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INFORMAL CLINICAL LEADERSHIP DEVELOPMENT: COHORT-BASED QUALITY IMPROVEMENT

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Abstract

Introduction: Informal clinical nurse leaders, bedside nurses without formal training and authority who influence their peers, are essential to quality care and team functioning, yet often lack structured leadership preparation. A needs assessment of a unit coordinating council in a 37-bed cardiovascular progressive care unit identified gaps in leadership confidence, leadership competencies, and change management skills.

Purpose: This quality improvement project aimed to increase the intrinsic leadership capability and preparation among unit-based informal nurse leaders through a structured development cohort.

Methods: Based on the theoretical framework of partnership, a three-month cohort intervention was implemented at a large Midwestern academic medical center. The program included three didactic sessions aligned with American Organization for Nursing Leadership "Leader Within" competencies, individualized mentoring, and visual cue reinforcement. Using iterative Plan-Do-Study-Act cycles, the curriculum was co-developed with participants. Pre- and post-intervention surveys assessed self-reported leadership identity, knowledge, confidence, and application.

Results: Eight participants completed the project. Mean scores from pre and post Likert questions improved across all domains, with the largest increase in competency identification. Neutral responses were largely eliminated post-intervention in favor of positive results. Qualitative leadership findings shifted from relational descriptions of leadership to systems-level influence, change management, and accountability.

Conclusion: A cohort-based leadership development model was associated with self-reported improved leadership confidence, knowledge, and application among informal nurse leaders. Collectively, these findings suggest that intentional, unit-based leadership development initiatives provide measurable value for informal nurse leaders at the bedside.

Keywords: informal nurse leader, development, cohort, partnership, quality improvement

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Frontline nurses provide pivotal bedside care and influence the future of nursing, yet are often excluded from formal leadership skill development in our healthcare systems. Clinical nurse leadership has long been recognized as essential to high-functioning care environments, with particular attention paid to formal leadership roles such as clinical nurse specialists, advanced practice nurses, and doctoral-prepared nurses (Enghiad et al., 2021; Guibert-Lacasa & Vázquez-Calatayud, 2022; Patrick et al., 2011). However, leadership at the bedside, often embodied by informal nurse leaders, has been relatively underemphasized in both academic literature and in current-day practice (Enghiad et al., 2021; Guibert-Lacasa & Vázquez-Calatayud, 2022; Patrick et al. 2011). A generally accepted definition of an informal clinical nurse leader is someone who, without a formal title, authority, leadership education or skill development, influences peers, guides clinical practice, and promotes a culture of safety and excellence at the point of care (Booher et al., 2023; Chavez & Yoder, 2015; Guibert-Lacasa et al., 2022). The increasing complexity of health care, rising patient acuity, and continued workforce instability reinforces the need for strong frontline leadership. The Institute of Medicine's (2011) report, *The Future of Nursing*: *Leading Change, Advancing Health,* highlighted the need for nurses to lead change and advance health, marking an early recognition of the critical role that frontline nurses play in transforming care delivery.

Within the health-care system where this project was conducted, a shared governance model engages staff nurses in decision-making and practice improvement. This model is operationalized through unit-level coordinating councils, supported by defined communication pathways that connect frontline staff with nursing leadership and

system-wide committees. On a 37-bed cardiovascular surgery progressive care unit, 11 staff nurses serve on the unit's governance council and represent their peers in decision-making processes. With an average nurse tenure of 1.6 years, the novice workforce lacks experience and formal leadership training. A needs assessment conducted with the nurse manager and nurse educator, in conjunction with a roundtable discussion with the unit governance council, identified opportunities for leadership development. The formal leadership team strongly expressed the need for leadership professional development. The staff nurses identified opportunities for growth in influencing peers, navigating change, and engaging in innovative quality improvement initiatives. Collectively, these findings suggest that these informal nurse leaders recognize gaps in their leadership competencies

Review of Literature

While the past two decades have seen an expansion in leadership training and formal educational pathways for nurses, research into elevating those at the bedside as informal clinical leaders began more narrowly in the late 1990s. Between 2012 and 2018, a small but growing body of literature sought to define, measure, and understand the behaviors and impacts of informal nurse leaders within clinical settings. These studies recognized that bedside nurses often assume leadership roles in team coordination, mentoring, decision-making, and patient advocacy, despite lacking formal leadership titles (Chavez & Yoder, 2015; Enghiad et al., 2021). The results of the studies showed statistically significant improvements in nurses' self-efficacy, perceived leadership, communication, and problem-solving skills (Fitzpatrick et al., 2016; Shen et al., 2018). Despite this momentum and growing literature, the emergence of the COVID-19 pandemic redirected scholarly and organizational focus toward crisis response, staff retention, and burnout mitigation; this effectively halted progress in the development and recognition of informal clinical leaders.

The shift to a crisis response has left a notable gap in both nursing scholarship and practice. As health systems recover and reimagine post-pandemic operations, there is

a renewed opportunity and urgent need to reinvest in the development of informal leaders at the bedside. These individuals are arguably the most influential stakeholders in patient outcomes, care quality, and team culture (Booher et al., 2020). Empowering them through targeted professional development, recognition programs, and leadership skill-building can serve as a catalyst for sustainable change (Booher et al., 2020; Fitzpatrick et al., 2016; Shen et al., 2018). Acknowledging and intentionally developing informal clinical nurse leadership may be one of the most impactful strategies to improve care at the point of delivery.

Theoretical Framework

This quality improvement (QI) project applied the domination–partnership framework to counter traditional hierarchies in health care and to intentionally advance partnership principles aligned with nursing practice. Eisler and Potter describe domination and partnership as two fundamentally different ways societies and organizations structure power (2014). Domination systems are organized around four core components: rigid top-down hierarchies, ranking of one group over another, normalization of abuse or coercion to maintain control, and belief systems that frame domination as normal (Eisler & Potter, 2014). In contrast, partnership systems are structured around hierarchies of actualization rather than control, gender and social equity, rejection of institutionalized violence, and shared cultural beliefs that support empathy, mutual respect, and collaboration (Eisler & Potter, 2014). The significance of a domination-versus-partnership model is that it defines cultural patterns shaping health-care environments and offers a practical framework for shifting away from hierarchies of domination and inequity towards effective interprofessional partnership and values.

The project design intentionally challenged domination structures by promoting partnership tenets. It strengthened the skills of informal nurse leaders through recognition and targeted development of their contributions. In doing so, it legitimized informal nursing authority and shifted influence and power closer to the bedside. The

core structure of this project was co-designed with the cohort members. Co-design is inherently partnership-based, as it is a collaborative approach to developing services or workflows with end users and key stakeholders as active partners (Sivola et al., 2023). Empowering informal leaders to co-design and use peer-led decision-making moves the culture from “power over” to “power with” (Eisler & Potter, 2014, p.55). Additionally, by defining bedside expertise and relational work as leadership, the project challenged professional and gendered hierarchies that have historically minimized the nursing voice (Eisler & Potter, 2014). Ultimately, this framework helped shape the project to challenge long-standing patterns of domination in health-care while advancing a culture of partnership grounded in nursing voices and values.

Purpose

The purpose of this project was to increase the 11 members of a unit coordinating council’s self-reported perceived intrinsic leadership capability and preparation through the implementation of an informal clinical nurse leader development cohort.

Methods

Project Site

This project was conducted at large Midwestern academic medical center. This center is known for its dedication to nursing excellence and professional governance. An established hospital-wide governance committee structure was in place prior to this project. Additionally, the organization has a cultural expectation of continued professional development.

Context

The project was implemented within an inpatient unit coordinating council. The 11 members are bedside nurses who volunteer to serve as informal, emerging leaders within their unit. These nurses represent a range of experience, with tenure spanning from 6 months to 40 years, and varied educational preparation from associate to

baccalaureate degrees in nursing. They are expected to contribute to unit-based and organizational-level quality improvement and to develop real-time process changes for their peers to incorporate into practice. The project leader was the unit manager, who supported dedicated agenda time for this professional development initiative through this QI project. Participation in the project was voluntary, and members were informed that they could withdraw at any time without consequence. Participants were also informed that data collected for this project would be de-identified prior to dissemination to protect anonymity and confidentiality.

Interventions

This QI intervention sought to elevate the skills of the informal nurse leaders and to increase their intrinsic confidence as leaders. Increasing both skill and confidence strengthens the presence of nursing voices within the hospital setting. This, in turn, supports more effective interprofessional partnerships and positions nurses to actively contribute to discussions and decision-making related to nursing practice. The intervention was designed as a three-month structured learning cohort for leadership development, consisting of a didactic curriculum supplemented with individualized mentoring and practical applications.

Design

The QI project was designed to be co-created by the project leader and the cohort members, following recurring Plan-Do-Study-Act (PDSA) cycles. The PDSA cycle is an iterative quality improvement method in which change is planned, implemented on a small and rapid scale, evaluated using data, and then refined based on learnings (Langley et al., 2009). Planning occurred during curriculum development; Doing occurred during curriculum delivery and practical applications; Study occurred during individual mentoring sessions with project leader reflection; Act occurred during changes to monthly content from original needs assessment topics and real-time refinement of curriculum for leadership development.

Leadership Development Curriculum

The curriculum included three one-hour interactive didactic sessions delivered at three consecutive monthly meetings. The curriculum was designed to be repeatable and sustainable, even with the same participants (the content remains open to all members of the cohort and is stored in their files for future use. Content was guided by the American Organization for Nursing Leadership (AONL) Nurse Leader Core Competencies (AONL, 2022). The central focus was on "Leader Within" (AONL, 2022). See Table 1 for curriculum content. Of note, the third topic was changed from the AONL competency of Professionalism to a non-competency of Individual Leadership Branding after mentoring sessions revealed that cohort members needed to understand their individual strengths and unique powers within the healthcare systems.

Table 1. *Curriculum Content*

Month	Domain Focus	Sub-Competencies Emphasized	Format Components
Month 1	Communication & Relationship Management	Effective communication; Influencing behaviors	Didactic instruction, case-based discussion, reflective prompts
Month 2	Leadership	Systems thinking; Complex adaptive thinking; Innovation	Design thinking didactic, group application exercise
Month 3	Professionalism	Self-awareness; Strengths-based leadership; Role clarity	Strengths identification activity, facilitated discussion, application planning

Mentoring Sessions

To supplement the monthly didactic leadership development sessions, each cohort member received multiple 20-minute one-on-one coaching and mentoring check-ins with the project lead. These sessions served as a core intervention of the QI project by bridging the gap between knowledge acquisition and real-world application. The didactic sessions provided foundational leadership concepts and shared learning experiences, while the one-on-one sessions offered targeted, learner-specific support to promote behavior change and skill integration. Grounded in evidence that mentoring

is among the most effective strategies for leadership development, these brief check-ins were intentionally designed to reinforce learning by allowing time for clarifying questions, contextual coaching, and practical guidance (Lysfjord & Skarstein, 2024; Robertson et al., 2024). The mentoring sessions provided time for connection between the project lead and participants, allowing the project lead to ensure that the leadership competencies introduced in the cohort were not only understood but also applied meaningfully in each nurse's daily workflow and responsibilities. When appropriate, role-playing was incorporated to practice high-impact scenarios such as providing feedback or navigating team dynamics (Lasley, 2022). The intent of the mentoring sessions was to enhance knowledge and skill retention, build confidence, and serve as a mechanism for accountability for the project lead and the cohort member. The goal was to increase the effectiveness of the overall intervention and drive sustainable leadership growth.

Visual Cues

The final intervention was a “locker poster” displaying the AONL Nurse Leader Core Competencies, which served as a consistent reminder of targeted leadership behaviors. Visual reminders are an effective teaching strategy that supports cognitive recall, reinforce key concepts, and promote behavior change in fast-paced clinical environments (Fink, 2013; Oermann et al., 2021). Because visual cues were already a culturally accepted and frequently used tool on this unit, this intervention leveraged an existing habit to reinforce leadership competencies introduced in the cohort. Integrating the locker poster into a familiar visual system enhanced real-time reflection and application while minimizing additional cognitive load.

Measurements

To identify success for this project, a variety of methods and tools were used, including surveys and tracking attendance at the didactic curriculum and mentoring sessions. A short, non-validated survey was created for this project. A pre- and post-intervention survey using a five-point Likert scale was administered to assess participants’ perceptions of leadership identity, knowledge, confidence, and intrinsic leadership

belief. This survey was built with six Likert questions for quantitative comparisons and two open-ended questions to gather qualitative data related to leadership development.

Data Analysis

There were 11 pre-intervention responses and 8 post-intervention responses. Due to different response counts between pre- and post-intervention surveys, findings were presented as distributional shifts rather than as matched individual changes. Mean shifts across the cohorts were also noted. Each item was summarized with reference to its corresponding figure (see Figures 1-7). Additionally, qualitative data was thematically reviewed and analyzed (see Table 1).

Ethical Considerations

This quality improvement project was reviewed for human subjects' protection using the online Institutional Review Board (IRB) determination tool developed by the University of Minnesota IRB. The responses indicated this project was a Quality Assurance/Quality Improvement project and did not meet the federal definition of Human Subjects Research. No additional IRB review was required for this project.

Results

The pre- and post- survey data reflected the success of the project's aim, showing an 80% increase in mean scores of self-reported intrinsic perceived leadership skills, 100% of available cohort members can verbalize one application of an AONL leadership competence, and 100% of the cohort members' ability to identify the AONL competencies. Outcome measures were validated with attendance to meet the goals of 80% attendance of didactic content and 75% attendance of mentoring sessions.

Quantitative Survey Results

The first survey question included with the intent to determine the intrinsic view of self-identification of leadership was "I identify as a leader" (see Figure 1). At baseline,

responses were favorable, with 81.8% selecting “agree” and 18% selecting “strongly agree”; no neutral or negative responses were reported. Post-intervention, responses were redistributed toward greater agreement. “Strongly agree” increased to 50%, while “agree” accounted for 37%. Although baseline scores were already high, the mean increased from 4.18 to 4.38 out of 5. Overall, findings demonstrate a shift from moderate agreement to stronger affirmation of leadership identity.

The second survey question to determine skill preparedness was “I feel equipped with the knowledge and skills needed to lead effectively” (see Figure 2). Pre-intervention responses reflected a wider response range with 36% selecting “neither”, 54% selecting “agree”, and 9% “strongly agree”. Post-intervention results showed complete elimination of neutral responses. “Agree” increased to 62%, and “strongly agree” increased to 25%. Mean scores rose from 3.73 pre-intervention to 4.00 post-intervention out of 5, reflecting improved perceptions of leadership readiness.

The third survey question to determine awareness of confidence in leadership was “I have the confidence and competence to lead others successfully” (see Figure 3). At baseline, 54% selected “agree” and 18% selected “strongly agree”, while 27% selected “neither agree nor disagree”. Post-intervention, neutrality decreased to 12.5%, and “strongly agree” increased to 50.0%. “Agree” accounted for 37%. Participants' perceived confidence and competence improved from a mean of 3.91 pre-intervention to 4.38 post-intervention out of 5, suggesting strengthened leadership self-efficacy.

The fourth survey question for knowledge of AONL skills was “I can identify the five competencies of a nurse leader” (see Figure 4). This item demonstrated the most substantial distributional change. Pre-intervention responses were predominantly unfavorable, with 54% selecting “disagree” and 18% selecting “strongly disagree”. The remaining 27% selected “neither agree nor disagree.” Post-intervention responses shifted to favorable categories: 75.0% selected “agree” and 12.5% selected “strongly agree”. Neutral responses were eliminated. Negative responses decreased to 12.5% “disagree”, with no “strongly disagree” selections. While not meeting the outcome

measure of 100% favorable, participants demonstrated the largest improvement on this item with the mean score increasing from 2.09 pre-intervention to 3.88 post-intervention out of 5 (+1.78).

The fifth survey question to determine intrinsic confidence was “I feel confident in my ability to apply change management strategies effectively” (see Figure 5). Pre-intervention responses reflected both uncertainty and some negative perception, with 45% selecting “neither agree nor disagree” and 18.2% selecting “disagree”. “Agree” accounted for 27% and “strongly agree” for 9%. Following intervention completion, neutral responses were eliminated. “Agree” increased to 55%, and “strongly agree” increased to 33%. Mean scores increased from 3.27 to 4 out of 5. The primary change was a shift from neutrality to favorable categories.

The sixth Likert question to assess skills and knowledge of innovation was “I have the skills and knowledge to generate innovative solutions to problems” (see Figure 6). Pre-intervention responses indicated uncertainty, with 54% selecting “neither”. “Agree” was selected by 36%, and “strongly agree” by 9%. Post-intervention, neutrality decreased markedly to 12.5%. “Agree” increased to 75%, while “strongly agree” remained stable at 12.5%. The mean score increased from 3.55 to 4.00 out of 5. Response shifts indicate greater confidence in innovation and problem-solving abilities following the intervention.

The final Likert question to assess support was “I have support and resources to develop leadership skills” (see Figure 7). Pre-intervention, responses were largely favorable but included neutrality, with 45% selecting “agree”, 27 % selecting “strongly agree”, and 27% selecting “neither”. Post-intervention showed a shift to 50% “agree” and “strongly agree,” an increase of 37%. One participant (12.5%) selected “disagree”. The mean scores rose from 4.00 to 4.12 out of 5, the smallest of all survey question mean shifts. Overall, these findings demonstrate sustained favorable perceptions.

Figure 1. *Survey Question 1*

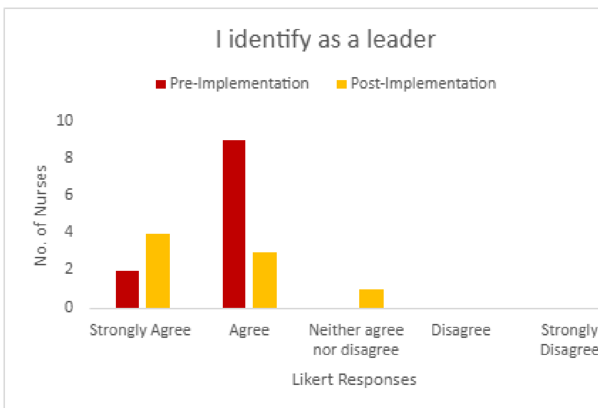


Figure 2. *Survey Question 2*

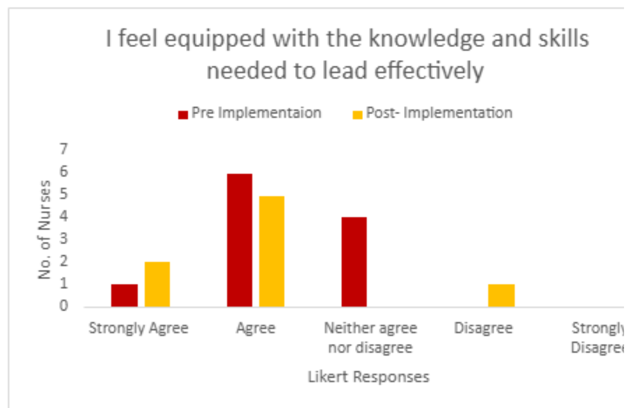


Figure 3. *Survey Question 3*

Figure 4. *Survey Question 4*

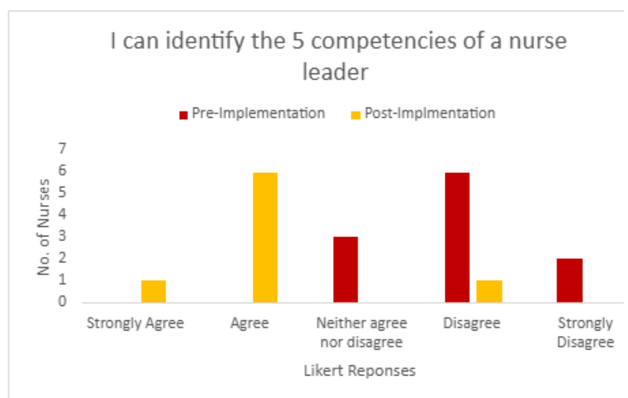


Figure 5. *Survey Question 5*

Figure 6. *Survey Question 6*

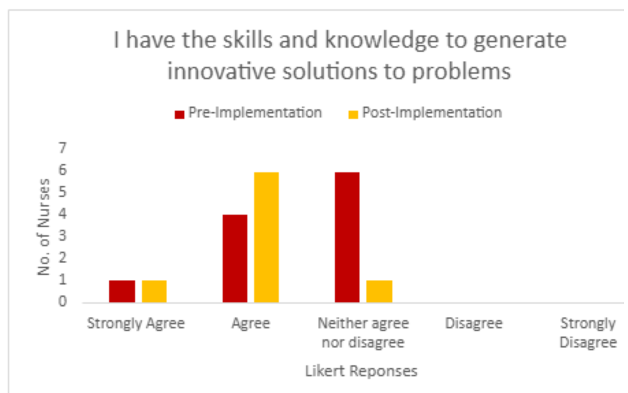
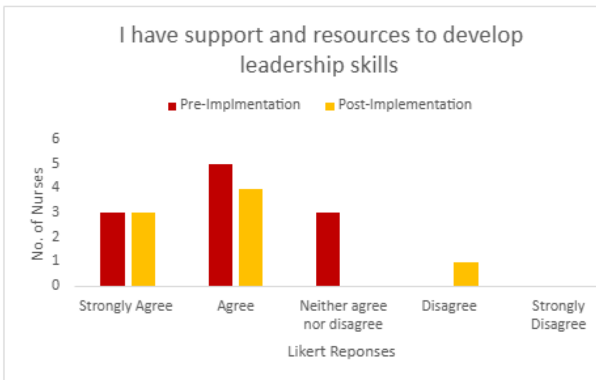


Figure 7. *Survey Question 7*



Qualitative Survey Results

The pre- and post-surveys included open-ended questions to gather qualitative data related to informal nurse leadership. The questions were “What does leadership mean?” and “How do I show up as a leader?”. See Table 2 for thematic responses to “What does leadership mean?”

Table 2. *Thematic Results for the Survey Question “What Does Leadership Mean?”*

Pre-Intervention	Post-Intervention
Approachability	Modeling desired change
Equality with peers	Authenticity
Answering questions	Empathy
Being present	Solution-focused listening
Precepting	Preparedness
	Leveraging team strengths

Pre-intervention responses reflected themes of approachability, equality with peers, answering questions, being present, and precepting. Leadership was primarily

described as relational and proximity-based. Cohort members stated leadership was "someone that walks with you and not ahead of you when it comes to solving a problem," "being a person someone can come to for questions, concerns and knowledge," and "having someone you can go to with problems and concerns and who can help you problem solve." Others emphasized visibility and support, stating "a leader shows up for their team, is easy to talk to, and provides support in every way." Leadership was also described as "being a trusted, knowledgeable person to guide a team" and "providing direction and support to others with strong communication strategies." Collectively, these statements show pre-intervention themes to be leadership centered on accessibility, guidance, and relational presence within the team.

Post-intervention responses demonstrated a broader conceptualization of leadership; they described leadership by modeling desired change, authenticity, empathy, preparedness, and leveraging team strengths. Cohort members articulated leadership as "the ability to steer change in a positive direction and affect positive patient outcomes." Others described leadership as "the ability to take in information [and] give direction for others to meet a goal." Accountability was emphasized through statements such as "lead by example and go out of your comfort zone to ensure policies are followed." Final themes of reflection and developing peers were highlighted: "It means I need to be open for feedback, understanding the strengths and weaknesses of the team, and can come up with plans for improvements," and "honesty, humility, willing to listen to and learn from experts, willingness to share knowledge, impact, inspire." The post-intervention responses reflect an expanded leadership scope of integrating influence, change management, strategic thinking, and measurable impact.

Discussion

The aim of this project was to increase the perceived intrinsic leadership capabilities of the unit professional members (cohort members) through the implementation of a three-month informal nurse leader cohort. Post-intervention findings demonstrate

observable improvement in leadership identity, preparedness, knowledge, and confidence

While pre-intervention identification as a leader was relatively high, as seen in the results, responses shifted toward strong agreement. The largest observable changes were related to perceived preparedness, confidence, and competence, and innovation skills (See Figures 1-7). Notably, most neutral responses went away across domains and questions. This suggests that the intervention moved cohort members from uncertainty of skill toward stronger internal leadership perceptions. Additionally, the largest distributional shift occurred in the knowledge of AONL competencies with mean scores increasing by a mean shift of 1.79. This indicated meaningful retention and gain of leadership skills and framework awareness.

Qualitative findings further supported the project's aim. Pre-intervention description of leadership emphasized approachability and peer support (see Table 2). Post-intervention responses expanded to include modeling change, strategic direction, and measurable impact, which are all skills covered in the didactic curriculum. This thematic shift reflected movement from relational leader to a systems-aware/oriented influence that aligns with the “Leader Within” competencies (AONL, 2022).

It should be noted that the project began with 11 participants. The final participant count of eight reflected cohort-planned rotations that were not accounted for in project planning. The success of the curriculum and mentoring intervention hinged closely on participating in designated sessions. The original goal of the project was to provide individual coaching to each cohort member between all didactic sessions. It quickly became apparent due to staff nurse scheduling and the priority of patient care that this was not feasible. The original process measure was 75% attendance of mentoring each month; this was modified to 75% of all cohort members participating in two coaching sessions. The final count of eight (100%) participants exceeded the project goals of 80% attendance for didactic learning and 75% participation in mentoring.

With analysis and context for the QI project, these results indicated that the intervention was associated with strengthened intrinsic leadership and a broader understanding of leadership knowledge. Causation cannot be claimed as this is not research and was not studied with intense statistical rigor and methods; however, the overwhelming positive shift across all measures suggests that this QI project format was successful and impactful for the cohort.

With consideration of the theoretical framework, dominance versus partnership, the project intentionally legitimized the informal bedside leader and shifted perceived confidence and skill closer to the bedside nurses. The framework emphasized a shift from "power over" (Eisler & Potter, 2014, p. 55) to relational power, which can be interpreted as success via positive trends in confidence and skill. By equipping the cohort members with leadership language, systems thinking, and mentoring support, power hierarchies were displaced. If the skills, knowledge, and confidence are sustained by the cohort, this could be a unit cultural movement toward partnership-based leadership.

Limitations of Study

Several limitations should be considered when interpreting the findings of this project. Most significant is that this project was conducted on a single unit within one hospital, thus the results lack generalizability. Second, this QI project leader was the direct manager of all cohort participants, which could have influenced survey outcomes to be more favorable. The project leader attempted to mitigate this risk with a disclaimer that the project would not fail based on survey results and rather emphasized that it was about the process. The third limitation is that the survey is a non-validated tool and its reliability, therefore, has not been tested or determined.

Conclusion

This quality improvement initiative was associated with measurable gains in self-reported intrinsic leadership confidence, as well as demonstrable growth in leadership

knowledge and skill among the members of the cohort. These outcomes were addressed through an intentionally structured leadership course that emphasized co-development of curriculum content, individualized mentorship, and consistent visual reinforcement of key concepts. Improvements in survey metrics, in conjunction with qualitative themes, reflect enhanced leadership insight. Overall, this indicates that bedside informal nurse leaders derive meaningful benefit from targeted, context-specific professional development.

This project offers a practical framework that can be adapted across clinical settings to support the intentional development of informal nurse leaders. The findings reinforce that purposeful investment in informal nurse leadership provides tangible benefits and may serve as a cornerstone for broader partnership transformation. Future efforts should focus on validation, scalability, and replicability across diverse practice environments to further establish the benefit.

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