim's rebel practice, Janet spoke up about the problem in an email to the physician and pharmacist but, interestingly, she only reported the problem and did not express her internal conflict or reveal her deviating action. During interviews, most participants mentioned that when challenging and changing nursing practices, it is necessary to openly acknowledge the internal conflicts that spark the deviating actions. Nevertheless, nurses, their managers, or other colleagues seldom did this in their daily work. Therefore, it was not an exception that Janet did not share her internal conflict and voice her deviating action. It was unclear why Janet did not mention it, but we understand that nurse managers are often too busy to take the time to sit with their nurses and reflect on internal conflicts in general. Additionally, when nurse managers did have the time, they often could not solve the problem (right away) and the internal conflict persisted. As a result, nurses felt they were not being taken seriously if they spoke up about their problems because nothing changed when they did. Nurses in the focus group interviews said that this makes them feel powerless and hence reluctant to talk about any problems that might arise in the future. However, we also noticed nurses often settled for the given answers and solutions and avoided the confrontations required to change these practices. They avoided having conversations with their nurse managers. The next example goes up a level to show a rebel leadership practice that was openly discussed with management and brought about a sustainable systemic change.

A hip fracture process on the radar

Prologue
Nurse managers are responsible for ensuring the continuity and effectiveness of nursing and sustaining and improving the quality of care. To do so, they have to work closely with their nursing team. A well-known method for improving the quality of patient care is collaborating on projects and action plans. To make the right choices before changing work processes, consensus on the blueprints of plans is crucial. However, it is not always feasible to capture everything in plans that everyone supports. Moreover, the complex nature of hospital organizations makes drafting these plans very time-consuming and thus slows down the improvement process.

Characteristic rebel practice

> “The orthopedic department (OD) and emergency department (ED) wanted to start working with a new and quicker way of admitting patients with a hip fracture. The nurses and nurse managers of both departments were still discussing the blueprint of this new process and had not formally agreed to it. Vic, the OD manager, told me (Ed: the interviewer) that Peter, an OD nurse, decided to experiment with this new process one evening shift. Peter’s colleagues supported him, and the process went smoothly. The next day, Jamie, the ED nurse manager, emailed Tess, the OD nurse manager, with a copy to Vic, their superior, to express disapproval of Peter’s actions as he had chosen to apply the new admission method without formal consent. Jamie asked Tess to discuss this with Peter. Vic was surprised by the email and contacted both nurse managers. He encouraged them to treat this experimental—deviating behavior—as a learning opportunity, to find out about the nurses’ motivation, and reflect on the outcome if they disapproved of this behavior. Vic told me (Ed: the interviewer) that nurse managers often struggle to sit back and see what happens when nurses challenge the status quo and show rebel nurse leadership.”
> *(Unit manager, H2, I6)*

Epilogue

This characteristic practice shows that the interplay between nurses and nurse managers can influence changes to the status quo. In several practices, we noticed that nurse managers find themselves ‘stuck in the middle’ between having the responsibility of ensuring the continuity and effectiveness of care and their nurses’ wish to control and decide their own practices. Nurse managers also have to deal with traditional structures and must deviate from them to support rebel nurse leadership practices. We repeatedly heard from managers, directors, and advisers that rebel nurse leadership is acceptable to ensure the continuity and effectiveness of care and improve its quality *“as long as patient safety is not compromised”.* However, in this last characteristic practice, Jamie, the ED nurse manager, immediately rejected Peter’s behavior even though things went smoothly for the patient. In Jamie’s opinion, only when the project team had a complete, approved plan could it be implemented in practice, whereas Peter wanted to see how the new way of working worked out in practice. Nurse managers can obstruct and hinder rebel nurse leadership practices by their disapproval and holding rebels accountable for deviant actions, which may contribute to these practices staying under the radar.

Nurse managers often said that nurses should be open about their deviant actions to build confidence in rebel nurse leadership practices. This view contrasts with the secrecy in which rebel nurse leadership practices typically occur. When nurses stay under the radar, nurse managers are likely to respond with control and discipline because they feel less confident of the skills and knowledge of their nurses. The fear of something preventable from going wrong also encourages nurse managers to act like this. As seen in the practices of Kim and Janet, it seems that nurses need their manager’s support to be transparent. They

need to feel confident that their managers’ will be supportive when they show rebel nurse leadership. To ensure the continuity and effectiveness of nursing and improve care quality, nurses and management must trust that rebel nurse leadership practices will benefit quality, and will not endanger patients or undermine organizational (power) structures.

In a few situations, we noticed that nurse managers explicitly trusted their nurses’ rebel actions. In these cases, the nurse managers had faith in the nurses’ knowledge and skills, fostering a sense of appreciation and respectful cooperation. Nurses and nurse managers listened to and valued each other’s perspectives during discussions. They reflected by asking questions and being aware of each other’s rationale, and instead of directly rejecting a change, learned together by experimenting. We noticed that nurses voiced their internal conflict and deviating actions more often in this situation. and nurse managers considered the encountered problem more in their collaboration and reflection with nurses. As a result, nurses and nurse managers were better able to address the unworkable practices and, together, challenge and change these traditional structures.

Discussion

This paper contributes to the nursing leadership literature by describing how nurses and nurse managers deal with rebel nurse leadership practices and dilemmas. This study also adds insight into the complexity of rebel nurse leadership practices in both the short and long term (Arena & Uhl-Bien, 2016; Uhl-Bien et al., 2020). Research shows sustainably changing systems is hard and relies on relationships between people collaborating to go beyond deviation. As Weberg (2012) states, *“the capacity for the system to effectively change and innovate [comes about] because effective change and innovation occur through relationship building, nonlinear processes, and co-evolution. […] Changing the deep assumptions of the organization requires new ways of acting and interacting within the informal culture”* (p. 269–270). Using the leadership-as-practice perspective (Raelin, 2016a, 2016b), we could study the dynamics and interconnectivity of current rebel nurse leadership practices and describe three characteristic practices exemplifying the informal culture and rules that nurses and nurse managers have to deal with. These leadership practices by rebel nurses were characterized by internal conflict, a positive feeling when deviating, local ingenuity instead of changing the status quo, and not voicing internal conflicts or revealing deviating actions.

Our study shows that deviating behavior always starts with an internal conflict. In line with previous research, this internal conflict was caused by the difference between *‘work as imagined’* and *‘work as done’* as described by Hollnagel & Clay-Williams (2022). Nurses want to act on their fundamental beliefs to provide good quality care (de Kok et al., 2022) and do justice to their intelligence and expertise as professionals (Thorne, 2021). To do this, they sometimes have to deviate from norms, rules, codes of conduct, protocols and guidelines, or organizational strategies (de Kok et al., 2021). Our study shows that nurses feel satisfied

when they act on their fundamental beliefs, intelligence, and expertise even if it requires challenging the status quo and their actions are just quick fixes.

We observed that actually changing nursing practices through rebel nurse leadership is difficult. Therefore, the extent to which nurses influence their practice in the long run is questionable. According to McNamara & Fealy (2010), nurses have a 'compensatory mode' for all that is poorly regulated in the healthcare system. They generate workarounds to regulate patient care if the systems do not match their professional standards (described in guidelines, protocols, and organization policy) (Debono et al., 2013; Hollnagel & Clay-Williams, 2022). We noticed that internal conflicts were triggered when nurses were disturbed by needless and non-contributing organizational imperatives. Allen (2014) shows that nurses are adept at coordinating and organizing patient care trajectories, and are seen as the 'glue' in the healthcare system that aligns the elements (materials, knowledge, people) needed to meet the individual patient needs. While Allen (2014) appreciates this, McNamara & Fealy (2010) are more dismissive of the 'compensatory mode' and find it obstructive to a professional nursing practice. In their opinion, workarounds help to reveal practices that are badly organized and limit the quality of care. However, these often remain invisible to others, which has two consequences. First, management and others in the organization do not see what kind of unworkable practices nurses encounter. Therefore, they cannot support their nurses in changing these unworkable practices or introducing (smart) innovations and solutions. Second, nurses try to solve everything themselves, which is time-consuming, frustrating (Debono et al., 2013; Edmondson, 2004), and often makes truly changing nursing practices problematic. Our study shows that undisclosed rebel nurse leadership practices often lead to ad hoc solutions and quick fixes. According to Lalleman et al. (2016) ad hoc problem solving results from the dominant urge to meet acute care needs. However, we also noticed that deviating actions foster job satisfaction and pride and make nurses feel in control of their practices such that nurses feel encouraged to continue deviating in the interest of their patient care.

Acting 'under the radar' not only keeps deviating actions quick fixes but also reduces the nurses' ability to confront (Banja, 2010). Realin (2016a) indicates that relationship building, confrontation, and stabilization are important in complex leadership practices. However, confrontation was rare in the rebel nurse leadership practices we observed. Nurses seldom voiced their tensions and seldom started conflicts with peers or their managers to change their unworkable practices. In line with Realin (2016a), Uhl-Bien et al. (2020) stipulate that a conflict is a *"natural process that begins when agents in a system begin to ideate around novel solutions in the face of complexity pressures"* (p. 111). In our view, this conflict is connected to rebel nurse leadership practices, because nurses experience internal conflicts that stimulate rebel leadership behavior. In contrast, research has also shown that discussing conflicting perspectives supports collaboration and the building of collective leadership in complex practices (Follet, 2011; Streeton et al., 2021; Uhl-Bien et al., 2020; Verhoeven et al., 2022). We noticed that speaking up and discussing conflicting perspectives and dilemmas in daily

practice helped nurses and nurse managers find a collaborative perspective. According to Davidson (2020), it is critical to talk about value, which cannot simply be assigned or entrusted to an organization by the 'leader', rather it should emerge from conversations about relational processes and experiences that occur in practice. Therefore, the next step to support rebel nurse leadership practices is for nurses and nurse managers to confront each other with their own perspectives, norms and ideas in order to build their relationship, enhance stabilization, and create sustainable change. This will also help show that rebel nurse leaders are 'the good folk' (McKeown, 2020) who act with positive intentions (Petrou et al., 2020). As McKeown (2020) phrases it, rebels *"can be both heroically radical on a grand stage and gloriously radical in the every-day"* (p. 1025). Moreover, they can achieve valued outcomes in organizations (Petrou et al., 2020).

Strengths, limitations, and future research

Although we collected a multitude of data with various methods to provide in-depth insights into rebel nurse leadership practices, there are some limitations to this study. Studying this topic is complex as we need to capture the interactions, collaborations, and contexts surrounding rebel nurse leadership (de Kok et al., 2022) and this behavior often takes place under the radar. Shadowing improved our understanding of rebel nurse leadership, but the researcher's presence may have influenced the observed practices. To reduce the limitations of shadowing as much as possible, we remained critical of the observed practices, were consciously aware of researcher bias and subjectivity, and considered the impact of the researcher's presence on the observed practices (Czarniawska, 2007; Ferguson, 2016; McDonald, 2005).

In addition, because both settings under study (H1 and H2) were already developing nurse leadership, it is possible that these two organizations valued rebel leadership practices more than organizations that pay little attention to rebel leaders. However, it became clear during our study that nurses and nurse managers were still experiencing dilemmas with rebel leadership practices despite the attention given to nurse leadership. We believe a strength of our findings is that they show how complex rebel nurse leadership practices are.

Our study reveals what nurses and nurse managers have to deal with in rebel nurse leadership. The secondary, comparative analysis between H1 and H2 cases revealed an avoidance of confrontation in rebel nurse leadership practices. Further research is needed to better understand this avoidance and to determine what is needed for nurses to confront and, importantly, voice their internal conflicts.

Conclusion

Rebel nurse leadership practices build upon highly complex and interactive relationships. In daily practice, rebel leadership starts when nurses experience an internal conflict that instigates accelerates the deviant behavior needed to meet their professional needs and provide individual patients with the best care. Deviating behavior fosters positive feelings among rebel nurses because these actions influence their mundane practices for the better. Nonetheless, deviating actions are often short-term solutions to unworkable practices rather than sustainable changes. Depending on local ingenuity for quick fixes does not help alter the status quo or create lasting solutions. An important, influential factor is the tendency of rebel nurses to act under the radar to avoid being disciplined or held accountable. As a result, others involved miss the opportunity to learn from the deviating practices to fix similar problems. Moreover, as rebel practices stay invisible and unknown to others, nursing managers cannot fully support their nurses in addressing unworkable practices. Hence, the problem with creating lasting solutions and sustainable change. Our study shows that in order to achieve sustainable change, nurses must voice their concerns and bring attention to the unworkable practices and other issues that management has overlooked. From a relational perspective nurses and nurse managers need to value each other's perspectives and share their dilemmas in order to learn together.

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7

GENERAL DISCUSSION

> "Rebels are needed […] to spot what's wrong and champion what's right, and to push for greater openness, constructive discussion, and evidence-based change."
> *(Godlee, 2021, p. 1)*

Rebel nurse leadership practices are important for sustainable innovation, which benefits the quality of care and the nurses' work environment (Clancy, 2010; Gary, 2013; Godlee, 2021; O'Malley et al., 2021; Wallenburg et al., 2019). Therefore, our study aimed to explore and understand the concept of rebel nurse leadership in daily nursing practices. In addition, we aimed to give insights into the stimulating and hindering factors in the development of rebel nurse leadership. This concluding chapter addresses the lessons learned from five years of qualitative research into rebel nurse leadership. We will discuss the main findings, reflect on rebel nurse leadership practices and our study approach, and provide recommendations for clinical nursing practice, research, and education.

Rethinking nurse leadership

Our study took a different approach to studying nurse leadership than most other studies (Cummings et al., 2018, 2021; Duignan et al., 2021; McGowan et al., 2020; Stanley & Stanley, 2018). First, we focused on the moral, emotional, and relational aspects because this perspective is limited in the relevant literature (Hutchinson & Jackson, 2013). Nurses work in a variety of teams under ever-changing dynamic circumstances with many relational contexts in their practices. It is never one single person who affects nursing practice as a whole. Secondly, we chose to approach the topic from the Leadership-As-Practice (LAP) perspective (Lehtonen & Seeck, 2022; Raelin, 2016) rather than formal leadership positions and the leader-follower point of view (Cummings et al., 2018, 2021; Hutchinson & Jackson, 2013). Our study adds profound insights to the nursing leadership literature on the everyday activities and interactions in rebel nurse leadership practices. The LAP perspective helped us to fully understand the collaborative, relational, and distributed nature of nurse leadership and uncover the interrelatedness and collaborations in these practices (chapters 2 & 4–6). We were able to describe the aspects that influence (stimulate or hinder) rebel nurse leadership. Moreover, we could show that someone's position in an organization is not a determining factor but, overall, a multitude of related aspects characterize and influence rebel nurse leadership practices.

We found rebel nurse leadership practices promising because in essence they are intended to change nursing practices for the benefit of the patient, quality of care, and the nurses work environment (Clancy, 2010; Gary, 2013; Godlee, 2021; O'Malley et al., 2021; Wallenburg et al., 2019). However, the LAP perspective allowed us to see that rebel nurse leadership practices are often not fully utilized. We noticed that deviating actions often remained quick fixes and applied local ingenuity and did not lead to sustainable change.

Nurses often solve the unworkable practices and problems they encounter locally with doable, modest choices that permit small wins or correct mistakes, but these often remain ad hoc solutions that ultimately do not change practices. Through the findings of our study, we can state that rebel nurse leadership practices should be handled differently. We need to learn from these practices to achieve sustainable change and also prevent the emergence of unworkable practices in future. In this chapter, the main findings explain why we think the potential of rebel nurse leadership is still underutilized and our reflections give food for thought for the future of rebel nurse practices.

Main Findings

Our study on rebel nurse leadership began by exploring the literature for what was already known and described about deviating behavior in nurses. The search strategy used various terms: 'Positive Deviance' (Gary, 2013), 'Tempered Radical' (Meyerson, 2008), and 'Rebels' (Bevan, 2013a, 2013b; Wallenburg et al., 2019). Our scoping review (chapter 3) enabled us to form a preliminary description of rebel nurse leadership, which we could use for our further empirical research:

> "Rebel nurse leaders have unconventional and non-confirmative behavior that varies or differs from norms, rules, codes of conduct, practices or strategies. Rebel nurse leaders challenge the status quo with their ability to develop and use social networks (peers, other disciplines and management) in- and outside their organization to obtain evidence-based knowledge, share information and gain the engagement of others to provide better outcomes for patients and organizations. As a result, rebel nurse leaders consistently outperform their peers using the same resources."
> *(de Kok et al., 2021, p. 2580)*

Following empirical research (chapters 2 & 4–6) we found rebel nurse leadership practices arise because nurses deviate from suboptimal or unworkable practices set in the professional norms and guidelines and/or organizational rules and regulations. They challenge the status quo to benefit their patient and/or better work processes and/or a positive work environment. We noticed rebel nurses break the rules, challenge vested ideas, and stretch boundaries to deviate from leadership practices (chapters 2, 4 & 6). They create and use space for doing things differently and have the reflexivity, creativity and innovativeness to act in other ways. Nurses deviate when, from their professional point of view, change is needed to reach the best quality of care (chapters 2–4 & 6). The patient's quality of life motivates nurses to reflect on ethics and values and influence their practices. To deviate, nurses seek elegant and efficient solutions, not just for their patients but also to solve unworkable practices and ultimately change systems. We found a number of crucial

aspects which characterized and influenced rebel nurse leadership practices. Five aspects recurred throughout our various studies:

First, **the internal conflict** nurses experience at the start of every deviating practice (chapter 6). Deviating nurses want to be good employees who meet the expectations of their organization. But they also want to adapt their actions, based on their professional knowledge and experience, to match what they perceive is necessary for good quality patient care (chapters 4 & 6). Second, to deal with this internal conflict, the act of reflection is essential. Using reflection, individual nurses can uncover the unworkable routines, professional norms, organizational rules and regulations, and problems in their practices (chapters 4–6). Moreover, reflection allows nurses to experience their positive impact on practices, which encourages their deviating behavior (chapter 6). However, collective reflection seldom occurs in nursing practice, which means that the full potential of rebel nurse leadership practices is not fully utilized. Hence, rules, regulations, systems, processes and unworkable practices are not sustainably changed.

The third aspect, **knowledge, work experience, and skills** plays a vital role for nurses to identify suboptimal or unworkable practices and come up with solutions. This tri-part aspect helps nurses to balance between professional norms, organizational rules, and regulations and to deviate from them (chapters 2 & 4–6). Responsible subversion—i.e., nurses knowing that they deviate but being able to defend why they do so—was often observed in rebel nurse leadership practices. Knowledge and work experience play a vital role in this and contribute to the ability to be a responsibly subversive nurse (chapter 4). Skills such as clinical reasoning and searching for evidence-based knowledge help nurses critically reflect on their quality of care and nursing practices (chapter 2). Social skills are used to navigate nursing practices, to challenge and change the status quo and *'rock the boat while staying in it'* (Bevan, 2010; Meyerson, 2008) (chapters 2 & 4). Deviating nurses value being seen as reliable professionals (chapter 4). They constantly explore the boundaries from which they can deviate and challenge the status quo. Exploring the boundaries is a balancing act between the freedom to deviate and the likelihood of being disciplined because a nurse does not want to ruin her image as a trusted professional. The presence or absence of credibility, trust, and autonomy affect this balancing act and the way rebel nurse leadership is exposed in nursing practice (chapters 4 & 6).

The fourth aspect, the **influence of networks, relationships, and collaborations** came up frequently (chapters 2 & 4–6) and affected the way nurses act in their deviating practices, both visibly ('above the radar') and invisibly ('under the radar'). They act 'above the radar' if they feel free to work professionally and are not being controlled or disciplined in their collaborative relationships (e.g., managers, nursing colleagues or physicians). If they are not sure how their actions will turn out, they experiment with their novel ideas 'under the radar' to create space for themselves to act in the best interest of their patient or to improve work routines (chapters 4 & 6). However, we noticed that nurses' deviating practices were not always hidden, because they know it could damage their image with colleagues and

management as trustworthy, reliable professionals (chapter 4). By sharing their knowledge and experience and setting good examples of their deviating actions, they are trying to uphold their reliable image. In addition, overall, they may act according to their fundamental beliefs, rebel nurses are committed to their organization's mission and do not go to extremes (chapters 4 & 6) even if they always search for opportunities to challenge and change their status quo. Besides primarily deviating and reflecting on the personal level, rebel nurses also went looking for like-minded people to get support and to reflect with others on their practices (chapters 2 & 4). They built informal networks, often multidisciplinary and with people both inside and outside their organization, to reflect on their fundamental beliefs, share knowledge, and discuss if their (invisible) actions are ethical and can be justified (chapter 4). In addition, in their practices rebel nurses try to motivate their colleagues to reflect on working habits and challenge the status quo to improve care in order to create more critical thinkers who will challenge the status quo with them (chapters 2 & 4). When rebel nurses are valued in their practices, they are seen as reliable resources and role models.

The fifth and final aspect, the **impactful collaboration between nurse managers and nurses** in rebel nurse leadership practices emerged clearly throughout our study (chapters 2 & 4–6). The interplay between nurses and nurse managers determined the impact and outcome of rebel nurse leadership practices. Nurse managers have a positive stimulating influence when they encourage and inspire nurses to reflect on their working habits by asking questions and being curious about the work of nurses. When they facilitate and create opportunities to improve patient care, allocate budget and spread creative solutions throughout the organization, they give nurses the feeling that they have their back, and this has a positive impact on rebel nurse leadership practices. Their influence has a negative impact and hinders rebel nurse leadership practices, when they overcontrol nursing practices and are not receptive when nurses challenge the status quo (chapters 2 & 4–6). However, the resistance of their nurse managers did not stop rebel nurses. They kept taking alternative paths and went 'under the radar' in pursuit of their fundamental beliefs (chapters 4 & 6).

Reflecting on rebel nurse leadership practices

Associations with rebel nurse leadership

The first reflection we want to make is about the associations people have with rebel nurse leadership. During our study, we noticed that 'rebel' is a normative concept (Kelly & Medina, 2014). It became clear that rebel nurse actions are accepted and seen as leadership only in specific situations and under certain conditions. Distinctions were made between 'good' and 'bad' rebel nurses and only 'good' rebel actions were seen as the leadership needed in nursing practices. 'Good' rebels are described as creative, have clear fundamental

beliefs, intrinsic motivation, and are persistent to achieve good quality care. ‘Good’ rebels are seen as the driving force for change because they like to experiment and find solutions for unworkable practices. This is similar to Mol, Moser, and Pols’ (2010) tinkering concept, in which healthcare professionals find local practical solutions through attentive experimentation. Van Schothorst-van Roekel et al. (2021) also describe the manifestation of experimentation in nursing practices. Besides affecting the quality of care, it also influences the way nurses take responsibility for their profession and work environment (van Schothorst-van Roekel et al., 2021).

In contrast, ‘bad’ rebel nurses have a self-interested and negative attitude to nursing practices. They often resist change and show hostile expressions such as grumbling and complaining. We noticed it was constantly necessary to come to a common understanding of rebel nurse leadership before nurses and nurse managers could share their experiences and reflections on these practices. We were not the only study to note the negative associations with rebel leadership. About a third of the participants in the study by Rusinovic et al. (2020) had a negative association with the term ‘rebel’. Because the negative associations influence the acceptance of rebel nurse leadership in nursing practices, it is important to be aware of them. It helps to understand why rebel nurse leadership may or may not be able to influence nursing practices.

We also noticed that the normative concept of rebel nurse leadership found in clinical practice exists in nursing science too. For instance, when we were submitting our study findings for publication in scientific journals, we encountered resistance to the concept of rebel leadership in several peer reviewers. We often had to explain to these reviewers the importance of rebel nurse leadership studies and convince them of the purpose and importance of its practices. The greatest resistance to publishing our work came from the quality and safety scholars. It is important to address this resistance because it affects how rebel nurse leadership practices are described in the literature. Perhaps this also explains why we found so little literature on deviant behavior in nurses and the description of ‘bad’ rebel practices. Thus it requires perseverance and a solid foundation to ensure that the complex concept of rebel nurse leadership from the relational perspective rather than the individual heroic perspective gains ground in nursing science.

The paradox of working ‘under the radar’

Nurse and nurse managers collaboration

Building on the first reflection, the second reflection considers the perspective of nurse managers and their paradoxical influence of the ‘under the radar’ mechanism. Much research has already been done on the complex role of nurse managers in nursing practices (for example, Lalleman, 2017; Oldenhof, 2015; van Schothorst-van Roekel et al., 2021). Nurse managers are tied to a system that emphasizes controlling cost and monitoring quality of care and feel torn between their clinical and managerial roles (Lalleman, 2017). Moreover, in

practice, nurse managers encounter several dilemmas, such as how to control the behavior of nurses (Aitamaa et al., 2021). They are often pushed to meet service standards and deliver excellence (Crewe & Girardi, 2020) to support and maintain the organizational constructs in nursing practices (Porter-O’Grady, 2023). Nurse managers also realize that experimentation is never without risk. For example, they might be worried about the ‘normalization of deviance’—when a deviant action is no longer regarded as deviant because everyone has adopted it, it can become a risk for patient safety (Banja, 2010). Their complex role and the various ways in which nurse managers lead their nursing teams have a substantial influence on rebel nurse leadership practices. Tensions between nurse managers and nurses affect the creation of space nurses need to influence their practices (van Schothorst-van Roekel et al., 2021). During our study, we often heard nurse managers say they found rebel nurse leadership acceptable “as long as it doesn’t compromise patient safety” (chapter 6). This indicates that although these nurse managers might support the idea of rebel nurse leadership, they see it as something accompanied by risk. If their nurses deviate, these managers tend to discipline and control them (Thorne, 2021), which causes tension. Consequently, nurses tend to deviate ‘under the radar’ the next time which only feeds the nurse managers’ habit of controlling. Nurse managers need transparency from their nurses to reduce their tendency to control, to build trust in the nurses‘ actions and improve their collaboration. Similarly, nurses need their nurse managers’ trust, their power to create space for them in order to collaborate and to be more visible for them. To address the paradox of the ‘under the radar’ mechanism in the collaborative relationship of nurses and nurse managers, according to Ulrich et al. (2017) success follows when these inherent contradictions work together. In other words, more discipline and control will not make nurses more transparent to their nurse managers. Crewe & Girardi (2020) suggest that nurse managers should deviate too, to make a difference in the nursing practices, because they too are trapped in the standards, systems and norms of the organization. We underline this because when nurse managers did deviate from the practices of their peer nurse managers in our study, we saw this benefited the collaborative relationship between nurses and nurse managers, and the potential of rebel nurse leadership practices improved. In these practices, nurses and nurse managers listened to and valued each other’s perspectives more, the nurse managers regarded nurses as more reliable and trustworthy professionals, and recognized rebel nurse leadership practices as necessary to achieve good quality of care. Our findings concur with Rusinovic et al. (2020) who also found that rebels do not intend to harm their organization but deviate responsibly for the benefit of patient care. To understand and gain confidence in the intentions behind rule-breaking behavior in nurses, nurse managers need to be curious about the motivations of rebel nurses, which Dahling (2017) also underlines. Being more curious about each other’s work enhances collaboration between nurses and nurse managers. Moreover, a collaborative relationship ensures that both parties are better able to learn from rebel nurse leadership practices and experiment together to challenge the status quo. We noticed nurses acted more visibly to their colleagues when the collaborative relationships were solid.

In sum, to fully utilize the potential of rebel nurse leadership practices, both nurses and nurse managers have to change how they interact with each other. Reflection plays a crucial role in achieving this. It helps nurses and nurse managers understand the impact of their actions and reactions to rebel nurse leadership practices. In line with this, according to Porter-O'Grady (2023), nurse managers need to find a way to best enable and facilitate the knowledge and good practices of nurses. In turn, nurses must realize their working 'under the radar' affects the collaboration with their nurse managers. They have to make conscious decisions about going 'under the radar' in their practices.

Sustainably changing nursing practice

The third reflection elaborates on the paradoxical influence of the 'under the radar' mechanism in rebel leadership practices from the perspective of nurses. This 'under the radar' mechanism not only affects the collaborative relationship between nurse managers and nurses but also hinders the nurses ability to influence their practices. By going 'under the radar' nurses try to create the space to influence their practices. However, it is questionable whether they do change their practices sustainably. Several times we observed the nurses' predominant urge to care, which Lalleman et al. (2016) also describe. On the one hand, the nurses' impulse to arrange the care their patients need (Allen, 2014) encourages them to deviate when they encounter badly organized practices that limit quality (McNamara & Fealy, 2010). As a result, nurses create workarounds to deal with and compensate for everything that is poorly regulated in the healthcare system. On the other hand, as their organizing work is often invisible to others (Allen, 2014) it is not recognized or valued. Also, it does not help that healthcare professionals often tend to accept things as they are, including small indignities that chip away at health and wellbeing (Essex, 2021a, 2021b).

We noticed that instead of speaking up about the problems they encountered in their daily work, nurses often came up with ad hoc solutions themselves. Such instances of local ingenuity often remained quick fixes because the changes were not shared, transmitted or learned from. Thus the tendency to stay 'under the radar' combined with a 'compensatory mode' (McNamara & Fealy, 2010) hinders nurses from exposing, addressing, and changing the encountered problems sustainably in their practices. It also does not help healthcare organizations prevent making the same mistakes in the future. Even though nurses feel that they are exerting influence when they make their workarounds, in the long term they keep running into the same unworkable practices and systems. If nurses want to achieve lasting change in work practices, it is important to rise 'above the radar' and voice their internal conflicts and unworkable practices. Nurses should not be blindly obedient but show more resistance in their practices when things do not contribute to good quality care. According to Essex (2021a) resistance is an influential means of achieving change, which is precisely what nurses want to achieve in their rebel nurse leadership practices. Furthermore, a 'can do' attitude in healthcare organizations will help nurses become more visible. To illustrate, during the COVID-19 pandemic we noticed rebel nurse leadership practices were more

accepted and nurses became more open about their deviations, working 'above the radar'. Deviating was valued and increasingly important, because the normal systems, standards, rules, and regulations no longer fit the care required by patient suffering from this unknown virus. Nurses quickly adapted new ways of working in caring for COVID-19 patients and demonstrated the power of their deviating behavior. Because there was a 'can do' attitude (Blecher et al., 2020) nurses took the lead, which their colleagues accepted. Furthermore, they gained the space and authority to act in this acute period and voiced their internal conflicts and unworkable practices. Nurse managers were more likely to arrange what nurses needed, questioned them on their practices, and listened more to their nurses. They supported their nurses by organizing (reflection) meetings to discuss dilemmas and unworkable practices. This makes clear that nurse managers have an important role in encouraging nurses to speak up. Because the organizing work of nurses was more valued and respected this encouraged them become more 'above the radar.' The lessons we can learn from the COVID-19 period have a lot of potential for the future of rebel nurse leadership practices. Although we are also aware that after the COVID-19 period, old certainties and systems rapidly returned.

Reflecting on the study approach

Besides reflecting on rebel nursing practices, it is also important to reflect on our approach in studying these practices. Our study employed multiple research methods (scoping review, and descriptive, explorative, qualitative, multiple-case studies) with a specific focus on LAP. We retrieved data from both 'Sayings' (interviews) and 'Doings' (shadowing) (Nicolini, 2010) which allowed us to gain a comprehensive overview of rebel nurse leadership in nursing practices. We were able to describe the concept, highlight what is going on, and portray the 'lived experiences' (Ospina et al., 2020, p. 442) in rebel nurse leadership practices. In addition, by combining the multiple research methods, we applied triangulation in our research. This added to the credibility of our study and increased and broadened the understanding of rebel nurse leadership. However, studying rebel nurse leadership practices also brought five particular challenges on which we want to reflect.

1) When our study began the LAP perspective was a relatively new concept in studying leadership (Collinson, 2017; Raelin, 2016a). It pursues and seeks to understand leadership activity wherever and however it appears (Raelin, 2017). Because LAP was new, most of the literature describe it as a theory (Carroll et al., 2008; Lehtonen & Seeck, 2022; Raelin, 2016; Raelin et al., 2018) rather than an accepted method for studying leadership practices, let alone that of nurses (Kempster & Gregory, 2017; Vuojärvi & Korva, 2020). This was a challenge for us in designing our study to collect and analyze data from this new perspective on leadership. By carefully choosing which steps to take, staying focused, and continuously reflecting on the data during the collection and analysis phases, we were able to incorporate the LAP perspective to guide our study.

2) Various semi-structured interview techniques, such as individual interviews, group interviews, and focus groups (Barbour, 2018; Kallio et al., 2016) enabled us to explore the experiences of rebel nurse leadership practices, identifying the associations the participants had with rebel nurse leadership and the importance of their coming to a shared understanding of leadership. At the beginning of each interview, we always reflected on what leadership meant to the participants and asked them how they identify leadership practices. From the LAP perspective, it is worth noting that it was challenging for participants to abandon the individual heroic image during the various interviews. We noticed nurses tend to discuss rebel nurse leadership in terms of individual traits, behaviors, abilities and competencies because they are seldom asked or challenged to think about leadership from a collective and relational perspective. This is caused by the predominance of the individual (heroic) perspective in nursing practices (Schweiger et al., 2020) and the thinking in terms of competency in nurse leadership development programs (Boamah et al., 2018; Carroll et al., 2008; Cummings et al., 2018, 2021; Kennedy et al., 2013; Posner, 2016). As researchers we had to be aware of these preferences and intervene when participants tended to give answers from the individual leadership perspective. We carefully prepared all the interviews by developing LAP topic lists and elicited verbally articulated practices with the 'interview to the double' technique (Nicolini, 2009) to help the participants to share their experiences from the LAP perspective.

3) Becoming aware of the limitations of studying only the 'sayings' (Nicolini, 2010) and of the difficulties participants felt in sharing examples from the LAP perspective (besides the 'interview to the double' technique (Nicolini, 2009)), we also chose shadowing (Czarniawska, 2007; McDonald, 2005) as a research method to study rebel practices. We were curious to know if and how the examples given in the interviews manifested in nursing practices. The LAP perspective gave us the opportunity to detach leadership from individuals and focus on leadership in everyday practices. However, we were also confronted by 'the disappearance of leadership' (Alvesson & Sveningsson, 2003), i.e., the risk of seeing everything done in nursing practices as leadership. In this, the definition of rebel nurse leadership generated through our scoping review helped us to frame what we were going to look for in nursing practices: instances when nurses, compared to their peers, showed unconventional and non-confirmative behavior in their practices. We then focused on the interactions, dynamics, agency, and artifacts that influence these practices. Describing and then discussing the 'normal' practices and characteristic rebel practices enabled us to describe our perspective on rebel leadership practices and show how they were manifested in nursing.

4) Another challenge in both interviewing and observing participants was the problem that rebel nurse leadership often takes place 'under the radar'. This challenged us as researchers to collect data on these practices. Several reasons complicated the data collection. For example, participants might have chosen not to share all their rebel nurse leadership practices with us, because they did not want to go 'above the radar' with their own deviant actions. In line with this, participants could have behaved differently or hidden

their deviating practices when we were observing in their practices. We were aware of this research bias and employed interventions, such as assuring participants that their data was processed anonymously and trying to create a trusted environment where everyone can behave freely and share everything. We made very clear that we were nonjudgmental in the interviews and observations. These interventions helped us overcome research bias as much as possible. However, we also realized we could never avoid all these hazards when studying rebel nurse leadership practices.

5) Finally, all our studies applied the thematic analysis steps of Braun & Clark (2006), because this iterative approach allows us to identify patterns and themes that emerge from large amounts of data. It also provides a clear and detailed account of the coding process and can be used to analyze data from a variety of sources. Moreover, it helps to identify the key concepts and meanings of the data, as well as explore the underlying patterns and relationships. Thematic analysis was therefore an appropriate approach to examine all the different data in this study. However, we were also aware of the criticism of this thematic analysis method (Thorne, 2020). Therefore, during our analysis phase, we added an extra step to really make sense of the dataset. We critically reflected on the themes, their interrelationships, and our interpretations to go beyond theming. For example, we asked ourselves which aspects could influence the themes found while analyzing the data, or what we did not find during the analysis process to fully explain and describe the practices of rebel nurse leadership. In conclusion, the way we present the data, providing elegant insights based on our descriptions of characteristic moments, also goes beyond theming and allows us to respectfully assume that we have succeeded in Thorne's call (2020) to guide nurse leadership studies to a new level of understanding.

The future of rebel nurse leadership in nursing practice

The outcomes of this study provide numerous opportunities for clinical practice, education and future research. Therefore, we take the opportunity to give our recommendations.

Our study underlines the facts that rebel nurse leadership practices are unruly. They are challenging to study (Edmonstone et al., 2019; Klag & Langley, 2022), and their potential could be better utilized. The unworkable practices nurses encounter are never isolated problems but often related to other processes and involve various stakeholders with diverse values and interests, described in the literature as "wicked problem". We observed a willingness among nurses to tackle these intractable, wicked problems. However, there is no one quick fix that can make rebel nurse leadership practices achieve sustainable change. During our study we noticed various aspects that do have a positive impact on rebel nurse leadership practices. These aspects were strengthening organizational structures to improve nursing governance, nurses taking responsibility for developing their own knowledge and skills, nurses challenging the status quo with quality-enhancing projects, and nurse managers

becoming more supportive of rebel nurse leaders (chapter 2). Therefore, the model we developed in chapter 2 can be used as a first step to reflect on how these processes are arranged in nursing practice.

Besides this model, other important interventions are needed to utilize the full potential of rebel practices. These interventions include collective reflection and learning, and taking action on five vital themes in rebel nurse leadership practices: the role of rules, agency, feedback, frames, and tensions (Klag & Langley, 2022). According to Klag & Langley (2022) considering these five themes will help those concerned to "recognize and embrace 'messiness', as opposed to taming it" (p. 5). We briefly address all five themes in relation to clinical practice, education and research.

1) **Rules:** organization-specific requirements and habits embedded in organizational behavior, and statutory and regulatory requirements (Institute for Healthcare Improvement, 2023) intended to support the delivery of safe, effective, and high-quality care. However, when rules themselves become the goal to achieve, they limit nurses' ability to innovate and tailor care to individual patient needs (Kuiper, 2020). Reflecting on the influence of rules and regulations can help people discern whether a rule is used as a general orientation to guide collective behavior without precisely defining it. Encouraging improvisation requires thinking and dealing differently with the rules and regulations in nursing. We are not under the illusion that it is easy to change the way rules and regulations are used in nursing or healthcare in general. Therefore, it is needed to further explore how practices could deal differently with rules and regulations and pay attention to the aspects that teach how to use rules as a general orientation in the education of professionals working in healthcare.

2) **Agency:** the capability of nurses to challenge and positively change their own practices. To achieve this, it is vital that nurses can act for themselves in their practices and organizational structures. 'Backbone infrastructures' that support initiatives without exerting formal authority over nurses are crucial to enable leadership (Uhl-Bien et al., 2020). Good examples of these structures are nurse-led clinics, where nurses are held responsible for organizing and delivering care to their patients, and organizations that rearrange their governance structure to ensure that the most knowledgeable person makes the overriding decision. Current efforts by the Dutch government to improve nursing governance in healthcare organizations nationwide (Landelijk Actieplan Zeggenschap, 2023) will give more support to structures that facilitate nurses' agency in their practices. Part of the effort involves establishing the education and training that supports nurses in actively arranging and deploying governance in their practices for themselves. This may include coaching nurses in speaking up and using their voices to influence their practices and becoming aware of the paradox of their 'under the radar' actions. But it also requires healthcare organizations to critically reflect on their current organizational structures and how these affect nurses agency. Further research can help to illustrate the effects of infrastructures that influence nurses agency in rebel nurse leadership practices. In addition, it is wise to review the outcomes of current efforts taken to improve nursing governance to understand how nursing governance actually impacts the agency of nurses.

3) **Feedback:** needed to identify leverage points for intervention to trigger change and make use of nurses' knowledge and experiences. Mobilizing feedback loops will help nurses and nurse managers to consciously use feedback in the nursing practice to reveal unworkable practices, improve the quality of care, improve the nurses' work environment, and help prevent making the same systematic mistakes over and over again. It is essential to improve the utilization of feedback moments in nursing practice. This requires reflecting on the impact of existing feedback loops on nursing practice. Supportive feedback moments should be embedded as a structural feature in nursing practice. Well-functioning feedback loops help nurses make rebel practices visible to the healthcare organization so that the organization can provide the necessary support, and ultimately this gives nurses the agency to influence their work environment.

4) **Frames:** concurring with Klag & Langley (2022), we note the importance of recognizing the existence of multiple value systems, associations, habits, references, and frames in rebel nurse leadership practices. This contributes to an understanding of the actors' issues and creates shared collective understanding and consensus on what rebel nurse leadership means and what it can contribute to quality of care and the nurses' work environment. It is essential that nurses and nurse managers pay attention to, and explore each each other's perspectives and to confront each other with the dilemmas they encounter in order to build collaborative relationships. Further research into existing habits and frames concerning rebel nurse leadership could reveal common misinterpretations. Bringing these misinterpretations to the surface in rebel nurse leadership practices will help the actors to recognize their unconstructive habits and frames, to learn together, and seize the opportunity to build on their collaborative relationships.

5) **Tensions:** Klag & Langley emphasize the *"importance of focusing on, versus smoothing over, tensions and paradoxes, as they tend to be where creativity emerges by putting people 'on the edge of chaos'"* (Klag & Langley, 2022, p. 25). However, changing their unworkable practices requires nurses to voice their tensions and conversational conflicts with peers or nurse managers. We briefly touched on the absence of conflict and the influence of tension in rebel nurse leadership practices, but more research is needed to understand the mechanisms and expose the tensions that are dealt with in the nursing practice. We noticed that nurses do not easily voice their internal conflict and lack the confidence to confront their nurse managers with their deviating actions. Thus, this aspect needs work in clinical practice and education.

Because rebel nurse leadership practices always expose messiness—wicked problems and unworkable practices—in nursing practice, it is recommended to collectively reflect (Raelin, 2022) and act on these five themes. Solving 'wicked problems' requires a willingness to embrace uncertainty, an acceptance of new learning, and the necessity of collaboration (Edmonstone et al., 2019). In line with this, learning capability is essential (de Kok et al., 2023) for ongoing improvements to nursing practices. According to Raelin (2022), it requires

individuals to *"unlearn their own private view of a problem […] and replace it with agreement on a shared objective reality"* (p. 28). Therefore a shift is needed in the trajectory of the flow of practices in any given project of activity (Raelin, 2022). How learning takes place in nursing practices should be critically examined to shift current trajectories. It requires patterns of action that allow nurses to process knowledge and experience, generate new knowledge based on existing knowledge and experience, and store knowledge for later use when the need arises (de Kok et al., 2023). In line with this, nurses have to stop remaining in the mode of ad hoc problem-solving (first-order or single-loop learning) and focus on preventing a problem from reoccurring (second-order or double-loop learning), and checking if the adjustments found are applicable to other processes (third-order or deuteron-learning) (Argyris, 1977, 2002; Boonstra, 2004)

If nurses and nurse managers want to fully utilize rebel nurse leadership practices, facilitating learning capability and improving overall agency in healthcare organizations are the final interventions to focus on (de Kok et al., 2023). Paying sufficient attention to the context in which nurses and nurse managers could deviate, considering the influence of the five themes (rules, agency, feedback, frames, and tensions), and enhancing the capability to share and learn from rebel practices, will ultimately expose the disruptive practices that up till now have been producing less than effective results and negatively influence the adoption of positive rebel nurse leadership practices.

Concluding remark

At the beginning of this study, we could never have imagined how much awareness and how many insights and reflections we would create about the practices of nurse leadership. We did not intend adding yet another definition of nurse leadership to the literature. We wanted to give words to current leadership practices, describe the day-to-day practices of nurses working in direct patient care and the deviating actions they took to benefit their patients and the arrangement of mundane practices. Putting everything we have learned together, nonetheless we do propose a new definition:

"Rebel nurse leadership practices occur when nurses deviate positively from norms, rules, codes of conduct, practices, or strategies to improve the current quality of care and nursing practices. It arises when nurses experience an internal conflict regarding quality of care and rules and regulations. Rebel nurse leadership practices will challenge the status quo by stretching the boundaries of collaborative relationships. Rebel nurse leaders use social networks (peers, other disciplines, and management) in- and outside their organization to obtain evidence-based knowledge, share information, and gain the engagement of others. Credibility, trust, and autonomy influence the visibility of rebel practices. Facilitating and improving rebel nurse leadership requires collaborative reflection and action on the role of rules, agency, feedback, frames, and tensions in rebel nurse leadership practices."

Eline de Kok

We would like to end this dissertation with a couple of remarks we heard often throughout our research. *"Rebel nurse leadership as you describe it is exactly what nurses should be doing in essence, right? Deviate from the standard when it's necessary for the patient?"* And: *"Should nurses have the space to influence their own practices to do their jobs well?"* In an ideal world, this would indeed be normal practice for all nurses. However, our research shows how turbulent nursing practices are and how hard it is to sustainably change nursing practices by deviating positively from the status quo. We can no longer ignore the fact that nurses do not (cannot) naturally deviate in their practices and accept this. Rebel nurse leadership practices are relational processes layered on several organizational and professional aspects. A range of factors influence them in either a stimulating or hindering manner. The insights found in this study assist the nursing profession by showing it is not a given that nurses can deviate easily from current practices. They must have the space to change their practices themselves.

We realize our study challenges the way in which we handle rebel nurse leadership practices. Change is required to challenge the present dynamics in the nursing practice. Nurses themselves have a responsibility to change this, but it is not just only up to them. We have shown the stimulating and hindering factors that are regulated by the interrelated, collaborative nature of nursing practices. If we want to change the influence of nurses on their own practices, this will need the cooperation of those who currently influence nursing practice. On both the level of healthcare organizations and on the national level we should pay more attention to the changes needed to fully utilize the benefits of rebel nurse leadership. Therefore, in closing, we appeal to everyone working in healthcare: please see rebel nurse leadership practices as having the creative potential necessary to deal with the challenges that will arise in the nursing practice in upcoming years. Support these practices, encourage them, value them, and reflect on the role of rules, agency, feedback, frames, and tensions in these practices. Keeping on doing what we do now in healthcare is the last thing we should be doing. Asking yourself what you can do to fully utilize the potential of rebel nurse leadership practices in your own circle of influence tomorrow is the first step to start with today.

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SUMMARY

The widely studied topic of nurse leadership has been defined in several ways. According to many scholars, nurse leadership ensures a high-quality healthcare system that consistently provides safe and efficient care. It plays a role in continuous quality improvement, patient safety practices, and the nurses' working environment. In their practices, nurses are often challenged to do things slightly differently and deviate when organizational rules and regulations do not fit their professional norms and beliefs in what is best for their patients. Nurse leadership is needed to deal with this duality in nursing practice. We call this rebel nurse leadership. Rebel nurses manage to stretch boundaries, color outside the lines without losing the support of colleagues and management, and as Meyerson (2008) puts it, "rock the boat while staying in it." However, as Wallenburg et al. (2019) note, this deviating behavior often happens out of the sight of others, 'under the radar'. Therefore, it is unclear what happens in rebel nurses' practices. To stimulate innovation in the nursing environment and understand nurse leadership practices more, we need to study and learn from these deviating leadership practices.

This thesis explores how and when rebel nurse leadership happens in nursing practice and gives insights into the factors that stimulate and hinder its development.

We began with a qualitative study to evaluate the Excellent Care Program (ECP) of the Dutch Nurses Association (V&VN) (**chapter two**). V&VN instigated the ECP to help healthcare organizations create a positive work environment with nurse leadership. We were interested in discovering how ECP contributed to developing nurse leadership to understand how it could be stimulated in nursing practice. We conducted a descriptive qualitative study comprising semi-structured group interviews in 17 organizations. A total of 52 nurses, nurse practitioners, (nurse) managers, and staff advisers participated. Through thematic analysis, we found four program processes that contributed to leadership development. 1) Nurses took responsibility for developing their knowledge and skills. Training programs were established in which evidenced-based practice knowledge and clinical reasoning skills were the most essential components. 2) Organizational structures were strengthened to improve nursing governance. These supported the exchange of knowledge, sharing best practices, and addressing and monitoring issues such as retaining nurses, patient-centered quality improvement, nursing research, and education. 3) Quality-enhancing projects challenged the status quo. Nurses began leading small improvements on the ward level and became more involved in organization-wide projects. 4) Awareness of the supportive role of the nurse manager was enhanced. Nurse managers substantially influence the preconditions to a positive work environment, for example, by clearing budgets for quality improvements and involving nurses actively in decision-making processes. We noticed that these four separate processes are interrelated and probably also strengthen one another. Overall, this study showed that nurse leadership development can be stimulated and enhanced differently by applying several processes at once.

Parallel to this qualitative study, we conducted a scoping review on rebel nurse leadership (**chapter three**). The aim was to obtain an overview of perspectives on rebel nurse leadership practices based on positive deviance, healthcare rebels, and tempered radicals. We summarized the studies on positive deviance, tempered radicals, and healthcare rebels; examined the competencies of rebel nurse leadership; and described factors that stimulate or hinder the development of rebel nurse leadership. We identified papers by searching on Scopus, CINAHL, PubMed, and PsycINFO. A total of 2,705 papers were identified after the initial search strategy and 25 papers were included in the final review. Analysis of the descriptions of positive deviance, tempered radicals, and healthcare rebels in these 25 papers yielded three aspects. 1) Most studies described positive deviance as a method to initiate conscious and systematic (behavioral) change in an organization. 2) The behavior of deviating healthcare professionals was often described as unconventional and non-confirmative behavior. 3) Social networks and personal relationships in and outside the organization were relevant to the descriptions of positive deviants and healthcare rebels. Important competencies of deviating professionals were the ability to (1) collaborate and network with diverse professionals and management in and outside the organization, (2) obtain and share expert (evidence-based) knowledge, (3) critically reflect on working habits, organizational logistics, and problems in daily care and to dare to challenge the status quo, and (4) generate ideas to improve care. Finally, factors that hindered and stimulated rebel nurse leadership in deviating professionals were analyzed. The first stimulating factor was the importance of formal and informal communication—dialogues and reflection—to reveal positive deviant behavior, support the exchange of normative points of view on the current situation, and collectively find new solutions to improve quality. Another stimulating factor was the ability to network in and outside the organization to share deviant activities and ideas that help to encourage others. Finally, management's willingness to stimulate professional deviation was both a stimulating and hindering factor for deviating behavior. Through this scoping review, we could form a preliminary description of rebel nurse leadership that could be used to study rebel nurse leadership further.

Next, we wanted to provide insights into the nurses' experience of rebel nurse leadership in their daily practices from a leadership-as-practice (LAP) perspective (**chapter four**). The LAP perspective studies the complex, collective, and relational context in which leadership occurs. This is necessary to understand how rebel leadership is reflected in nursing practices. In this explorative study, we held eight focus group interviews with 47 nurses and three nursing students working in a hospital or long-term care organization. After thematic coding of the data, we extracted and described four themes about rebel nurse leadership practices. 1) Talking about rebel nurse leadership. When the participants started talking about rebel nurse leadership, we noticed they first needed to create a shared understanding before they could further discuss rebel nurse leadership practices. 2) Defining 'good' rebel leadership practices. The nurses illustrated the differences between 'bad' and 'good' rebel leadership practices. They considered knowledge, work experience, and patient-driven motivation necessary for 'good' rebel leadership. 3) Reasons for rebel leadership. Deviating nurses challenge vested ideas and the status quo, deviating from well-founded rules, regulations,

and guidelines to improve the patient's quality of life. They show responsible subversion - they know that they deviate but can substantiate why they do this. 4) Rebels' relations and collaborations. Continuous social influencing and challenging the boundaries were important in relation to and collaboration with colleagues. Deviating nurses switch between acting 'above the radar' (visibly) and 'under the radar' (invisibly) in their organizations. Credibility, trust, autonomy, freedom, and preserving relationships determined whether rebel nurses acted visibly or invisibly. Moreover, deviating nurses did not go to the extreme or doing everything 'under the radar' to retain their image as a reliable professional. Overall, this study gave valuable insights into the nurses' experience of rebel nurse leadership and helped us to refine the concept. However, we experienced some challenges using focus group interviews to explore rebel nurse leadership practices from a LAP perspective. For example, participants struggled to give examples of the LAP perspective on abandoning the individual 'heroic' image. As rebel nurse leadership practices also happen 'under the radar,' this might have stopped us from discussing all the aspects with the participants. This encouraged us to observe rebel leadership in practice.

The COVID-19 pandemic occurred during our study, which gave us the opportunity to study rebel nurse leadership in an acutely changed work environment **(chapter five)**. Our descriptive qualitative study aimed to provide insights into how nurses took on the responsibility to reshape their work environment in response to the changed organizational structures. We held a total of 26 semi-structured interviews with nurses, outpatient clinic assistants, nurse managers, and management (including one member of the Nurse Practice Council) working in a large Dutch teaching hospital (one of the first to be flooded with COVID-19 patients). After the analysis, we identified five topics related to the changed nursing environment and nurse leadership. 1) Implementing a staff deployment plan, including shifting patients to other wards and creating new micro-teams of nurses and outpatient clinic staff and/or nursing students. 2) Ensuring adequate staffing in micro-teams. Nurses took the lead and balanced their capacity on each shift to avoid reducing the quality of care and increasing the workload. 3) Ensuring competence in the micro-teams. Nurses were responsible for professionalizing all roles. They needed effective communication and coaching skills to work with various colleagues with unknown competencies on a daily basis. 4) Interprofessional collaboration increased during the COVID-19 pandemic. Nurses experienced solidarity and positive vibes, which led to more equal relationships between disciplines as well mutual respect and autonomy. 5) More supportive nurse managers; who tackled nurses' concerns, advocated on behalf of nurses, and relieved stress among nurses by improving work conditions. Overall, this study showed nurses found new ways to cope with rules and regulations. They reshaped their work environment, which increased their professional autonomy in making decisions and showing leadership to deliver good quality patient care. Although the COVID-19 pandemic negatively affected the nurses' work environment, it allowed them to positively influence their daily practices.

Finally, we conducted a multiple case study in two Dutch hospitals between January 2020 and December 2022 (**chapter six**). We shadowed (115.5 hours) and interviewed (21.75 hours) nurses, nurse managers, and other professionals to find out how rebel nurse leadership is reflected in the nursing practice. We also reflected on the dilemmas nurses and nurse managers face in these practices. This study identifies the most common 'lived' experiences and dilemmas of nurses and nurse managers in three characteristic practices. 1) 'High fives for climbing onto air mattress carts' shows how nurses find creative solutions to the encountered systemic problems and challenge the status quo when their practices are unworkable. Deviating actions foster a positive feeling among nurses, because these actions influence their mundane practices for the better. Consequently, this positive feeling also encourages nurses to retain their deviation actions. However, we noticed that deviating actions often remained quick fixes rather than leading to sustainable change and concluded that the next step is to utilize these rebel practices fully. 2) 'Crumbling suppositories sparking internal conflict' addresses the internal conflict deviating nurses often experience. Internal conflict is triggered when nurses are disturbed by needless, non-contributing organizational imperatives and causes an acceleration of deviating behavior to provide the best quality care. However, we observed that nurses seldom voice their internal conflict in their organizations. 3) 'A hip fracture process on the radar' illustrates how the interplay between nurse managers and nurses influences a change to the status quo. Nurse managers have a significant impact on the expression of rebel nurse leadership practices and this also affects the way nurse managers and nurses collaborate. Overall, this study shows that in order to achieve sustainable change, nurses need to voice their internal conflicts more and draw attention to unworkable practices that management has overlooked. From the LAP perspective, nurses and nurse managers need to build on relationships that value each other's perspectives. They can achieve this by sharing their dilemmas, asking questions, and supporting learning through experimentation.

The last chapter (**chapter 7**) presents our general discussion, conclusions and recommendations for clinical practice, research, and education. Because we applied the LAP perspective in our study we were better able to understand the collaborative, relational, and distributed nature of nurse leadership practices. In addition, we discovered a multitude of related aspects that characterize and influence rebel leadership. Over, reflecting on rebel nurse leadership practices, we noticed various associations, including the paradox of the 'under the radar' mechanism in the collaboration between nurses and nurse managers, and the impact nurses have on creating sustainable change in their practices. To fully utilize the potential of rebel nurse leadership practices in healthcare we recommend focusing on developing nurses' knowledge and skills, investing in quality-enhancing projects, and strengthening nursing governance structures. Besides these factors, realizing the potential of rebel nurse leadership requires collective reflection and action on the role of rules, agency, feedback, frames, and tensions within rebel practices. In conclusion, we regard nurses and healthcare organizations both responsible for working on developing rebel nurse leadership as a creative option for dealing with the challenges that will arise in nursing practice in upcoming years.

SAMENVATTING

Verpleegkundig leiderschap is een veel bestudeerd onderwerp dat op verschillende manieren wordt gedefinieerd. Volgens wetenschappers draagt verpleegkundig leiderschap bij aan voortdurende kwaliteitsverbetering, patiëntveiligheid en de werkomgeving van verpleegkundigen. In hun praktijken worden verpleegkundigen vaak uitgedaagd om anders te handelen wanneer de regels en voorschriften van de organisatie niet passen bij hun (professionele) normen en overtuigingen in het geven van de juiste zorg. Verpleegkundigen wijken dan af van die regels en voorschriften om in het belang van hun patiënten te handelen. We noemen dit rebels verpleegkundig leiderschap. Rebelse verpleegkundigen slagen erin grenzen te verleggen, buiten de lijntjes te kleuren zonder de steun van collega's en management te verliezen en zoals Meyerson (2008) het verwoordt "rock the boat while staying in it". Echter, zoals Wallenburg et al. (2019) opmerkten, gebeurt dit afwijkende gedrag vaak buiten het zicht van anderen, 'onder de radar'. Het is dan ook onduidelijk wat er gebeurt binnen rebelse verpleegkundige leiderschapspraktijken. Om innovatie in de verpleegkundige praktijk te stimuleren en verpleegkundige leiderschapspraktijken beter te begrijpen, is het belangrijk deze praktijken van rebels verpleegkundig leiderschap te bestuderen en ervan te leren.

Dit proefschrift onderzoekt hoe en wanneer rebels verpleegkundig leiderschap plaatsvindt in de verpleegkundige praktijk en geeft inzicht in de factoren die de ontwikkeling van rebels verpleegkundig leiderschap stimuleren en belemmeren.

We zijn begonnen met een kwalitatief onderzoek om het Excellente Zorg Programma (EZP) van Verpleegkundigen & Verzorgenden Nederland (V&VN) te evalueren (**hoofdstuk twee**). V&VN ontwikkelde het EZP om Nederlandse zorgorganisaties te helpen bij het creëren van een positieve werkomgeving door het leiderschap van verpleegkundigen te ontwikkelen. Aan de hand van kwalitatief onderzoek, bestaande uit semigestructureerde groepsinterviews in 17 organisaties, hebben we onderzocht hoe het EZP heeft bijgedragen aan de ontwikkeling van verpleegkundig leiderschap. In totaal namen 52 verpleegkundigen, verpleegkundig specialisten, (verpleegkundig) managers en stafadviseurs die betrokken waren bij het EZP in hun organisatie deel. Via thematische analyse werden vier processen gevonden die bijdroegen aan leiderschapsontwikkeling. 1) Verpleegkundigen namen verantwoordelijkheid voor de ontwikkeling van hun kennis en vaardigheden. Er werden verschillende trainingsprogramma's opgezet, waarbinnen het ontwikkelen van Evidence-Based kennis en klinische redeneervaardigheden de meest essentiële onderdelen waren. 2) Versterken van organisatiestructuren om de verpleegkundige zeggenschap te verbeteren. Dit ondersteunde de uitwisseling van kennis, het delen van best practices en het aanpakken en monitoren van onderwerpen zoals het behoud van verpleegkundigen, patiëntgerichte kwaliteitsverbetering, verpleegkundig onderzoek en onderwijs. 3) Uitdagen van de status quo met kwaliteitsverbeteringsprojecten. Verpleegkundigen leidden kleine verbeteringen op afdelingsniveau en werden meer betrokken bij de organisatie van brede projecten. 4) Het bewustzijn over de ondersteunende rol van de verpleegkundig manager werd vergroot. Verpleegkundig managers hebben aanzienlijke invloed op de voorwaarden voor een positieve werkomgeving, bijvoorbeeld door budgetten vrij te maken voor kwaliteitsverbeteringen en verpleegkundigen actief te betrekken bij besluitvormingsprocessen. Naast deze vier afzonderlijke processen die de ontwikkeling van verpleegkundig leiderschap beïnvloedden, merkten we op dat deze vier processen met elkaar verband houden en elkaar waarschijnlijk ook versterken. Al met al toonde dit onderzoek aan dat de ontwikkeling van verpleegkundig leiderschap op meerdere manieren gestimuleerd en verbeterd kan worden door verschillende processen (tegelijk) op gang te brengen.

Parallel aan dit kwalitatieve onderzoek hebben we een scoping review uitgevoerd over rebels verpleegkundig leiderschap (**hoofdstuk drie**). Het doel van deze scoping review was om inzicht te krijgen in de verschillende perspectieven op rebels verpleegkundig leiderschap aan de hand van de concepten 'Positive deviance', 'Tempered radicals' en zorgrebellen. We beschreven de concepten van positive deviance, tempered radicals en zorgrebellen, de competenties van rebelse verpleegkundigen en de factoren die de ontwikkeling van rebels verpleegkundig leiderschap stimuleren of belemmeren. Artikelen werden gevonden door te zoeken in Scopus, CINAHL, PubMed en PsycINFO. Na de initiële zoekstrategie werden in totaal 2.705 artikelen gevonden en uiteindelijk zijn 25 artikelen opgenomen in de definitieve review. De analyse van de concepten leverde drie interessante inzichten op, namelijk 1) de meeste studies beschreven positieve afwijking als een methode om bewuste en systematische (gedrags)veranderingen in een organisatie te initiëren, 2) het gedrag van positief afwijkende zorgprofessionals werd vaak beschreven als onconventioneel en niet-confirmatief en 3) beschrijvingen van positief afwijkende zorgprofessionals merkten steeds de sociale netwerken en persoonlijke relaties binnen en buiten de eigen organisatie op. Belangrijke competenties van afwijkende professionals professionals waren het vermogen om (1) samen te werken en contacten te leggen met diverse professionals en management binnen en buiten de organisatie, (2) expertkennis (Evidence-Based) te verkrijgen en te delen, (3) kritisch te reflecteren op problemen in de dagelijkse zorg en de status quo uit te durven dagen gericht op werkgewoonten en organisatorische logistiek en (4) ideeën te genereren om de zorg te verbeteren. Ten slotte werden een aantal stimulerende en belemmerende factoren voor rebels leiderschap gevonden. De eerste stimulerende factor is het belang van formele en informele communicatie - dialoog en reflectie - om positief afwijkend gedrag te bespreken, normatieve standpunten uit te wisselen en gezamenlijk nieuwe oplossingen te vinden om de kwaliteit van zorg te verbeteren. Een andere stimulerende factor is het in staat zijn om netwerken op te bouwen binnen en buiten de eigen organisatie. Als laatste is de bereidheid van het management om professionele afwijking te ondersteunen zowel een stimulerende als belemmerende factor voor afwijkend gedrag. Uiteindelijk hebben we door deze scoping review een voorlopige definitie van rebels verpleegkundig leiderschap kunnen beschrijven die gebruikt kon worden in ons vervolgonderzoek.

Met ons volgende onderzoek wilden we inzicht krijgen in de ervaringen van verpleegkundigen met rebels verpleegkundig leiderschap in hun dagelijkse praktijk

vanuit een Leadership-As-Practice (LAP) perspectief (**hoofdstuk vier**). Het LAP-perspectief heeft als voordeel dat het de complexe, collectieve en relationele context bestudeert waarin leiderschap plaatsvindt. Dit is noodzakelijk om te begrijpen hoe rebelse leiderschapspraktijken tot uiting komen in de verpleegkundige praktijk. In deze verkennende studie hebben we acht focusgroep interviews gehouden met 47 verpleegkundigen en drie verpleegkundestudenten die werkzaam waren in een ziekenhuis of een langdurige zorgorganisatie. Na het thematisch coderen van de gegevens werden vier thema's over de ervaringen van verpleegkundigen met rebels verpleegkundig leiderschapspraktijken geëxtraheerd en beschreven. 1) Praten over rebelse verpleegkundig leiderschap. We merkten op dat deelnemers eerst een gedeeld begrip creëerden voordat de deelnemers hun ervaringen konden delen over rebels verpleegkundig leiderschap. 2) Het definiëren van 'goede' rebelse leiderschapspraktijken. De deelnemers illustreerden verschillen tussen 'slechte' en 'goede' rebelse leiderschapspraktijken. Ze beschouwden kennis, werkervaring en patiëntgerichte motivatie als noodzakelijk voor 'goed' rebels leiderschap. 3) Redenen voor rebels leiderschap. 'Goede' rebelse verpleegkundigen dagen gevestigde ideeën en de status quo uit, wijken goed onderbouwd af van de regels, voorschriften en richtlijnen om de patiëntenzorg te verbeteren. Ze tonen verantwoordelijk subversief gedrag - ze weten dat ze afwijken, maar kunnen onderbouwen waarom ze dit doen. 4) Relaties tussen en samenwerkingen van rebellen. Continue sociale beïnvloeding en het uitdagen van grenzen werden aangegeven in relatie tot de samenwerking met collega's. Rebelse verpleegkundige schakelen daarbij tussen het handelen 'boven de radar' (zichtbaar) en 'onder de radar' (onzichtbaar). Geloofwaardigheid, vertrouwen, autonomie, vrijheid en het behouden van samenwerkingsrelaties bepaalden of rebelse verpleegkundigen zichtbaar of onzichtbaar handelden. Om hun imago als betrouwbare professional te behouden, gaan rebelse verpleegkundigen niet constant tot het uiterste of ze doen alles 'onder de radar'. Dit onderzoek gaf waardevolle inzichten in de ervaringen van verpleegkundigen met rebels verpleegkundig leiderschap en hielp het ons het concept verder te verfijnen. Echter ondervonden we enkele uitdagingen bij het gebruik van focusgroep interviews om rebelse verpleegkundige leiderschapspraktijken vanuit een LAP-perspectief te onderzoeken. Zo hadden de deelnemers bijvoorbeeld moeite om vanuit het LAP-perspectief voorbeelden te geven en het individuele beeld van verpleegkundig leiderschap los te laten. Daarnaast kan het zijn dat niet alle praktijken zijn besproken, omdat rebelse leiderschapspraktijken 'onder de radar' plaats kunnen vinden. Dit moedigde ons aan om rebels verpleegkundig leiderschap in de praktijk te observeren.

Tijdens onze studie vond de COVID-19-pandemie plaats, wat ons de mogelijkheid gaf om rebels verpleegkundig leiderschap te bestuderen in een acuut veranderde werkomgeving (**hoofdstuk vijf**). Op basis van een beschrijvende kwalitatieve studie wilden we inzicht geven in hoe verpleegkundigen verantwoordelijkheid namen om hun werkomgeving opnieuw vorm te geven als reactie op de veranderde organisatiestructuren. In totaal werden 26 semigestructureerde interviews gehouden met verpleegkundigen,

zorgassistenten, verpleegkundig managers en het hoger management (inclusief een lid van de Verpleegkundige AdviesRaad) werkzaam in een Nederlands topklinisch ziekenhuis (welke als één van de eerste werd overspoeld met COVID-19-patiënten). Tijdens het analyseren van de data werden vijf onderwerpen geïdentificeerd die verband hielden met de veranderde werkomgeving van verpleegkundigen en hun leiderschap: 1) Implementatie van een nieuw personeelsplan, inclusief het verplaatsen van patiënten naar andere afdelingen en het creëren van nieuwe microteams van verpleegkundigen en zorgassistenten en/of verpleegkundestudenten. 2) Het zorgen voor voldoende personeel in de microteams. Verpleegkundigen namen het voortouw en zorgden voor een evenwichtige bezetting tijdens elke dienst om de kwaliteit van zorg te waarborgen en de werkdruk te verlichten. 3) Het zorgen voor bekwaamheid in de verschillende microteams. Verpleegkundigen namen verantwoordelijkheid voor het professionaliseren van alle rollen. Effectieve coachings- en communicatievaardigheden waren nodig voor verpleegkundigen om dagelijks met verschillende collega's met onbekende competenties te werken. 4) De interprofessionele samenwerking nam toe. Verpleegkundigen ervaarden meer solidariteit en positieve sfeer, wat leidde tot gelijkwaardige relaties tussen disciplines, wederzijds respect en autonomie. 5) De ondersteuning van verpleegkundig managers; bij het aanpakken van zorgen van verpleegkundigen, het opkomen voor verpleegkundigen en het verminderen van stress onder verpleegkundigen door verbetering van de werkomstandigheden. Dit onderzoek toonde aan dat verpleegkundigen nieuwe manieren vonden om om te gaan met regels, voorschriften en hun veranderende werkomgeving. Dit vergrootte de professionele autonomie bij het nemen van beslissingen en het tonen van leiderschap wat bijdroeg aan het leveren van hoogwaardige zorg. Hoewel de COVID-19-pandemie een negatieve invloed had op de werkomgeving van verpleegkundigen, gaf het hen de mogelijkheid positieve invloed uit te oefenen op hun dagelijkse praktijken.

Tot slot hebben we een meervoudige casestudy uitgevoerd in twee Nederlandse ziekenhuizen tussen januari 2020 en december 2022 (**hoofdstuk zes**). Daarbij hebben we verpleegkundigen, verpleegkundig managers en andere professionals geobserveerd (115,5 uur) en geïnterviewd (21,75 uur) om erachter te komen hoe rebels verpleegkundig leiderschap tot uiting komt in de verpleegkundige praktijk. Daarnaast reflecteerden we op de dilemma's waarmee verpleegkundigen en verpleegkundig managers werden geconfronteerd in deze praktijken. Deze studie beschrijft de meest voorkomende ervaringen en dilemma's van verpleegkundigen en verpleegkundig managers aan de hand van drie karakteristieke praktijken. 1) 'High fives voor het beklimmen van antidecubitusmatraswagens' laat zien hoe verpleegkundigen de status quo uitdagen en creatieve oplossingen vinden voor niet werkbare systemische problemen in hun praktijken. Afwijkende acties bevorderden een positief gevoel onder verpleegkundigen, omdat deze acties hun alledaagse praktijken ten goede beïnvloede. Als gevolg hiervan moedigde dit positieve gevoel verpleegkundigen aan om hun afwijkende acties voort te zetten. We merkten echter op dat afwijkende acties vaak bij snelle oplossingen bleven in plaats van dat ze leidde tot duurzame verandering. We merkten

op dat er een volgende stap nodig is om deze rebelse praktijken volledig te benutten. 2) ‘Verkruimelende zetpillen veroorzaken interne conflicten’ gaat in op het interne conflict dat afwijkende verpleegkundigen vaak ervaren. Dit interne conflict wordt getriggerd wanneer verpleegkundigen zich storen aan nutteloze, niet-bijdragende dwingende organisatorische maatregelen die hen belemmeren de beste kwaliteit van zorg te kunnen bieden. We hebben echter waargenomen dat verpleegkundigen zelden hun interne conflicten uiten binnen hun organisaties. 3) ‘Een heupfractuurproces op de radar’ illustreert hoe de interactie tussen verpleegkundig managers en verpleegkundigen een verandering in de status quo beïnvloedt. Verpleegkundig managers hebben een aanzienlijke impact op de uiting van rebelse verpleegkundige leiderschap praktijken en dit beïnvloedt ook de manier waarop verpleegkundig managers en verpleegkundigen samenwerken. Over het geheel genomen laat deze studie zien dat, om duurzame verandering te bereiken, verpleegkundigen hun interne conflicten meer moeten uiten en de aandacht moeten vestigen op onwerkzame praktijken die over het hoofd worden gezien door het management. Daarnaast is het belangrijk dat verpleegkundigen en verpleegkundig managers voortbouwen op relaties die elkaars perspectieven waarderen. Ze kunnen dit bereiken door hun dilemma’s te delen, vragen te stellen en leren elkaar te ondersteunen door middel van experimenteren.

Terugkijken op alle studies beschrijven we in het laatste hoofdstuk (**hoofdstuk zeven**) de algehele discussie, conclusie en aanbevelingen voor de klinische praktijk, onderzoek en onderwijs. We bespreken de belangrijkste bevindingen van ons onderzoek naar rebels verpleegkundig leiderschap en hoe deze bijdragen aan het begrijpen van dit concept. We benadrukken daarnaast de implicaties van ons onderzoek voor de klinische praktijk, waarbij we aandacht besteden aan het belang van het ondersteunen van rebels verpleegkundig leiderschap om de kwaliteit van zorg te verbeteren en een positieve werkomgeving voor verpleegkundigen te bevorderen. Ook identificeren we lacunes in de literatuur en doen we aanbevelingen voor toekomstig onderzoek, waarbij we de nadruk leggen op de noodzaak van meer praktijkonderzoek vanuit het LAP-perspectief en de ontwikkeling van interventies om rebels verpleegkundig leiderschap te bevorderen. Tot slot benadrukken we het belang van het integreren van rebels verpleegkundig leiderschap in het verpleegkundig onderwijs om de ontwikkeling van competente en zelfverzekerde verpleegkundige leiders te ondersteunen.

DANKWOORD

Het is zover, mijn proefschrift is af! Terugkijkend op de afgelopen 5 jaar besef ik mij des te meer dat ik dit nooit had kunnen bereiken zonder de steun van velen. Steun in verschillende vormen, zoals bereid zijn om deel te nemen aan het onderzoek, samen te werken, te adviseren en voor de nodigen afleiding te zorgen tijdens dit intensieve traject. Graag wil ik in dit dankwoord stilstaan bij die mensen die direct of indirect bij hebben gedragen aan de totstandkoming van dit proefschrift. Zij zorgden ervoor dat ik deze prestatie neer kon zetten!

Allereerst mijn promotieteam – wat ben ik dankbaar voor het avontuur dat jullie met mij wilden aangaan en voor jullie kundige begeleiding om mijzelf als een volwaardig onderzoeker te ontwikkelen;

Pieterbas - Wat is het gezegde, van een promotie komt een promotie? Ik weet in ieder geval nog heel goed dat tijdens jouw promotiefeest ter sprake kwam of ik ook niet zou moeten promoveren. Toen overviel het mij, maar na wat mijmeren van mijn kant en gesprekken met jou wilde ik de sprong in het diepe wagen. En wat ben ik blij dat ik dat heb gedaan. Er ging een sociologische en historische wereld voor mij open en ik ontwikkelde een andere (kritische) kijk op de verpleegkundige beroepsgroep. Je daagde mij uit om af te wijken van de tot dan toe overheersende kijk op verpleegkundig leiderschap en terug te gaan naar de nitty-gritty praktijk van verpleegkundigen. Daarbij hoorde ook het challengen van mijn eigen gedragingen, neigingen en denkwijze als verpleegkundige en als mens. In ieder geval met als resultaat een rebelse promotie en een groeiende beweging waarbij meer aandacht is voor de processuele en relationele aspecten van de collectieve leiderschapspraktijken in de zorg.

Anne Marie - Wat ben je een groot rolmodel voor mij. Vanaf die mooie voorjaarsdag in 2018 dat we op het terrasje op Science Park in Utrecht kennis maakte en samen met Pieterbas geanimeerd spraken over verpleegkundig leiderschap en jouw onderzoek naar rebelse zorgprofessionals was het plan gesmeed. We startten het schrijven van een subsidievoorstel en zo werd het onderzoeksplan gemaakt. In het traject daarna heb jij mij het rebels zijn zeker verder geleerd, je daagde mij er regelmatig op uit. Want ook ik kon soms aardig binnen de lijntjes kleuren. Naast je scherpe visie op de inhoud en frisse blik vanuit de klinische én bestuurlijke praktijk, ben ik je ook dankbaar voor alle persoonlijke en open gesprekken die we gevoerd hebben. Ondanks al je bewonderingswaardige werkzaamheden was je er altijd voor mij, op zowel inhoudelijk als ook persoonlijk en privévlak. Bij jou zag ik hoe je goede wetenschap kunt bedrijven, maar daarbij de praktijk niet uit het oog verliest en daardoor juist bijdraagt aan de werkpraktijken van verpleegkundigen.

Lisette - Nadat we vanuit de VAR samen met de Raad van Bestuur drie plekken voor hoogleraren Verplegingswetenschap wisten te creëren binnen het UMC Utrecht ontmoette ik jou. Ik werd gelijk enthousiast toen ik kennis met je maakte, een gedreven vakvrouw met een enorme bak aan kennis en ervaring. Ik was dan ook blij toen je aangaf mijn promotor te willen zijn en ik heb je begeleiding als zeer fijn ervaren. Ik weet nog goed dat je tegen mij zei: “Eline, je maakt je eigen keuzes binnen het onderzoek, als jij ze goed kunt beargumenteren dan zal ik je daarin volgen. Anders zal ik je helpen en sturen in het onderzoek.” En dat heb je gedaan. Je hebt mij vanaf het begin het vertrouwen en de vrijheid gegeven om zelf richting te geven aan de inhoud van mijn proefschrift en je gaf op een prettige wijze feedback op mijn werk. Je hebt me de kans gegeven om te groeien als wetenschapper en vooral ook als mens.

Lees- en beoordelingscommissie – **Prof. Dr. Nienke Boonstra, Prof. Dr. Paul Boselie, Prof. Dr. Bianca Buurman, prof. dr. Pauline Meurs** en **prof. dr. Marieke Schuurmans**, dank voor de tijd die jullie hebben gestoken in het zorgvuldig lezen en beoordelen van mijn proefschrift. Hopelijk hebben jullie allen het proefschrift met veel interesse gelezen.

Collega’s van V&VN - Wat ben ik blij met de ruimte en mogelijkheid die ik heb gekregen om onderzoek te doen naar een belangrijk thema voor onze leden, verpleegkundig leiderschap. Het was niet altijd logisch dat ik als promovenda rondliep binnen de beroepsvereniging, maar door jullie heb ik mijzelf kunnen blijven uitdagen en mogen ontwikkelen in het prachtige verpleegkundige vak. Graag sta ik in het bijzonder nog even stil bij:

Sonja – Toen ik in 2018 bij je kwam met mijn wens om te promoveren op het thema rebels verpleegkundig leiderschap had ik geen fijnere reactie kunnen wensen! Je stond er gelijk voor open en vond dat dit de beroepsgroep alleen maar meer zou brengen. We gingen op zoek naar een manier waarop ik het onderzoek kon combineren met mijn werk binnen Excellente Zorg en zo geschiedde. Dank voor de kansen die je mij hebt geboden!

Yvonne – Je durfde het aan om met mij in het diepe te springen en het promotietraject vanuit V&VN te begeleiden vanaf 2021. Regelmatig kwamen we voor dingen te staan die nieuw waren voor ons beide. Maar om maar even Pippi Langkous te quoten: Ik heb het nog nooit gedaan, dus ik denk dat ik het wel kan. Met recht een motto dat we samen hebben opgepakt in dit traject waarin we met elkaar leerden, organiseerden en rebels durfden te zijn, met als resultaat deze afgeronde promotie!

En natuurlijk **Kirsten** en **Celine** - Vanaf het begin van mijn promotieonderzoek zijn jullie altijd erg betrokken geweest. Menig collega kende ons als ‘de drie musketiers van Excellente Zorg’ en wat waren we er trots op! We werkten snoeihard, maar we kregen zoveel energie van onze leden en alle organisaties waarmee we samenwerkten terug. Helaas kwam er een punt waarop we binnen en buiten V&VN andere werkzaamheden gingen verrichten, maar we zijn elkaar nooit uit het oog verloren. Ik ben blij dat we het inhoudelijke maar ook persoonlijke contact konden blijven voortzetten. Jullie hielden mij spiegels voor en stelden kritische vragen, maar bovenal motiveerden jullie mij altijd om door te gaan!

Collega’s van het UMC Utrecht - Wat vond ik het heerlijk om met jullie samen te werken tijdens mijn verpleegkundige diensten op de longafdeling. Even echt met de essentie van ons vak bezig zijn, zorgen voor patiënten. Daarnaast de inhoudelijk gesprekken die we voerden over ons vak en de verschillende perspectieven van jullie daarop. Jullie hielden mij

met beide benen op de verpleegkundige grond en zorgden voor de nodige afleiding tijdens mijn promotie. Elke vrijdagavond was ik te vinden op de verpleegafdeling en kon ik even loskomen van mijn onderzoek. Meestal de meest chaotische diensten van de week, maar zo fijn om even in actie te zijn! Voorlopig zet ik mijn werk samen met jullie graag voort, want in hart en nieren ben ik een verpleegkundige die het vak zeker nog niet alleen 'vanachter een bureau' wil uitoefenen!

Veel dank ben ik verschuldigd aan alle verpleegkundigen die bereid waren een inkijkje te geven in hun bijzondere werk. Ik ben er trots op dat zoveel collega's en organisaties door het hele land wilden bijdragen aan deze studie. Het was tof om op zoveel plekken te mogen komen en aan de slag te gaan met het rebelse leiderschap van verpleegkundigen. We hebben een beweging met elkaar in gang gezet die hopelijk niet meer te stoppen is. Met extra grote dank wil nog even stil staan bij:

Beweging 3.0 en in het bijzonder **Heleen Post, Marlous van de Bunt, Miranda Buijs** en **Ageeth Ouwehand** – Met jullie en alle coördinerend verpleegkundigen gingen we aan de slag. Een nieuwe functie met de nodige uitdagingen. Mooie gesprekken heb ik met jullie kunnen voeren en stappen werden gezet om de functie steviger neer te zetten. Ik zal de organisatie altijd een warm hart toe dragen! Niet alleen vanwege mijn onderzoek, maar ook omdat ik bij jullie mijn eerste carrièrestappen in de zorg kon zetten. Op jonge leeftijd al wanneer ik mijn moeder kwam 'helpen' en later tijdens mijn studie toen ik menig weekend en zomervakantie bij jullie kon werken. En als laatste voor de waardevolle zorg die jullie aan mijn oma hebben geboden.

Het **Diakonessenhuis** in Utrecht en in het bijzonder **Anita Kroneman, Ellen Maassen, Emily Westerbrink, Hanneke Veldhuisen, Rana Achterberg** en **John Taks** – Toen jullie hoorden van mijn promotieonderzoek werd al snel duidelijk dat jullie hier graag aan wilden deelnemen. Jullie hadden het Nightingale programma voor verpleegkundigen in huis en wilden graag met mij de opbrengsten van het programma inzichtelijk maken en verder ontwikkelen. Een actieonderzoek volgde waarin we samen aan de slag gingen. Twee jaar heb ik binnen jullie organisatie mogen schaduwen en gesprekken kunnen voeren. Ondanks de COVID-19 pandemie, die de nodige uitdagingen met zich meebracht, bleven we de mogelijkheden vinden om het onderzoek voort te zetten. Met als resultaat mooie uitkomsten en leerlessen rondom het rebelse verpleegkundig leiderschap binnen jullie organisatie.

Het **St. Antonius ziekenhuis** en in het bijzonder **Annette van Duijn, Annika Reijneveld, Corijna Reede, Lisa Suidman, Odette Kotter,** en **Luc Demoulin**. Dat jullie een organisatie zijn die zich verder wil ontwikkelen en met elkaar wil leren is wel duidelijk geworden tijdens de leergeschiedenis die we samen maakten. We gingen aan de slag met het inzichtelijk maken van de rol van verpleegkundig leidinggevende bij de ontwikkeling van verpleegkundig leiderschap. Daarbij haalden we het meerstemmige verhaal binnen jullie organisatie op met als doel het stimuleren van een dialoog en reflectie op het samenspel tussen teamhoofden en verpleegkundigen. We achterhaalden wat helpt bij de ontwikkeling van rebels verpleegkundig leiderschap, maar ook wat minder behulpzaam is. Met als kers op de taart een podcast serie die al meer dan 1000 keer beluisterd is!

Studenten Verplegingswetenschap, Health Policy & Management en **Verpleegkunde** – Bedankt voor jullie inzet en betrokkenheid binnen de verschillende onderdelen van mijn promotieonderzoek. Samen leerden en groeiden we in ons vak! Met een speciale dank aan:

Kirsten - Wat was het heerlijk om jou als collega te mogen begeleiden in je afstudeeronderzoek voor de Master Health Policy & Management. Het uitdenken en ontwikkelen van het onderzoek, op pad om interviews door het hele land af te nemen en de enorme berg aan data om te analyseren. Het was een feestje om dat samen met jou te doen. Het leverde mooie uitkomsten op die we niet alleen konden gebruiken voor mijn promotie en jouw masterthesis, maar ook voor de doorontwikkeling van het Excellente Zorg Programma. Ik ben trots op de stappen die je zet. En hoe hard je ook riep 'dat promoveren is niets voor mij', volgens mij heb ik je toch aangestoken om dit pad te gaan bewandelen. Ik ben er trots op dat ik jou daarin als copromotor mag gaan begeleiden!

Corijna - Wat was ik blij verrast toen jij mij een mail stuurde met de vraag of jij je masterthesis voor verplegingswetenschap mocht schrijven binnen mijn promotieonderzoek. Je hoorde toentertijd van je collega Annette dat ik de REBEL-V studie binnen het St. Antonius ziekenhuis zou gaan opstarten. In je mail gaf je aan dat de titel van het onderzoek je enorm nieuwsgierig maakte en dat je wel toe was aan meer rebellen in de zorg. Een proactievere student had ik niet kunnen wensen! Je kritische vragen, je hulp bij het houden van alle focusgroepen en de reflectieve gesprekken over wat we hadden opgehaald hebben ons beide veel gebracht. Zie het resultaat, je master met verve behaald, een mooie publicatie op zak en een hele fijne baan binnen het St. Antonius ziekenhuis!

Bardia - Onverwacht kwam je op mijn pad. Doordat jij voor je Master Health Care Management in alle tijdschriften van TVZ en Ziekenhuiswezen bent gedoken, kwamen we meer te weten over de ontwikkeling van de verpleegkundig leidinggevende in de Nederlandse gezondheidszorg. Een interessante inkijk in hoe verpleegkundigen zich in deze functie ontwikkelden. Dank daarvoor!

Researchgroepen, vakgenoten en mede PhD-ers - Het leven van een (buiten)promovenda is niet altijd makkelijk, maar door de support die ik vond bij verschillende onderzoeksgroepen en mede-onderzoekers heb ik dit pad goed kunnen bewandelen. In het bijzonder sta ik graag stil bij:

De **Verplegingswetenschap onderzoeksgroep** UMCU. Bij jullie kon ik zo nu en dan mijn vragen neerleggen tijdens researchbesprekingen. Het was fijn om bij jullie aan te mogen sluiten en te leren van elkaars onderzoekstrajecten. Wat wordt er prachtig en waardevol onderzoek gedaan binnen onze beroepsgroep!

De PhD duiventil van het Julius Centrum in **kamer 6.101** waar ook ik af en toe naar binnen

vloog. PhD-ers van verschillende onderzoeksgroepen, maar opvallend genoeg hadden we in de basis dezelfde uitdagingen en dat bond ons. Dank voor alle 'cake van de week' momenten en de afleiding met het ontwikkelen van een heuse Escaperoom!

De **actieonderzoeksgroep** ontstaan vanuit de Erasmus School of Health Policy & Management onder bezielende leiding van Anne Marie. Dank voor alle fijne bijeenkomsten waarin we onze actieonderzoek-avonturen konden bespreken en opgedane kennis van gevolgde cursussen/trainingen met elkaar deelden. Of het nu het maken van een infographic was, het doen van een realist evaluation of to Speak up, we leerden van en met elkaar!

De vele inspirerende vakgenoten die klaar stonden voor reflectie, meedachten bij complexe vraagstukken en mij verschillende perspectieven op het verpleegkundig vak meegaven. Met in het bijzonder **Annemarie de Vos, Ariane van Wamel, Catharina van Oostveen** en **Rosemarie van Troost.** Ik waardeer het enorm dat jullie mij supporten op wat voor manier dan ook binnen het verpleegkundig vak!

En als laatste mijn mede PhD genootjes waarbij ik zo nu en dan even mijn ei kwijt kon, maar die ik ook vanuit mijn eigen ervaringen kon helpen. **Arjan, Hugo, Dieke, Inge, Janet, Jannine, Mariëlle, Mildred** en **Susanne,** dank voor jullie steun en inspirerende gesprekken! We worstelden ons samen door complexe sociologische artikelen heen, hielden elkaar scherp binnen het geweld van alle leiderschapsliteratuur, dachten met elkaar mee als we er even niet meer uit kwamen, gaven elkaar feedback tijdens het uitdagende schrijfproces, reisden met elkaar naar congressen/bijeenkomsten en bovenal maakten we het promoveren met elkaar vele malen leuker!

Natuurlijk wil ik ook mijn vrienden en familie bedanken die de afgelopen jaren zo hebben meegeleefd. Dank vooral jullie steun, interesse, betrokkenheid en gezelligheid naast het werkende leven!

Anna-Lena & Maarten, Arjan & Paul, Bas & Jelmer, Bianca & Kars, David & Aafke, Dennis & Elsemieke, Eva & Stephan, Iris & Joost, Maartje, Terrens & Pauline, Wendy & Bas, zonder al jullie kopjes thee met lekkers momenten, uren wandelen, creatieve 'kom los uit je hoofd' afspraakjes, klusmiddagen (inmiddels ben ik pro vloerverwarming leggen), etentjes, weekendjes weg, en het organiseren van een heuse bruiloft had ik deze prestatie niet tot z'n succes kunnen brengen. Door mijn soms moordende werkschema was het des te belangrijk dat ik ook tijd nam om te ontspannen. Jullie hebben mij daar ontzettend mee geholpen. Dank voor onze kostbare vriendschappen!

Mijn lieve schoonfamilie - **Cora en Pieter** - Wat bof ik met jullie! Jullie staan altijd voor mij en Pieter klaar en wanneer we in Amerongen zijn ontzorgen jullie ons totaal. Wat geniet ik van de fijne wandelingen in het Amerongse Bos en de gesprekken bij de open haard. Helemaal opgeladen kunnen Pieter en ik de werkweek telkens weer helemaal aan! En **Matthijs, Iris & Phillip** en **Davida**, dank voor de vele momenten waarop we onder het genot van glaasjes wijn en lekkers onze avonturen op deze aardbol, hoe klein of groot ook, delen.

Lieve **Hilde, Jonathan & Cato** – Wat zijn jullie belangrijk voor mij! Ik ben ongelofelijk blij met zo'n zus, zwager en nichtje aan mijn zij. Jullie steunen mij door dik en dun, staan samen met mij stil bij gouden momentjes, bieden een troostende schouder op de momenten dat het nodig is, moedigen mij aan om het beste uit mijzelf naar boven te halen en bovenal genieten we samen van het vieren van de feestjes die het leven biedt. Een onvoorwaardelijke band die ik enorm koester!

Lieve **Mam** - Jij bent degene die mij vanaf jongs af aan de passie voor het verpleegkundige vak heeft meegegeven. Ik weet nog goed dat ik met je mee mocht om je te 'helpen' op werk. Het kon ook bijna niet anders dan dat ik in jouw voetsporen zou treden. Je was niet alleen mijn moeder maar ook mijn rolmodel en sparringpartner binnen ons prachtige vak. Mijn interesse voor rebels verpleegkundig leiderschap heb jij zeker aangewakkerd, want wat was jij rebels! En wat heb ik daar veel van kunnen leren en genieten. Ik weet dat je ergens op een wolkje meegeniet met alle stappen die ik zet en dat ik je keer op keer weer een trotse mama maak.

Lieve **Pap** - Zonder jouw liefde, advies, steun en wijze woorden was ik nooit op het punt gekomen waar ik nu sta. Al van jongs af aan vertelde je mij dat wat ik wilde bereiken in mij zat. Je gaf mij zo nu en dan trucjes om dat zelf ook in te zien. Ik kan mij nog heel goed een wiskundetentamen herinneren waarvoor je het advies gaf: 'als je er niet uit komt ga naar de volgende vraag, je hersenen blijven echt wel verder kraken!' En ja hoor, het werkte. Deze les ben ik altijd blijven toepassen, want ook tijdens mijn promotie heb ik momenten gehad waarbij ik het echt even niet meer wist. Door los te laten kon ik vervolgens met de oplossing komen. Pap dank voor je onvoorwaardelijke liefde en steun waardoor ik kan blijven leren en groeien als mens!

Allerliefste **Pieter** – Wat hebben we de afgelopen jaren veel meegemaakt met elkaar en wat zijn wij een sterk team! Toen ik je leerde kennen, was jij bezig met het afronden van jouw promotie. Toen ik dat zag werd ik er zelf een beetje onzeker van, want kon ik dat uiteindelijk ook? Maar je liefde en steun hebben gemaakt dat ook ik deze prestatie kon neerzetten. Hoe hoog de pieken of laag de dalen ook zullen zijn, ik weet dat we ze aan kunnen met elkaar! Lieve schat, dank dat je samen met mij elke dag weer nieuwe avonturen durft aan te gaan. Ik kijk uit naar de toekomst met jou!

ABOUT THE AUTHOR

Elia Theodora Adriana (Eline) de Kok was born in Roosendaal and Nispen, The Netherlands on May 1ste 1990.

She began her career as a nurse in 2008 starting the Bachelor of Nursing at Windesheim University of Applied Sciences in Zwolle. During her study, she had side jobs at various healthcare organizations. In 2012 she obtained both her Bachelor's degree in Nursing and finished the pre-master in Nursing Science at the University of Utrecht. After obtaining these degrees Eline started working as a Nurse at the General Neurology and Neuromuscular Diseases unit (2012 – 2015) at the University Medical Center in Utrecht (UMCU). Eline followed her studies by completing a Master's degree in Nursing Science at the University of Utrecht in 2014. Her nursing career continued on the Pulmonary Diseases unit (2015 – present) at the UMCU. From 2014 till 2019 she joined the nursing advisory board of UMCU, first as a member (2014), followed as vice president (2015), and later as president (2016 – 2019). During this period, she received the Most Promising Nurse Award of Rho Chi at Large Chapter of Sigma Theta Tau International Honor Society of Nursing (2015).

After completing her Master's degree in 2014, Eline started to combine her work as a nurse with her position as an advisor at the Dutch Nurses Association (V&VN). Her work involved various projects related to nursing career paths, nurse leadership, nursing governance, and the nurses' work environment. Between 2016 – 2021 Eline was the program leader of the 'Excellent Care' program. During this period, she collaborated with numerous (healthcare) organizations and developed a keen interest in nurse leadership. Subsequently, in 2018 she started her PhD project on Rebel Nurse leadership in partnership with Prof. Dr. L. Schoonhoven, Prof. Dr. J.W.M. Weggelaar-Jansen, and Dr. P.C. Lalleman.

Throughout her PhD project, Eline continued to work as an advisor at V&VN and as a nurse at UMCU. Furthermore, Eline joined various networks and committees to improve the nursing practice (e.g. Consultative group 'Toekomstbestendige Arbeidsmarkt Zorg en Welzijn (TAZ)', Committee 'Ad hoc Commissie Arbeidsmarkt Zorg (ACAZ) Sociaal Economische Raad (SER)', Consultative group 'Met Verve!', Advisory board healthcare 'Centrum Arbeidsverhoudingen en Overheidspersoneel (CAOP)'), and collaborated with several (healthcare) organizations on nurse leadership. Alongside her research, she also teaches several courses (nurse leadership, quality, and innovation) as visiting lecturer at Ede Christian University of Applied Sciences (CHE) and supervised various Master's and Bachelor's theses. Recently she finished the Blikverruimers Academy (2022-2023) and started as a trainee at the Supervisory Board of Carint Reggeland (2023).

In the future, Eline will continue to integrate both clinical and academic work into her career and hopes to further engage in improving nurses' leadership, governance, and their work environment. In doing so, she hopes to be a role model for clinical (academic) nurses.

LIST OF COURSES, PUBLICATIONS, PRESENTATIONS, AND HONOURS & AWARDS

Courses

2022–2023	Blikverruimers Academy, Blikverruimers
2022	Speak-up dear!, Nobbe Mieras
2022	The art of presenting science, Artesc
2022	Writing a scientific paper, Graduate School of Life Sciences, University Utrecht
2020	Advisory skills for policy makers, McChange
2019	Pragmatic Projectmanagement, Projectmanagement in de zorg
2019	School for Change Agents, Future Learn, NHS
2019	Writing in English for publication, Babel, Utrecht
2018	Connecting Leaders, University Medical Center (UMC) Utrecht

Publications (articles, interviews, and podcasts (selection on chronological order)

2023	**de Kok, E.**, Schoonhoven, L., Lalleman, P., & Weggelaar, A. (2023). Understanding rebel nurse leadership-as-practice: challenging and changing the status quo in hospitals. *Nursing Inquiry. e12577,* 1 – 10. **https://doi.org/10.1111/nin.12577**
	de Kok, E. (2023) Bespreking: Podcast 'Rebelse leider in het wit'. *Onderwijs & Gezondheid, 47*(3), 6.
	Interview 'Inspiratie sessie verpleegkundig leiderschap', Webinar Talent Care l March. **https://talentcare.nl/terugkijken-inspiratiesessie-rebels-verpleegkundig-leiderschap/**
	de Kok, E., Weggelaar, A.M., Reede, C., Schoonhoven, L., & Lalleman, P. (2023). Rebels leiderschap. *TVZ - Verpleegkunde in Praktijk En Wetenschap, 133*(3), 46–47. **https://doi.org/10.1007/s41184-023-1834-9**
	de Kok, E., Janssen-Beentjes, K., Lalleman, P., Schoonhoven, L., & Weggelaar, A. M. (2023) Nurse leadership development: A qualitative study of the Dutch Excellent Care Program. *Journal of Nursing Management,* 1-11. **https://doi.org/10.1155/2023/2368500**
2022	Podcast 'Leiders in het wit', podcast series developed in collaboration with St. Antonius hospital l December. **https://open.spotify.com/show/5ceOCI5f3tJ0SqiGhFsSY2?si=91a2d09a49af4c48**
	Interview and contribution book 'Zorg. Een betere kijk op de mens', Lynn Berger, De Correspondent l EAN: 9789493254152.
	de Kok, E., Weggelaar, A. M., Reede, C., Schoonhoven, L., & Lalleman, P. (2022). Beyond transformational leadership in nursing: a qualitative study on rebel nurse leadership-as-practice. *Nursing Inquiry, 30*(2), 1 – 11. **https://doi.org/https://doi.org/10.1111/nin.12525**
	Interview and Researchposter 'Rebel-V studie naar verpleegkundig leiderschap', Universitair Medisch Centrum Utrecht l March. **https://www.umcutrecht.nl/nieuws/rebel-v-studie-naar-verpleegkundig-leiderschap**
	Podcast 'Zuster Roos de Podcast' Theme nurse leadership | February. **https://open.spotify.com/episode/2V5G1t995NGrh53q2KebYQ?si=50b8dbc46e8343c9**
	de Kok, E., Weggelaar-Jansen, A. M., Lalleman, P., & Schoonhoven, L. (2022). Rebels verpleegkundig leiderschap. *TVZ - Verpleegkunde in Praktijk En Wetenschap, 132*(1), 50–51. **https://doi.org/10.1007/S41184-021-1070-0**
2021	**de Kok, E.**, Lalleman, P., Weggelaar-Jansen, A., Schoonhoven, L. (2021) Rebels leiderschap. Een meerjarig onderzoek naar verpleegkundig leiderschap onder de radar. *Verpleegkunde, 36*(3), 9–11. **https://doi.org/10.24078/vpg.2021.9.127837**
	Interview SER magazine 'Zorgmedewerkers zijn onmisbaar. Hoe houden we ze gemotiveerd?' | July. **https://www.ser.nl/nl/actueel/zicht/op/zorgmedewerkers-zijn-onmisbaar**
	Podcast 'Innovatie in de Zorg, aflevering 3 – In gesprek met Eline de Kok, Keygroup l March. **https://open.spotify.com/episode/3XL9DPfp3CcVeQjvQYCUGe?si=7ab07a013a454351**
	de Kok, E., Weggelaar-Jansen, A. M., Schoonhoven, L., & Lalleman, P. (2021). A scoping review of rebel nurse leadership: Descriptions, competences and stimulating/hindering factors. *Journal of Clinical Nursing, 30*(17–18), 2563–2583. **https://doi.org/10.1111/jocn.15765**
2020	Podcast 'Waardecast Excellente Zorg', Radicaal Vernieuwen Waarde-vol Onderwijs (RVWO) | November. **https://www.radicalevernieuwing.nl/praktijkvoorbeelden/thema-excellente-zorg/**
	Podcast 'Verpleegkundig Leiderschap', McChange | August. **https://www.mcchange.com/updates1/**
	Interview 'Prachtvak: 5 trotse verpleegkundigen vertellen', University Medical Center Utrecht | May. **https://www.umcutrecht.nl/nieuws/prachtvak-5-trotse-verpleegkundigen-vertellen**

Presentations (selection out of 75 on chronological order)

2023	'REBELs, durf jij het aan?', Presentation conference Headnurse Network (Netwerk verpleegkunde) Oostende | September
	'REBELs leiderschap, durf jij het aan?', Presentation & paneldiscussion conference HRM in healthcare | September
	'REBELs verpleegkundig leiderschap', Presentation National conference Nursing Governance Landelijk Actieplan Zeggenschap | June
	'REBELs leiderschap, het stille conflict?', Presentation BRUIS festival RN2Blend | June
	'REBELs leiderschap', Presentation Nursing conference ZuidOostZorg | May
	'REBELs leiderschap', Presentation Research conference Gelre Ziekenhuis | April
	'REBELs leiderschap', Presentation 10th conference Nurse Practitionars Oncology | March
2022	'REBELS leiderschap – durf jij het aan?', Presentation Nursing conference Leiden University Medical Center | December
	'Rebel Nurse Leadership in the daily work of nurses', Presentation European Nursing Congress Future Proof Nursing | October
	'Baas over eigen werk', Presentation & paneldiscussion Webinar Landelijk Actieplan Zeggenschap | September

	‘Rebel Nurse Leadership in the daily work of nurses’, Presentation International Nursing Research Congress Sigma | July
	‘REBELS leiderschap – durf jij het aan?’, Presentation Erasmus Center for healthcare governance, course New Nursing Leadership | July
	‘REBELS leiderschap – durf jij het aan?’, Presentation Nursing conference Arkin | May
	‘Verpleegkundig en verzorgend leiderschap, het gebeurt meer dan je denkt!’, Presentation Nursing conference Rivas | May
2021	‘Rebels Verpleegkundig Leiderschap’, Presentation Conference Nurse Leadership, Leids Congres Bureau | November
	‘A scoping review of rebel nurse leadership: Descriptions, competences and stimulating/ hindering factors’, Presentation Webinar Global Advanced Nursing, Patient Safety and Healthcare | November
	‘Rebels Verpleegkundig Leiderschap’, Presentation Course nursing advisory boards Rotterdamse Zorg | October
	‘Rebels Verpleegkundig Leiderschap’, Presentation Conference nurse leadership, Nursing | April
2020	’A scoping review of rebel nurse leadership: descriptions, competences, and stimulating/ hindering factors Leadership in daily practice’ Poster presentation Conference ‘Leadership in daily practice’, Rho Chi at Large Chapter, Dutch Nurses Association (V&VN) ‘Wetenschap in Praktijk’ & Alumni association ‘Verplegingswetenschap Nederland’ | December
	Presentation & paneldiscussion ‘Rebels Verpleegkundig Leiderschap’, Webinar Nursing day Health and Youth Care Inspectorate (IGJ) | November
	‘Hoe pas je verpleegkundig leiderschap toe in je werkomgeving’, Presentation Conference nurse leadership, Nursing | September
2019	‘Rebels Verpleegkundig Leiderschap’, Presentation Nursing conference Amsterdam University Medical Center | September
	‘REBEL-V studie’, Poster presentation Conference nurse leadership, Nursing | October
	‘Excellente Zorg hoe doe je dat?’, Presentation Ambassador programs Dutch Nurses Association (V&VN) | February

Honours & awards

2023	Top downloaded article ‘Beyond transformational leadership in nursing: a qualitative study on rebel nurse leadership-as-practice’, Nursing Inquiry.
2022	Top downloaded article ‘A scoping review of rebel nurse leadership: Descriptions, competences and stimulating/hindering factors’, Journal of Clinical Nursing.
2021	Nominee Best Poster (Second place), The Erasmus Graduate School of Social Sciences and the Humanities (EGSH).
2020	Best Poster Presentation, Conference ’Leadership in daily practice’, Rho Chi at Large Chapter, Dutch Nurses Association (V&VN) ‘Wetenschap in Praktijk’ & Alumni association ‘Verplegingswetenschap Nederland’


"...DOES THINGS SLIGHTLY DIFFERENTLY, WITH THE RIGHT INTENTIONS, WITHOUT HARMING PATIENTS OR THE ORGANIZATION"