Nurse Retention in the Hospital Setting

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ABSTRACT

The purpose of this study is to gain insight into the problem of nurse retention and the importance of transformational leadership in the hospital setting. This study is relevant in light of the ongoing nursing shortage, the high cost of replacing a hospital nurse, and ultimately, the wellbeing of the hospital patient. According to the American Association of Colleges of Nursing, “The United States is projected to have a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows” (American Association of Colleges of Nursing, 2010, p. 1). The participating hospital in this study had a higher nurse turnover rate than the national average. To gain an understanding of their nurse retention problem, the hospital conducted exit interviews. After analyzing the exit interviews, hospital administrators believed the high turnover rate of nurses was due to nurse managers’ poor leadership skills. Using this data the hospital had gathered, a secondary data analysis research design was used to further examine these exit interviews for patterns or trends. Using the MLQ Survey, a quantitative survey research design study was conducted at the participating hospital, a regional medical center, to measure 62 hospital nurses’ perception of their immediate managers’ leadership style. Face-to-face interviews were also conducted with former nursing staff and with key nurse managers. The information obtained from this research was given to the participating hospital to assist in developing a nurse retention plan centered on the transformational style of leadership.
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Nurse Retention in the Hospital Setting

Chapter I

In some markets the cost of losing a nurse is very high. “Nurse retention has become a workplace priority in hospitals. Recent studies reporting the $65,000 cost to replace one nurse has caused hospitals to refocus energy and money to retain nurses” (Wieck, Dols, & Landrum, 2010, p. 7).

This problem of high costs involved in the lack of nurse retention becomes even larger as the aging population increases. Tamara B. Dolan (2011) stated that the Bureau of Labor Statistics (BLS) predicts that the demand for RNs will increase by 22% from 2008-2018. With the aging population continuing to grow, Dolan (2011) asserted,

By 2018, a staggering 58% of the RN workforce is projected to be employed in long-term and home health care, a sharp rise from the current rate of 12.7%. Recent healthcare legislation, decreased reimbursement rates, and technological advances are also expected to shift the allocation of jobs. Today, almost 73% of RNs are employed in a hospital setting, but BLS projects a dramatic drop to 17% in the hospital setting by 2018 (p. 11).

Statement of the Problem

According to the American Association of Colleges of Nursing (2010), the United States is projected to have a nursing shortage that is expected to increase as the baby-boom generation age and the need for health care grows. With this problem looming, the importance of nurse retention in the hospital setting becomes substantial. The problem of nurse turnover in a hospital setting is costly. Jones and Gates (2007) stated, “Examples of direct costs of nurse turnover
included advertising costs and those costs incurred by Health Care Organizations (HCOs) to market nursing positions in an attempt to recruit and hire nurses to fill turnover vacancies” (p. 1).

Research Questions

The purpose of this study was to gain insight into the problem of nurse retention and the importance of transformational leadership in the hospital setting. The goal was to find ways to empower nurses and create a better workplace. By creating a better work environment, hospitals may be able to retain more of their nurses. This would cut the cost of replacing nurses and assist hospitals with the ongoing nurse shortage. This study determined if the coaching and mentoring style of leadership affected nurse retention. This study focused on the following questions.

Q1 “In a participating hospital, what are the nurses’ perceptions of their immediate nurse manager’s leadership style?”

Q2 “Is nurse managers’ leadership style affecting nurse retention in the participating hospital?”

Hypotheses to be Tested

I. Transformational Leadership:

1. Null Hypotheses: There is no significant statistical difference in the mean of the sample group and the mean of the national average.

2. Alternative Hypotheses: There is a significant statistical difference in the mean of the sample group and the mean of the national average.

II. Transactional Leadership:

1. Null Hypotheses: There is no significant statistical difference in the mean of the sample group and the mean of the national average.
2. Alternative Hypotheses: There is a significant statistical difference in the mean of the sample group and the mean of the national average.

III. Passive-Avoidant Behavior:

1. Null Hypotheses: There is no significant statistical difference in the mean of the sample group and the mean of the national average.

2. Alternative Hypotheses: There is a significant statistical difference in the mean of the sample group and the mean of the national average.

IV. Outcomes of Leadership:

1. Null Hypotheses: There is no significant statistical difference in the mean of the sample group and the mean of the national average.

2. Alternative Hypotheses: There is a significant statistical difference in the mean of the sample group and the mean of the national average.

Rationale and Significance of the Study

The rationale and significance for this study include the reality of the nurse retention problem, gaining more insight into the problem, and assisting the healthcare community with information that could save thousands of dollars for hospitals. This study may also provide solutions to the nurse shortage that is predicted to worsen over the next few years.

The growing proportion and numbers of older adults in the American population will have a profound impact on all sectors of society, including health care. According to Frey, the baby boom generation is quickly approaching age 65. Frey (2010) stated,

The next two decades will see a rapid rise in America’s senior population as the baby boom generation, born between 1946 and 1964, passes age 65. A precursor to this growth was seen in the previous decade as the leading edge of baby boomers (those born
between 1946 and 1955) entered the group of people ages 55 to 64 years. This population expanded by nearly half between 2000 and 2010. The growth of the age 45- to 54-year-old group by nearly one fifth can be attributed to the second part of the baby boom (those born between 1956 and 1965), who will not become ages 65 and older until 2020 to 2030. The ascension of these two parts of the baby boom will inflate the size of the age-65-and-older population during the next two decades” (p. 29).

Auerhahn, Mezey, Stanley, and Wilson (2012) indicated that the older adult population will double in the near future. This includes the aging baby boom population and the life expectancy of individuals who are 65 increasing by an additional 20 years. Auerhahn et al. (2012) stated, “The older adult population is expected to double by 2030. As the population over the age of 65 grows in size and lives longer, there will be an increase in the incidence and prevalence of chronic illnesses and multiple comorbidities” (p. 194).

The recent changes in the economy as well as the political climate have only added to the stress of the average hospital nurse. Not only has the economy created uncertainty in the nursing industry, but the political climate, including the Affordable HealthCare Act, has also contributed to an even more unstable atmosphere. The economy has created stress concerning job security, budget cuts, and downsizing which could increase the nurse’s patient load. The National Healthcare & Nurse Retention Report (2012) indicated that the current uncertainty that is enveloping the health care industry is unprecedented. The report suggested that this is due to a large population of uninsured, an uncertain economy, and high unemployment rate. “The aging of the population, the mandate on quality and safety, the squeeze in reimbursements, the competition for patient volume, the shortage of nurses and allied professionals, and healthcare reform are stressing the industry” (Colosi, 2012, p. 1).
Colosi suggested that even during tough economic times, hospitals need to continue to attract and retain staff. The value that hospitals place on their staff will have a direct effect to their commitment to the organization. Colosi (2012) further stated, “Enhancing culture and building programs to reinforce these values is critical to driving retention. Hospitals believe that retention is a key strategic imperative, yet are slow to translate this into a formal strategic plan. Focus on strategies that enhance culture and eliminate those which do not” (p. 10).

Definition of Terms

The discussion of this topic requires an initial definition of the terminology used throughout this study. Some of these terms are unique to the medical community and subject under investigation. Consequently, some degree of definition is beneficial for understanding.

Nurse retention

Nurse retention refers to the percentage of Registered Nurses that leave the Participating Hospital in a given year. This study will focus on the National average, Southeastern average, and the average of the PH.

Participating hospital

The hospital used for this study has requested to remain anonymous. It will be referred to as the Participating Hospital (PH). The PH is a major medical facility located in the Southeastern portion of the United States.

Registered nurses

Registered Nurses require at least two years of nursing school and must be licensed in the state where employed.

The six-factors to be measured and their operational definitions are provided below.
1. Charisma/Inspirational - Provides followers with a clear sense of purpose that is energizing; a role model for ethical conduct which builds identification with the leader and his/her articulated vision.

2. Intellectual Stimulation - Gets followers to question the tried and true ways of solving problems; encourages them to question the methods they use to improve upon them.

3. Individualized Consideration - Focuses on understanding the needs of each follower and works continuously to get them to develop to their full potential.

4. Contingent Reward - Clarifies what is expected from followers and what they will receive if they meet expected levels of performance.

5. Active Management-by-Exception - Focuses on monitoring task execution for any problems that might arise and correcting those problems to maintain current performance levels.

6. Passive Avoidant - Tends to react only after problems have become serious to take corrective action and may avoid making any decisions at all.

Leadership Styles Measured

*Idealized Attributes*

The first category measures Idealized Attributes (IA). The leadership style that possesses idealized attributes exhibits characteristics such as instilling pride in others, going beyond self-interest for the good of the group, acts in ways that build others' respect, and displays a sense of power and confidence.

*Idealized Behaviors*

The characteristics of Idealized Behaviors (IB) This leader will talk about important values and beliefs, specify the importance of having a strong sense of purpose, consider the
moral and ethical consequences of decisions, and emphasize the importance of having a collective sense of mission.

*Inspirational Motivation*

Avolio and Bass (2004) stress that leaders with strong Inspirational Motivation (IM) characteristics behave in ways that motivate “those around them by providing meaning and challenge to their followers' work. Individual and team spirit is aroused. Enthusiasm and optimism are displayed. The leader encourages followers to envision attractive future states, which they can ultimately envision for themselves” (p.94).

*Intellectual Stimulation (IS)*

Avolio and Bass (2004) asserted that leaders who rate high in this area are able to stimulate their followers' creativity and problem solving skills. “There is no ridicule or public criticism of individual member’s mistakes. New ideas and creative solutions to problems are solicited from followers, who are included in the process of addressing problems and finding solutions” (p.95).

*Individual Consideration*

Avolio and Bass (2004) suggested that these leaders pay attention to the individual’s need for achievement and growth by coaching and mentoring. “Followers are developed to successively higher levels of potential. New learning opportunities are created along with a supportive climate in which to grow. Individual differences in terms of needs and desires are recognized” (p.95).

*Transactional Leadership*

Transactional Leadership traits are measured by Contingent Reward (CR) and Management by Exception: Active (MBEA). Avolio and Bass (2004) stated that transactional
leaders display behaviors associated with corrective and constructive behaviors. The constructive style is labeled “contingent reward and the corrective style is labeled management-by-exception. Transactional leadership defines expectations and promotes performance to achieve these levels. Contingent reward and management-by-exception are two core behaviors associated with 'management' functions in organizations” (p.95).

*Contingent Reward*

Avolio and Bass (2004) suggested that, “Transactional contingent reward leadership clarifies expectations and offers recognition when goals are achieved. The clarification of goals and objectives and providing of recognition once goals are achieved should result in individuals and groups achieving expected levels of performance” (p.95).

*Management-by Exception*

The seventh column measures the second half of the transactional management style. This style is Management-by Exception; Active (MBEA). Avolio and Bass (2004) suggested that this type of leader identifies the standards for compliance, as well as what constitutes “ineffective performance, and may punish followers for being out of compliance with those standards. This style of leadership implies closely monitoring for deviances, mistakes, and errors and then taking corrective action as quickly as possible when they occur” (p.95).

*Passive/Avoidant Behavior*

Avolio and Bass (2004) asserted that the Passive/Avoidant management style is passive and reactive. This style does not respond to situations and problems appropriately. “Passive leaders avoid specifying agreements, clarifying expectations, and providing goals and standards to be achieved by followers. This style has a negative effect on desired outcomes—opposite to what is intended by the leader-manager. In this regard it is similar to laissez-faire styles.”(p.96).
Management-by-Exception

Characteristics of Management-by-Exception: Passive (MBEP) include failing to interfere until problems become serious, waiting for things to go wrong before taking action, showing a firm belief in "if it ain’t broke, don’t fix it."

Passive/Avoidant Behavior is the Laissez-Faire (LF)

Avolio and Bass (2004) argued that characteristics of the Laissez-Faire (LF) leadership style included avoiding getting involved when important issues arise, being absent when needed, avoiding making decisions, and delaying responding to urgent questions.

Outcomes of Leadership

Outcomes of leadership is divided into three sections Extra effort (EE), Effectiveness (EFF), and Satisfaction with the Leadership (SAT). Avolio and Bass (2004) argued that transformational and transactional leadership are both associated with the success of the group. Success is measured with the MLQ by how “often the raters perceive their leader to be motivating, how effective raters perceive their leader to be at interacting at different levels of the organization, and how satisfied raters are with their leader’s methods of working with others” (p.96).

Chapter II

Review of Literature

According to Aiken, Cheung, and Olds (2009) the nursing shortage is both a real and worsening problem. The researchers noted,

Some 587,000 new jobs are expected to be created for nurses between 2006 and 2016—a rate of job growth that is much higher than for most other occupations. Creation of new jobs in combination with large numbers of retirements from an aging nurse workforce is
expected to produce a substantial nurse shortage in the next decade. Estimates of the shortage vary from between 300,000 to more than a million by 2020–2025. Even a deficit of 300,000 would be nearly three times greater than any nurse shortage experienced in the United States during the past fifty years. The United States has a historic opportunity to solve the nurse shortage well into the future by acting now to expand nursing school enrollments at a time when applications are at an all-time high. Indeed, in 2008 more than 40,000 qualified applicants were turned away from baccalaureate and graduate nursing programs because of limitations in educational capacity (p. 1).

Elaine Sorensen Marshall (2011) argued that the nursing shortage is becoming a worldwide problem. Marshall also asserted that the nursing shortage is not just a global problem, but is also unprecedented. Marshall stressed, “We are on the brink of a health care disaster. With millions of Baby Boomers marching their way toward Alzheimer’s disease, our nation will see a major long-term care work force shortage and dramatic drop in care quality unless we address this problem immediately” (p.144).

Faculty Shortage

One issue that has contributed to the nursing shortage is a lack of qualified faculty in the nursing institutions. The American Association of Colleges of Nursing (2012) reported on the scope of the faculty shortage. According to AACN’s report on 2011-2012 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing,

U.S. nursing schools turned away 75,587 qualified applicants from baccalaureate and graduate nursing programs in 2011 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Almost two-thirds of the nursing
schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs (p. 1).

This report suggests that there are many individuals who want a career in the nursing field. The problem is that there is not enough faculty or clinical slots to meet the needs of those willing to enter the field. This problem only intensifies the need for qualified nursing staff.

According to a special survey on vacant faculty positions released by AACN (2012), there were a total of 1,088 faculty vacancies identified in a survey of 603 nursing schools with baccalaureate and/or graduate programs across the United States. Along with the vacancies, the nursing schools cited the need to create an additional 104 faculty positions to accommodate the growing student demand. The survey further reported, “The data show a national nurse faculty vacancy rate of 7.7%. Most of the vacancies (91.4%) were faculty positions requiring or preferring a doctoral degree. The top reasons cited by schools having difficulty finding faculty were a limited pool of doctorally-prepared faculty (31.3%) and noncompetitive salaries compared to positions in the practice arena (26.72%)”(p. 1).

This data suggests that there are very few nursing professionals available to fill the vacancies in the nursing schools. It also points to the issue of salaries being competitive enough to attract qualified instructors. Until these issues are addressed, the nursing shortage will continue to grow.

Dolan (2011) indicated that one frequently used strategy to relieve the nursing shortage is to increase the pipeline of nurses by boosting enrollment numbers in nursing schools. Dolan wrote,

The nursing school faculty vacancy rate in 2010 was 6.9%. Of the unfilled positions, more than half listed a doctorate degree as a prerequisite for employment. Although the
extensive commitment required to complete a PhD program, as well as the compensation disparity between academic faculty positions and clinical positions are potential impediments to achieving a doctoral education, when it comes to explaining the reasons for the lack of PhD-prepared nurses, there is not one simple answer (p. 10).

Karen J. Egenes (2012) echoed the concern regarding qualified nursing faculty. Egenes described the scarcity of qualified faculty for nursing institutions as the other shortage. She stated, “In 2010, more than 54,000 qualified applicants were denied entry to schools of nursing offering the baccalaureate degree because of insufficient faculty, lack of sites for clinical placements, budget constraints, and other factors. Further, many current faculty members plan to retire within the next 10 years” (p. 21).

While this study will not seek solutions to the shortage of faculty in nursing institutions, it is important to see how this problem has contributed to the shortage of hospital nurses. It is also important to see the significance of retaining nursing staff because of this shortage. The primary focus of this study is to gain insight into the problem of nurse retention and the importance of transformational leadership in the hospital setting.

Job Satisfaction

Job satisfaction is imperative in retaining nurses. A recent article in the *Journal of Nursing Management* reported that, “The nursing shortage has been linked to overall job satisfaction and specifically to nurses’ satisfaction with the professional practice environment. Initiatives to increase retention and recruitment and decrease turnover have been linked to work satisfaction among nurses” (McGlynn, Griffin, Donahue, & Fitzpatrick, 2012, p. 260).

Job satisfaction, particularly in nursing, is a critical challenge for healthcare organizations, as labor costs are high and shortages are common. As the demand for nursing staff
increases, supply is not sufficient to meet the demand. Zangaro and Soeken (2007) argued that an “additional 703,000 jobs would be created for registered nurses between 2004 and 2014, 29% more than already employed. As baby boomers begin to retire, there will be an estimated shortfall of approximately 400,000 nurses to care for this population” (p. 445).

William F. Martin (2008) suggested that some job dissatisfaction comes from the physician and nurse relationships. Disruptive behavior in the hospital setting continues to be a problem for medical professionals. Martin (2008) disclosed, “Physicians throwing charts, nurses berating less experienced nurses, and supervisors publicly belittling staff are all common examples of disruptive behavior. Such behavior represents one of those managerial challenges that affect not only the target but also the organization itself”. (p. 21). Elaine S. Marshall (2011) suggested that disruptive behavior appears to be more prevalent among physicians. Marshall stated, “The abundant evidence of disruptive behavior attributed to physicians uniquely predominates. Such behavior in medicine and health care is uniquely more rampant than in any other professional discipline, industry, or workplace” (p. 112).

At times, this type of disruptive behavior can lead to acts of violence in the workplace. Severe disruptive behavior affects the entire organization. Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) reported, “Acts of violence affect not only the nurse who experiences them, but also the organization as well in direct and indirect ways such as low employee morale, increased turnover, decreased trust, and increased expenses in lost workdays” (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005, p. 393).

Jackson, Claire, and Mannix (2002) argued that violence towards nurses can emanate from many different quarters. Patients, relatives and friends of patients can all become violent in a hospital setting. It is noteworthy when the workplace violence comes from other medical staff.
Jackson, Claire, and Mannix (2002) stressed that medical staff were the most “frequent cause of nurses’ feelings of intimidation and lack of confidence in their own abilities as professionals. Depending on their clinical area, between 42 and 55% of nurses suggested that doctors were responsible for the workplace aggression they encountered” (p. 16).

This type of disruptive behavior can lead to a nurse to relocating to another health care setting. Martin (2008) wrote,

On the level of individual employees, researchers have shown that those who are the targets of disruptive behavior report less organizational citizenship behavior, more psychological distress, greater dissatisfaction with work and life, and an increasing intention to quit work. With the national nursing shortage already being a critical problem, hospitals cannot afford to have another cause for turnover. On the organizational level, disruptive behavior has a negative effect on patient satisfaction, staff performance, and—in more recent studies—quality of care. First, Rosenstein (2008) found a link between disruptive behavior and patient satisfaction. Second, other researchers have established a relation between disruptive behavior and staff health, retention, and even patient care. Field (2002) found that bullying was associated with staff turnover, absenteeism, impaired performance, decreased productivity, and poor teamwork. As hospitals struggle with staffing because of labor shortages and escalating hospital costs, hospital leaders and managers must remove all obstacles to staff performance and then develop a culture of high performance (p. 23).

According to McGlynn et al., (2012) particular attention needs to be paid to professional interactions in the hospital setting. Attention should not only be paid to nurse-physician interactions, but also to nurse-nurse relationships. McGlynn et al., (2012) indicated that, “In
light of the present nursing shortages and predictions of the number of available nursing positions increasing by 21%, attention needs to focus on maximizing the desirability of the work environment to satisfy RNs” (p. 264). The intrinsic rewards of good relationships in the hospital setting are extremely important to nurses. Morgan and Lynn (2009) stated, “Nurses have the potential for relatively high rewards in intrinsic and relationship dimensions. Intrinsic work values and identity, then, could play an important role in determining work satisfaction and subsequent commitment” (p. 402).

McCaffrey et al., (2012) suggested that clear and appropriate communication is a must in order to foster collaboration between all hospital disciplines. McCaffrey et al., stated that good communication fosters a positive work environment. McCaffrey et al., (2012) asserted that effective communication also, “Improves patient care, and decreases patient morbidity and mortality. Studies show that nurses who work in environments that foster collaboration among health professionals experience improved job satisfaction thereby improving recruitment and retention rates when compared to a non-collaborative environment” (p. 294).

Not only does poor communication and working relationships affect job satisfaction, it can also affect the nursing staff physically. Moore, Leahy, Sublett, and Lanig (2013) stated, “Poor nurse-to-nurse relationships have grave consequences for nurses, the nursing profession, and health care organizations including poor work performance, absenteeism, and rapid job turnover. Targeted nurses can experience physical and psychological signs, including moderate-to-severe stress” (Moore, Leahy, Sublett, & Lanig, 2013, p. 173).

Conflict

Conflict is inevitable. Healthcare facilities, like all other organizations will experience conflict. According to Maureen Catterson and Bob Price (2008), conflict is unavoidable in the
health care setting. The authors wrote that there are times when “it is necessary to confront problems, differences of experience, expectation or opinion that enable stakeholders to clarify what they are trying to achieve and to work more constructively together. Leaving a problem unaddressed, values or interests unexpressed, can sometimes increase resentment in teams” (p. 25). This can lead to disgruntled staff, poor performance, and staff turnover.

Craig E. Runde and Tim A. Flanagan (2007) agreed that conflict is inevitable, “You may as well equip yourself with the skills to deal with it. Your workplace may be a Fortune 500 company or a family owned small business. It may be government offices, schools, or non-profit agencies. It really doesn’t matter because conflict occurs in all workplaces” (p. 1). The healthcare worker must prepare himself for conflict in the organization. Lee G. Bolman and Terrence E. Deal (2008) wrote, “Some groups are blessed with little conflict, but most encounter predictable differences in goals, perceptions, preferences, and beliefs. The larger and more diverse the group, the greater the likelihood of conflict” (p. 184). Elaine S. Marshall (2011) agreed that conflict stems from differences among a diverse working environment. Marshall asserted, “To recognize the diversity and fundamental differences in personal experience, viewpoints, and values among human beings is to acknowledge conflict to be a normal characteristic of human interaction. Conflict is a human experience. It is fundamentally about differences” (p. 110).

As leaders in the healthcare environment, nursing staff must set an example and demonstrate moral courage. Cynthia Ann LaSala and Dana Bjarnason (2010) insisted, Nurse leaders demonstrate moral courage when they oppose work environments that put patient safety at risk. For example, chief nurses act with moral courage when they firmly oppose cost-containment measures, such as nursing layoffs or reductions in healthcare
services that would jeopardize the delivery of safe, competent patient care. Nurse leaders can create environments that support moral courage by clearly providing guidelines for nurses to use when they observe unethical practices and by providing resources, such as ethics committees, shared governance structures, and mentoring opportunities that enable nurses to confront ethical dilemmas in practice (p. 10).

Cowden, Cummings, and Profetto-McGrath (2011) suggested that a nurse’s perception of leadership and the practice environment are key to the retention problem. The researchers indicate that the nursing shortage is projected to continue well into the future, “and efforts to retain current staff are critical to minimizing the effects of the shortage of nurses. Staff nurses’ perceptions of nursing leadership and the practice environment are directly related to their behavioral intentions of staying with or leaving the organization” (p.471). The researchers have reported that relationally-focused leadership results in quality nursing work environments.

Relationally-focused leadership implies that the manager focuses on the individual needs of his staff and strives to meet those needs. This type of manager is more likely to retain his staff. The work environment greatly affects the staff nurses intent to stay. Cowden et al. (2011) suggested that nurses employed in environments where they felt supported by their leaders and peers, recognized and valued for their contributions, and encouraged to participate in decision making were “generally more likely to remain in their positions, were more satisfied and more committed to the organization. Health care managers need to address quality of workplace issues in order to provide an environment conducive to decisions to remain” (p. 471).

Mediating Conflict

The conflict competent healthcare manager must mentor his workers. Catterson and Price (2008) asserted that as long as all peers confront conflict as part of their professional work, there
will be a need to assist each one to understand why conflicts arise, how they feel about conflict, and “what could be done usefully to cope with the challenges that are present. Where such skill analysis work leads to more strategic plans and improvements in care, we can argue that the effort is well worth while and that it is appropriately developmental” (p. 30).

Management Style and Retention

Management style is a major factor in an employee’s decision to stay or leave an organization. Lee and Cummings (2008) asserted that front line managers are an important link between hospital leadership and the floor nurse. Lee and Cummings (2008) wrote,

"Front line managers ensure that nurses are individually effective as well as help to create a supportive and collaborative practice environment for nurses which influences recruitment and retention. With the forthcoming shortage of nursing leaders, it is important that organizations act to sustain viable nursing leadership. Identifying the predictors of job satisfaction will help front line managers, their supervisors and organizations to develop strategies to implement, develop and support nursing leadership to ensure that organizations can continue to provide quality patient care (p. 781)."

Runde and Flanagan (2007) agreed with the importance of mentoring staff. Leaders must also be willing to help their reports directly by providing one-on-one mentoring as well as coaching to help improve their conflict management skills. Runde and Flanagan stated, “In their roles as mentors, leaders use their experience to advise and give suggestions to others about how to handle specific conflict situations. Leaders might recommend particular actions to take or specific behaviors to use that they personally have found helpful in similar situations” (p. 180).

James M. Kouzes and Barry Z. Posner (2007) described a military hospital that suffered from many issues. The first issue was an unfavorable accreditation report by the Joint
Commission on Accreditation of Healthcare Organizations, which could have ended the military career of nearly everyone on staff. Kouzes and Posner wrote, “Brian found a group of talented people in disarray and an organization with low morale, a set of rigidly followed institutional rules, and a high degree of conflict between doctors and nurses.” (p. 268).

Within two years Dr. Brian Baker had made a dramatic change in this hospital. Kouzes and Posner (2007) described how this dramatic change was possible. “What Brian did was coach. He listened, mentored, and fundamentally changed the culture and the decision-making process. Restoring his staff’s sense of self-confidence was the first challenge” (p.268). Morgan and Lynn (2009) echoed the importance of mentoring and coaching as a way to enhance the collegiality of the work environment. They stated, “Having other nurses, physicians and support staff who understood the contribution nursing makes to patient care and feeling respected brings real rewards for nurses engaging in the professional role” (p.405).

Runde and Flanagan (2007) viewed the competent leader as a conflict coach, who assists not by giving advice, but in focusing staff on what they want to accomplish. Runde and Flanagan asserted that this is done “by the use of what is known as powerful questions. These questions encourage self-discovery, increase insights, and help people reflect on what they want out of the conflict” (p. 180).

Runde & Flanagan (2007) suggested that the task for healthcare managers is to “become personally competent in dealing with conflict. Understanding some of the basic dynamics of conflict is an important beginning. Becoming aware of their responses to conflict and the perceptions of others when dealing with conflict is critical for improving self-awareness” (p. 187).
Gerardi (2003) indicated that the health care worker is more likely to encounter conflict due to the diverse disciplines that must work together. Gerardi stressed, “Regardless of the role of the professional; physician, nurse, administrator, manager, social worker or technician, as a group, health care professionals face more conflict and greater complexity than any other profession” (p. 1). Conflict is often caused by a simple misunderstanding between parties. Conflict competent leaders will remind their workers that conflict is inevitable and to expect it. Marshall (2011) agreed that the diverse workforce of a hospital naturally leads to conflict. Marshall stated, “In complex environments with a highly diverse workforce and laden with high-risk situations, conflict happens. Nursing and healthcare organizations can be particularly vulnerable” (p. 110).

Catterson and Price (2008) wrote that that one way to manage conflict is by demonstrating skill analysis at work and to “encourage others to begin exploring skill analysis as one means of enriching the care delivered to older people. In our case study, points have been made about the significance of inner conflict, the decisions that nurses have to make and the importance of imagining consequences when managing conflict” (p. 31).

The conflict competent leader must mentor and coach staff in ways of dealing with perceived conflict. Healthcare workers must observe their managers standing up for the ethical treatment of the patients. Marshall (2011) suggested that this is evidenced by showing, “sensitivity to the human condition, to suffering, pain, illness, anxiety, and grief. A nursing leader is engaged and professional and acts as an advocate for health and dignity” (p.2). By providing coaching to his staff, the healthcare leader can assist his workers in developing skills to deal with conflict in the future. Marshall (2011) encourages nurse managers to draw upon
their, “highest levels of emotional intelligence, which can help you to frame conflict situations as opportunities for learning” (p. 111).

Dubrin (2007) argued that in addition to communicating clear expectations, relationship building is needed to coach staff. Dubrin asserted, “Effective coaches build personal relationships with team members and work to improve their interpersonal skills. Having established rapport with team members facilitates entering into a coaching relationship with them” (p. 309).

LaSala and Bjarnason (2010) acknowledged that the health care environment is very challenging. Professional nurses must be patient advocates and role models to other staff. LaSala and Bjarnason stated, “Quite simply, the accountability and responsibility for creating environments that promote moral courage in practice and transform the workplace is an obligation shared by all nurses, in every role, in every specialty, in every setting” (p. 11).

As with all organizations, the effective healthcare leader must continue to hone his leadership skills. Runde & Flanagan, (2007), indicated that being a successful leader is a process of life-long learning. Leaders must, “become aware of their most effective strengths and use them relentlessly. They are just as aware of their limitations, or developmental opportunities, and strive to improve, or in some cases minimize, the effects of these limitations” (p. 3).

Nurse Recognition Programs

A study conducted by Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) indicated that forty-three percent of nurses surveyed had not noticed an increase in efforts to reward nurses for excellence. The study asked RN’s “if, in the past year, their organizations had increased nurse recognition events in a deliberate effort to improve retention and only 31% indicated that their organizations had made such an effort” (p. 393). An article published by the Psychological
Associates and Daisy Foundation (2009) discussed the positive outcomes of recognition programs. The article reported, “The number one positive outcome of increased recognition of nurses’ performance is that it contributes directly to higher job satisfaction. (p. 8).

The Psychological Associates and Daisy Foundation (2009) also confirmed the negative outcomes of not having nurse recognition. The study suggested that the number one negative outcome when recognition for job performance is not given is dysfunctional job turnover. The study also reported

“that organizations have to measure the costs involved in turnover including: separation and vacancy costs, recruitment costs, and education costs. Once programs are implemented to reduce turnover (such as improved feedback and recognition programs) the efficacy of the programs can be clearly computed by comparing the cost of implementing the program versus the savings realized in reduced turnover, thus providing chief financial officers with quantifiable proof of the program’s efficacy (p. 11).

Wieck et al. (2010) indicated that the expectations of nurses regardless of their generation, expect personal attention from their managers. “Previous studies have described the twenty something generation as wanting a manager who attends to their personal needs, nurtures and supports them, provides a motivating environment, and has good people skills” (p. 8).

Wieck et al., (2010) also stressed that studies of experienced and mature nurses have shown that they, too, expect, “Personal attention from their managers. One way to position healthcare institutions to be that employer of choice may be to find ways they can provide generation specific satisfaction and fulfillment to their nurse employees” (p. 8).
Micromanagement

Dubrin (2007) defined micromanagement as “the close monitoring of most aspects of group member activities” (p. 271). Goleman et al. (2002) argued that excessive control of an employee can, “undermine an employee’s self-confidence and ultimately create a downward performance spiral” (p. 61). According to Mark Presutti (2006), when staff in general begins to feel anger and lose respect for their superiors due to a mistrusting, stressful, or adversarial situation, “excessive turnover may result. Indicative of this, particularly when reliable, tenured employees resign, is inconsistency of care, the most critical symptom of the revolving door syndrome” (p. 36).

Harry E. Chambers (2004) described the distrust that micromanagement produces. “Cynicism becomes rampant when a micromanager refuses to delegate or collaborate. It reinforces perceptions that micromanagers are control freaks who do not trust the people around them” (p. 60). Goleman et.al (2002) argued that micromanagement encourages an employee to “believe that the leader sees them as mere tools for accomplishing tasks, which makes them feel underappreciated rather than motivated” (p. 62).

Stephen Covey (1991) indicated that micromanagement “reflects what many see as a conflict between the need for operational integrity and the benefits of greater self-supervision” (p.211). Dubrin (2007) echoed the idea of self-supervision. Dubrin stated that a good manager must “give group members ample opportunity to manage their own activities. Avoiding micromanagement is a core ingredient of employee empowerment because empowered workers are given considerable latitude to manage their own activities” (p. 271).

Purchasing director at Blueline Distribution Inc., Jerry Weyland (2006), described micromanagement as his least favorite management style. Weyland wrote,
My personal un-favorite leadership model is that of the owner-president who feels he or she has to make every decision in the organization. We call these people micromanagers. I’m talking about a person who tells you not only why things need to be done (vision) and what needs to be done (mission), but also the who, how, when and where. As a side benefit, your micromanager also will tell you where the coats need to be hung, where the computer printers should be placed, how the paychecks should be passed out and how you must deal with the individual nuances and peculiarities of the employees in your department. Your classic micromanager will rescind your decisions, stifle new thought and generally throw a wet blanket on exciting and new ideas (p. 62).

When describing servant leadership, Covey (1994) stated, “When we’re in a formal leadership role, if we’re not into micromanaging, hovering over, checking up, and managing crises, what do we spend our time doing? We create a shared vision. We strengthen, coach, and mentor to help develop the capacities of individuals and teams. We build relationships of trust” (p. 251).

Culture of Trust

Dubrin (2007) defined trust as “a person’s confidence in another individual’s intentions and motives and in the sincerity of that individual’s word” (p. 35). Covey, Merrill, and Merrill (1994) suggested that good leaders will find ways to motivate and empower their staff, and the best way to empower employees is by building trust. Covey, Merrill, and Merrill asserted that managers who build trust must “value other people and recognize unlimited potential for third-alternative solutions. People of character are free to interact with true synergy and creativity, unrestrained by the doubt and suspicion that permeate low-trust cultures (p. 258).
Along with building a high trust culture, the managers need to realize their limitations. There is only so much that the manager can control. Joseph L. Badaracco, Jr. (2002) suggested that most leaders are modest about how much they can do and stated, “Real leaders see the big picture, pursue some compelling vision, and don’t get bogged down by day-to-day matters” (p. 175). Bozkurt and Ergeneli (2012) suggested that sharing power by delegating has been used as a means to motivate employees. The authors argued that “delegation improves the morale of employees. For example, if employees know that they will have to answer for decisions, this will improve the status of their work and provide a motivational factor” (p.583).

Mark Presutti indicated that a leader can empower his or her employees by setting clear goals. Writing to give advice to nursing home administrators, Presutti (2002) asserted,

The administrator should establish short and long term goals with department managers after enthusiastically accepting their input. Departmental goal setting must be sufficiently expansive to include staff participation at all levels. Encouraging independence in achieving those goals and providing and eliciting positive feedback about this at regular, but limited, intervals will enhance confidence and reestablish motivation, initiative, and productivity throughout the facility. Staff members may now initiate broader task completion and confidently address issues with supervisors and public health auditors without fear of disciplinary reproach. All staffers and the organization as a whole will reap the benefits and ultimately secure that critical element of collaborative teamwork (p. 37).

Covey (1991) wrote that a good manager must let the employee know what is expected. Covey suggested that managers should be specific about results, quantity, and quality of the work. Discussion must be made describing the expected results. Covey purported, “Set target
dates or timelines for the accomplishment of your objectives. These objectives essentially represent the overlap between the organizational strategy, goals, needs, and capabilities.” (p. 192).

Dubrin (2007) asserted that a leader can avoid micromanaging by setting an example to his or her reports. Dubrin explained, “Actions and words confirm, support, and often clarify each other. Being respected facilitates leading by example because group members are more likely to follow the example of leaders they respect” (p. 236).

Self-supervision should be the goal of a good manager. Covey (1991) argued that self-supervision should “become the practical process in which individuals plan, execute, and control their own performance within the agreement. Win-win facilitates effective autonomy in which individuals have access to the primary elements of empowerment, knowledge, skill, desire, and opportunity.” (p. 214). Farr-Wharton, Brunetto, and Shacklock (2012) agreed that true empowerment comes by allowing employees to take more control of their work, “their general ability to do things successfully. It hinges on supervisors releasing control and encouraging employees to take responsibility for making decisions related to the job, thereby increasing the meaning of work for them and their level of competence” (p.1394).

Servant Leadership

Sandra Swearingen (2004) found that there were no difference in the needs of the baby boomer nurses and the generation X nurses. The study concluded that “what the nurses wanted most was Servant-Leadership” (p. 139). Servant Leadership is described by Borek, Lovett, and Towns (2005) as “those who recognize that the real secret of leadership is found in identifying the needs of others and ministering to them. This leader believes people will follow if their leader is meeting their needs” (p. 209-210).
Swearingen (2004) found that a positive perception of nursing leadership characteristics had a positive impact in relation to the retention of nurses in an organization. Swearingen observed, “The presence of Servant leadership characteristics demonstrated a positive impact on nursing job satisfaction and nurse retention. Those leaders that demonstrate Servant-leadership characteristics result in increased job satisfaction for their employees and increased nurse retention for their organizations” (p. 139).

Elaine S. Marshall (2011) indicated that all leadership is about serving others. Marshall argued,

As a leader in health care, servant leadership has significant meaning. Never forget that after all the theories, structures, and processes, health care is about promoting health and caring for the suffering. Health care happens with patients and their families. As a leader, if you do not serve patients and families by your own direct care, you serve someone who does. All leadership is ultimately about serving those who promote health and care for others who suffer (p. 19).

Covey, Merrill, and Merrill (1994) asserted that servant leadership can create cynicism in the absence of the conditions of empowerment. The authors asserted, “But when the conditions of empowerment are in place, servant leadership creates powerful results” (p. 209). Shekari, and Nikooparvar (2012) agreed that the servant leader must incorporate the ideals of empowerment and wrote that this model of leadership “emphasizes increased service to others; a holistic approach to work; promoting a sense of community; and the sharing of power in decision making. Servant-leaders must be value and character-driven people who are performance and process oriented” (p.54).
James M. Kouzes and Barry Posner (2007) echoed that servant leaders must create a climate of collaboration, and “they need to determine what the group needs in order to do their work and to build the team around common purpose and mutual respect. Leaders put trust and team relationships on the agenda; they don’t leave it to chance” (p. 223). By building team relationships, the servant leader instills a sense of community. Shekari and Nikooparvar (2012) argued, “The servant leader will seek to identify some means for building community among those who work within a given institution. Servant leadership suggests that true community can be created among those who work in businesses and other institutions” (p. 60).

The servant leader also has a quality of connecting with their team. James L. Garlow (2002) wrote, “Connectivity is about caring, about reaching out. It is about valuing people (yes, valuing them even more than yourself). It is about adding greater value to the lives of other people” (p. 133). Shekari and Nikooparvar (2012) stressed that servant leadership differs from other models of leadership “in that it focuses on leaders meeting the needs of followers, in that, if followers are treated as ends in themselves, rather than means to an end, they will reach their potential and so perform optimally” (p. 56). Peter Northouse (2007) agreed that servant leaders must focus on the needs of the followers. Northouse further asserted, “The way a person emerges as a leader is by first becoming a servant. A servant leader focuses on the needs of followers and helps them to become more knowledgeable, more free, more autonomous, and more like servants themselves” (p. 349).

Mentoring/Coaching

In their book *Primal Leadership*, Goleman, Boyatzis, and McKee (2002) define coaching as helping people identify their unique strengths and weaknesses and tying those to their personal and career goals. Goleman et al. argued, “They encourage employees to establish long-term
development goals, and help them to conceptualize a plan for reaching those goals, while being explicit about where the leader’s responsibility lies and what the employee’s role will be” (p. 60-61). Goleman et al. (2002) emphasized the importance of allowing employees to explore their own goals and stated that a leader should “act as a counselor, exploring employees’ goals and values and helping them expand their own repertoire of abilities” (p. 62).

Block, Claffey, Korrow, and McCaffrey (2005) suggested that nursing mentorship is defined as a relationship between two nurses formed on the basis of respect and compatible personalities “with the common goal of guiding the nurse towards personal and professional growth. Mentorship incorporates support, guidance, socialization, well-being, empowerment, education, and career progression. Stated simply, mentoring creates a supportive environment in which nurses want to come to work” (p. 134-135).

Preceptor Program

Some hospitals such as the University of Michigan Health System (UMHS) have developed preceptor programs. These programs pair stable and experienced nurses with new hires. The experienced nurses act as coaches for the new hires. The preceptor programs have also been used in nurse retention plans. UMHS demonstrated that nurse preceptor programs assisted in lowering the nurse turnover rate. Block et al. stated, “Two preceptor action days (PAD) were planned, which focused on career enhancement, new skill development, and professional collaboration. The first PAD had 135 participants and included topics such as institutional preceptor expectations, teaching techniques, and understanding an orientee’s perspective” (p. 138).

After the PAD program developed, UMHS noted an increase in nurse retention. Block et al., (2005) continued,
In the months following the PADs, there was a decrease in the turnover rate from 13 to 11%. The UMHS retention plan acknowledged the contribution of nursing preceptors, built meaningful institutional relationships, strengthened support for new hires, and facilitated educational growth. Although the study did not indicate any negative aspects of the PADs, the concept of utilizing recognition to bolster nurse retention and professional development is logical. Preceptor initiatives that allow for growth of mentorship for new hires is a prized concept that positively affects staff satisfaction and ultimate nurse retention, which translates into cost savings for an institution (p. 138).

Transformational/Transactional Leadership

Kouzes and Posner (2007) argued, “Transformational leadership occurs when, in their interactions, people raise one another to higher levels of motivation and morality. Their purposes, which might have started out as separate but related, as in the case of transactional leadership, become fused” (p. 122). Dubrin (2007) asserted that the transformational leader, “Helps bring about major, positive changes by motivating group members beyond their self-interests and toward the good of the group, organization, or society” (p. 84).

Transformational leadership recognizes the importance of coaching/mentoring behavior. Shiparski agreed that mentoring and coaching are essential elements of transformational leadership. The hospital environment of today requires managers who have the ability and desire to coach and mentor staff (Shiparski, 2005). Transformational leaders prefer to coach staff rather than control their behaviors (Bass, 1998). In doing so, they create a supportive climate where individual differences are recognized, two-way communication is promoted, and effective listening skills are valued (Bass, 1998).
Nurse Managers can play a significant role in guiding and supporting floor nurses as their coaching skills evolve. McGuire and Kennerly (2006) argued that nurse executives who hire and retain nurse managers that are transformational leaders will have a more committed workforce and will maintain a healthier work environment. To develop a committed nursing staff, McGuire and Kennerly suggested that nurse management positions be filled with individuals who can demonstrate a balance of leadership characteristics which are more transformational than transactional. “Employing charismatic nurse managers who have high ethical and moral character and integrity and exhibit risk-taking behaviors is an absolute plus at a time when corporate compliance, conflict of interest, and unethical business practices are scrutinized closely” (p. 185).

Elaine S. Marshall (2011) agreed that transformational nurse managers must give their reports individual attention. Marshall writes,

The transformational leader has a kind of humility that looks beyond self to the mission of the organization and the value of the work of others. He or she uses many professional skills, including listening, coaching, empathy, support, and recognition of the contributions of followers. The transformational leader enables others to act toward a shared vision. The effective leader recognizes and promotes the contributions of others and creates a culture of sharing, celebration, and unity within the entire team. Who gets the credit is less important than how team members affirm the work of each other (p. 5).

Deborah L. Rhodes (2006) discussed the differences in transactional and transformational leadership. She stressed that transactional leadership involves an exchange relationship between leaders and followers, who cooperate on the basis of self-interest in pursuit of mutual gains. Rhodes wrote that in transformational leadership, “leaders and followers raise one another to
higher levels of motivation and morality, beyond everyday wants and needs. They aspire to reach
more principled levels of judgment in pursuit of end values such as liberty, justice, and self-
fulfillment” (p. 6).

Craig E. Johnson (2009) agreed that transformational leadership seeks to meet the higher
needs of employees. Johnson stated, “Transactional leaders appeal to lower-level needs of
followers, that is, the need for food, shelter, and acceptance. They exchange money, benefits,
recognition, and other rewards in return for the obedience and labor of followers; the underlying
system remains unchanged” (p.169). McGuire and Kennerly (2006) suggested that
transformational leaders “stimulated follower commitment to a shared vision and goals.
Followers were stimulated to approach old problems in new ways” (p.180).

The Characteristics of Transformational Leadership

Johnson (2009) described the four characteristics of transformational leadership. He
identified the first characteristics as “idealized influence. Transformational leaders become role
models for followers who admire, respect, and trust them. They put followers’ needs above their
own, and their behavior is consistent with the values and principles of the group” (p. 169).

The second characteristic of transformational leadership is described as “inspirational
motivation. Transformational leaders motivate by providing meaning and challenge to the tasks
of followers. They arouse team spirit, are enthusiastic and optimistic, and help followers develop
desirable visions for the future” (Johnson, 2009, p. 170).

Johnson identified the third characteristics as,

Intellectual stimulation. Transformational leaders stimulate innovation and creativity.
They do so by encouraging followers to question assumptions, reframe situations, and
approach old problems from new perspectives. Transforming leaders don’t criticize mistakes but instead solicit solutions from followers (Johnson, 2009, p. 170).

The final characteristic is identified as,

Individualized consideration. Transformational leaders act as coaches or mentors who foster personal development. They provide learning opportunities and a supportive climate for growth. Their coaching and mentoring are tailored to the individual needs and desires of each follower (Johnson, 2009, p. 170).

Mary Atkinson Smith (2011) stated that transformational leadership is a must for nurses in the ever changing healthcare environment. Smith argued that due to the ever changing nature of this country's healthcare system, it's important for nurse managers to develop a transformational leadership style, which encourages adaptation to change. Transformational leadership allows for the recognition of areas in which change is needed and guides change by inspiring followers and creating a sense of commitment to the organization. Smith suggested, “Adopting the qualities of a transformational leader will allow nurse managers to feel more comfortable and confident when engaging in the development of healthcare policies, the ever-changing components of healthcare technology, and the mentorship of new graduate nurses” (p. 44).

The benefits of the transformational leader in a healthcare organization include promoting teamwork, encouraging positive self-esteem, motivating staff to function at a high level of performance, and empowering staff to become more involved in the development and implementation of policies and procedures. The traits of a transformational leader are very important for new nursing graduates. Smith (2011) argued, “A transformational leadership presence is vital, especially in clinical areas where new graduate nurses are present.
Transformational leadership qualities promote a healthy environment for employees and staff, which will produce improved staff satisfaction, retention, and patient satisfaction” (p. 44).

Marshall agreed that transformational leadership is important for new nurses. Marshall (2011) asserts, “The leader must consider a logical succession plan in developing tomorrow’s nurse leaders and demonstrate competencies and skills as a mentor, coach, role model, and preceptor. The leader teaches by example and fosters continual growth” (p.73).

Laissez Faire Leadership

According to the Nursing Administration Handbook (1997), the term laissez faire was originally coined for the doctrine that government should not interfere with commerce. It is sometimes called “free rein.” Under such leadership, subordinates are permitted to function within the limits set by the manager’s own supervisor. Rowland and Rowland (1997) wrote, “There is no interference within the group by the manager, who, although participating in the decision making, attempts to do so with no more influence than any other member of the group. The subordinates basically have complete freedom in making decisions, with minimum participation by the manager” (p. 9).

According to McGuire and Kennerly (2006), the Laissez Faire leadership style is ineffective. They further explained that laissez faire leadership basically indicates an absence of leadership. When this leadership style is used, nothing happens. Decisions are not made, actions are not carried out, and responsibilities are ignored (Bass, 1998). McGuire and Kennerly (2006) reported, “There is no significant purposeful interaction between the leader and employees, so a group of followers does not form. Laissez faire leadership is ineffective in promoting purposeful interaction and contributes to the organization’s demise” (p. 182).
Bass echoed that the Laissez faire model is an absence of leadership. Bass described the
Laissez faire style of leadership as “the avoidance of leadership, such as absent when needed,
and takes no action even when problems become chronic was strongly associated with
subordinate dissatisfaction, conflict, and ineffectiveness” (Bass, 1999, p. 21).

Bass (1998) indicated that a balance between transformational and transactional
leadership is an effective leadership style. This form of leadership can lead to a stronger
commitment to the organization. Bass’ research also indicated that the effective leader achieves a
balance between transformational and transactional behaviors, thus creating a leadership style
that matches the needs of followers. The leader can then help followers to realize greater
stressed,

Followers who feel more self-confident and involved, have a sense of belonging, and
share a common sense of direction tend to emerge as committed and loyal employees of
the organization. The strength or degree of this commitment is reflected by a strong value
in and acceptance of the organization’s goals and values. There is a readiness to expend
considerable effort on behalf of the organization and a strong desire to remain a member
of the organization (p. 182).

Chapter III
Methodology of Study

This chapter describes the methodology of the study and is divided into three
sections. The first section provides a description of the population who agreed to participate in
the study. The second section describes the type of research used and the survey tool that was
administered to the participants. The third section describes the procedures that were used to obtain the participants, administer the measures, and collect the data.

Description of the Population

The population for this study focused on floor nurses at a large regional hospital located in the Southeastern United States. The Participating Hospital (PH) is a 350 bed facility. The hospital employs over 2,000 individuals. The PH was founded in the early 1940’s and has grown to include a 304-bed, not-for-profit teaching hospital, and a full range of ancillary services in the region. The facility includes a state-designated Level II Trauma Center, a behavioral health center, and a primary care and urgent care network of providers. Over 2,000 babies are born and cared for at the facility each year in one of their three nurseries. Sixty-five percent of the nursing staff are associate degree level nurses and thirty-five percent are bachelor degree level nurses.

The sample for the study focused only on bedside Registered Nurses (R.N.s). The survey was completely voluntary and confidential. One hundred surveys were posted for the sample population, and the response rate was 100%. However, some participants chose not to answer particular questions. When a participant left an answer blank, the answer was not included as part of the results. Sixty-two registered nurses completed the survey.

Registered Nurses are required to have extensive training prior to employment. Nursing students must take courses in anatomy, physiology, microbiology, chemistry, nutrition, psychology and other social and behavioral sciences. A Bachelor of Science in Nursing (BSN) program of study typically takes four years to complete; Associate degree in Nursing (AND) and diploma programs usually take two to three years to complete. According to the Bureau of Labor Statistics (2012-13), “All programs also include supervised clinical experience in hospital departments such as pediatrics, psychiatry, maternity, and surgery. A number of programs
include clinical experience in extended and long-term care facilities, public health departments, home health agencies, or ambulatory (walk-in) clinics” (p. 1).

For the nursing student wishing to pursue a bachelor’s level degree, he or she would be required to take more specialized training including course work in physical and social sciences, communication, leadership, and critical thinking. Nursing schools also offer more clinical experience in nonhospital settings. “A bachelor's degree or higher is often necessary for administrative positions, research, consulting, and teaching. Generally, licensed graduates of any of the three types of education programs (bachelor's, associate’s, or diploma) qualify for entry-level positions as a staff nurse” (Bureau of Labor Statistics, 2012-13, p. 1).

Quantitative Survey Research Design

When conducting survey research, a sample of respondents are selected from the target population and interviews or surveys are conducted. McMillan and Schumacher (2010) wrote, “Interviews are conducted either by phone or face to face. Surveys are used to learn about people’s attitudes, beliefs, values, demographics, behavior, opinions, habits, desires, ideas, and other types of information” (p.235). According to Alessi and Martin (2010) during the past decade, increasing numbers of researchers have been shifting to the use of Internet-based survey methodologies from traditional recruitment strategies and paper-and-pencil data collection methods. The authors stated that the internet has become more “accessible to ordinary people, not just those who are computer savvy. In 2007, 61.7% of all U.S. house- holds had Internet access inside the home, and 71.0% had access outside the home. Furthermore, user-friendly survey software has streamlined the questionnaire design process and simplified the process of collecting and inputting data” (p. 122).
McMillan and Schumacher (2010) agreed that the pervasiveness of the Internet has encouraged researchers to use online surveys more frequently. The authors stated, “These kind of surveys may be called online electronic surveys, e-surveys, email surveys, or Internet surveys. The common feature is that the Internet is used to send the survey and usually to receive the results, as well” (p.240).

The following steps suggested by McMillan and Schumacher (2010) were used to conduct the survey:

1. Define the purpose and objectives.
2. Select resources and the target population.
3. Choose and develop techniques for gathering data.
4. Instructions. It is important to develop clear instructions for the respondent.
5. Sampling.
6. Letter of transmittal. The letter should be brief and establish the credibility of the researcher and the study.

Exit Interviews.

In December, 2012, exit interviews were developed and conducted by the Human Resources Department of the PH in an attempt to understand the reason for high nurse turnover at their facility. The exit interviews were completely voluntary. The exit interviews consisted of 10 open-ended questions pertaining to the reasons the employee was resigning from her position. RNs were asked to complete the exit interviews after their resignation was received. All resigning nurses were asked to take the exit interview in person or by phone. The exit interviews were given to the researcher for review in March, 2013. The exit interview tool is not necessarily a valid and reliable research tool. It was devised by the hospital and has not
been tested for reliability or validity. However, the exit interviews were utilized as a means to gain further insight into the retention problem. The exit interviews were reviewed prior to the administration of the Multifactor Leadership Questionnaire (MLQ) survey.

Research Survey Tool

The MLQ contained 45 questions which covered nine conceptually distinct leadership factors and three leadership outcomes. Five scales were identified as characteristic of transformational leadership (Idealized influence attributed and behavior, Inspirational motivation, Individual consideration, and Intellectual stimulation). Three scales were defined as characteristic of transactional leadership (Contingent reward, Management-by-exception-active, and Management-by-exception-passive). One scale was described as non-leadership (Laissez-faire).

The Multifactor Leadership Questionnaire (MLQ [5X-Short]) developed by Bass and Avolio (1999) offers many advantages to this study and was used to rate and measure the nursing staff’s perception of the leadership style of the nurse managers at the PH. The results were also used to identify the range of management styles that are perceived by the nursing staff. The survey results were compared to the MLQ national average. According to Avolio and Bass(2004),

At the ineffective end of the range, the MLQ assesses perceptions of leadership behaviors that represent avoidance of responsibility and action. This is called Laissez Faire leadership. At the most effective end of the range, the MLQ assesses perceptions of leadership behaviors that generate the higher order developed and performance effects, which is called transformational leadership. The range of ineffective and effective leadership behaviors in the MLQ is typically much broader than other leadership surveys.
commonly in use. Therefore, the MLQ is more suitable for administration at all levels of organizations and across different types of production, service, and military organizations. The use of the MLQ has many advantages. One of the principal ones is its 360° capabilities. It can be used to assess perceptions of leadership effectiveness of team leaders, supervisors, managers, and executives from many different levels of an organization. For example, the leadership behaviors of a non-supervisory project leader can be observed by his or her co-workers, or the leadership behaviors of a CEO can be observed by his or her senior vice presidents and board members. The MLQ can also be used for ratings of leaders from peers or direct reports in any organization or industry. Also, considerable evidence has been accumulated indicating that the MLQ factors can be universally applied across cultures. Even clients or customers can serve as sources of MLQ ratings (p. 4).

The MLQ Survey provides a five point Likert-scale for rating the frequency of observed leader behaviors. The survey questions request answers based on a ratio of 4:3:2:1:0. The six-factors to be measured and their operational definitions are provided below:

**Rating Scale for Leadership Items**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
</tr>
<tr>
<td>1</td>
<td>Once in a while</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes</td>
</tr>
<tr>
<td>3</td>
<td>Fairly often</td>
</tr>
<tr>
<td>4</td>
<td>Frequently, if not always</td>
</tr>
</tbody>
</table>
Validity

Bass and Avolio (1999) stressed that The Multifactor Leadership Questionnaire (MLQ (5X-Short) has been a reliable research tool. The MLQ has been used in military and civilian organizational studies. The current version of the MLQ has been translated into thirteen languages. Bass and Avolio (1999) asserted that “the latest version of the MLQ, Form 5X, has been used in nearly 300 research programs, doctoral dissertations and masters theses around the globe in the nearly ten years between 1995 and 2004” (p. 33).

(Kirkbride, 2006) stated that “the MLQ is the most widely used instrument to assess transformational leadership theory” (p.23). (Ozaralli, 2003) argued that the MLQ “is considered the best validated measure of transformational and transactional leadership” (p. 338). Armstrong and Muenjohn (2008) concluded that researchers could be confident in using the MLQ because the survey “is successful in adequately capturing the full leadership factor constructs of transformational leadership theory” (p.10).

Avolio, Bass, And Jung (1999) established the reliability of the MLQ by using a relatively large sample “in the initial set of analyses (N=1394)” (p. 449). The MLQ scales exhibited high internal consistency and factor loadings. Avolio and colleagues reported reliabilities for total items and for each leadership factor scale that ranged from 0.74 to 0.94. Den Hartog, Van Muijen and Koopman (1997) researched the internal consistency of the MLQ subscales. Their participants consisted of approximately 1200 employees from, “two commercial businesses, two welfare institutions, two health-care organizations, one local government organization, and two departments of air traffic control” (p. 23). Cronbach’s Alpha coefficient for the subscales of transformational leadership ranged from 0.72 to 0.93 and transactional leadership ranged from 0.58 to 0.78.
Measured Leadership Styles.

Idealized Influence is described when a leader is a role model for his/her followers and encourages the followers to share common visions and goals by providing a clear vision and a strong sense of purpose. Inspirational Motivation represents behaviors when a leader describes the importance of desired goals in simple ways, communicates high level of expectations and provides followers with work that is meaningful and challenging. Intellectual Stimulation refers to leaders who challenge their followers’ ideas and values for problem solving. Individualized Consideration refers to leaders who spend more time teaching and coaching followers by treating followers on an individual basis.

In contrast to transformational leadership, transactional leadership is mainly based on contingent reinforcement. Three components of transactional leadership were identified. Contingent Reward refers to an exchange of rewards between the leaders and followers in which effort is rewarded by providing rewards for good performance or threats and disciplines for poor performance. The leader who relies heavily on Management-by-Exception (Passive) intervenes with his or her group only when procedures and standards are not met. In contrast, Management-by-Exception (Active) leaders are characterized as monitors who point out mistakes. The last leadership behavior is Laissez-faire or non-leadership that is exhibited when leaders avoid clarifying expectations, addressing conflicts, and making decisions. This style is basically a lack of leadership.

Interviews.

In July, 2012, informal phone interviews were conducted with current and former nurses at the PH. The nature of the study was explained to the nurses, and plans to use the results for
this study were stressed. The interviewees were informed that their identity would remain anonymous.

A set of 6 questions was asked and responses were recorded regarding the individuals experience at the PH. For the convenience of the participants, all interviews with the exception of one were conducted by phone.

Procedures to Obtain Participants

Prior to the collection of the data, permission was requested from Mind Garden, Inc. to administer the Multifactor Leadership Questionnaire Rater Only survey. On February 26, 2013, permission was given by Mind Garden to administer the survey to up to 100 participants. In February, 2013, the researcher contacted the PH to request permission to conduct the study at their facility. An agreement was made the human resources department that the PH would remain anonymous as would the participants of the survey.

On March 12, 2013, the PH Institutional Review Committee granted written permission to conduct the survey. A letter was provided to the PH to send to potential participants. The letter indicated (1) that participation in the survey was completely confidential, (2) the survey had been approved by the administration at the hospital, (3) the study would require less than 20-25 minutes to complete, (4) the survey would ask the participant to rate the management style of his immediate nurse manager, (5) no names would be listed on the survey, (6) the survey was being conducted electronically, and (7) a coding system would be used to protect the confidentiality of the volunteers. A link was provided on the letter for the participant to access the survey on the Mind Garden website. The letter was sent by email to all bedside nurses in the facility through the hospital intranet. The survey was available for approximately one month in the spring of 2013.
One hundred nurses responded to the survey; however, only sixty-two nurses completed the survey. Some chose not to answer particular questions. When a participant left an answer blank, the answer was not included as part of the results.

Face-to-Face Interviews

In July, 2012, face-to-face interviews were conducted with nursing educators in the Northwest Georgia area. The researcher devised a questionnaire of eight questions related to nurse retention. Requests for interviews were made at all four nursing schools in the Rome, GA. area. Of the four schools, two agreed to do an interview. One interview was conducted in person at the Berry College Campus. The other was conducted by phone. These interviews were conducted to get a better understanding of the manager role and how this role affects the nurse turnover rate. The interviews were recorded with a mini cassette recorder.

Following the interview, the data was transcribed and provided to the interviewee for his inspection, correction, and approval. Any further comments by the participant were added at this stage. Field notes were made prior to and after each interview.

Limitations of the Study

One of the limitations of the study relates to the generalizability of the sample. The sample is of a large regional medical center, located in the Southeastern United States, which may lead to an inability to generalize the data to other groups in others areas. In addition, the hospital is a not-for-profit organization and this may impact the findings in relation to for-profit healthcare organizations. The study may also lead to an inability to generalize the findings to areas that have experienced the down turn of the economy in a much more severe fashion. It must also be mentioned that the exit interviews conducted by the PH may not be a reliable and valid research instrument.
Analysis of Data

Data Organization

Using an Excel spreadsheet, the data was analyzed to sum the responses for each of the 45 questions by response (blank, zero, one, two, three, or four), and these responses were then summed into aggregate values corresponding to the correspondence of questions to Characteristic/Scale Name designations (IA, IB, IM, IS, IC, CR, MBEA, MBEP, LF, EE, EFF, and SAT) according to the mapping provided with the Multifactor Leadership Questionnaire documentation. The aggregate data for each Scale was then converted into mean scores by dividing the aggregate score for each Scale by the total number of (non-blank) responses for all of the questions related to that Scale. The resulting value represents a mean response score on the scale of values ranging from zero to four.

Statistical Procedures

Using the self-reported answers to the MLQ Survey, these values were then compared to the table of Percentiles for Individual Scores Based on the US National Average (Bass 1999). Percentile values for each Scale was then determined via linear interpolation using the table of values provided.

Research Question 1

To investigate the first question, “In a participating hospital, what are the nurses’ perceptions of their immediate nurse manager’s leadership style?” the items were grouped by scale measuring the participants perception of Transformational leadership characteristics of their immediate manager. The scales measuring Transformational leadership were, IA, IB, IM, IS, and IC. The scales measuring the perceived Transactional leadership style of the nurses’ immediate manager were also grouped. The Transactional Scales were CR, and MBEA. The
scales measuring the perceived Passive/Avoidant leadership traits were also grouped. These scales were MBEP, and LF.

Once the scales were grouped according to the MLQ Manual (p.106) the average was calculated by scale. (Example: The items which are included in the Individualized Influence are questions 10, 18, 21, and 25). The scores for each response was added and divided by the total number of responses for that question.

The results of the scores were compared to the table of Percentiles for Individual Scores Based on the US National Average (Bass 1999). The leader or group of leaders were then identified as (for example) more transformational than the norm, or less transactional than the norm.

Research Question 2

To investigate the second question, “Is nurse managers’ leadership style affecting nurse retention in the participating hospital?” The perceived Outcomes of Leadership by the participants (Scales, EE, EFF, and SAT) were grouped by scale measuring the participants’ perception of their immediate manager’s ability to motivate, interact with, and how satisfied the raters were with their leader’s methods of working with others. Once the scales were grouped according to the MLQ Manual (p.106) the average was calculated by scale.

The results of the scores were compared to the table of Percentiles for Individual Scores Based on the US National Average (Bass 1999). The overall satisfaction of the perceived leadership style of the nurses’ managers’ was then identified as more satisfied than the norm, or less satisfied with the leadership than the norm.

The Mann-Whitney-Wilcoxon U Test
In order to test whether the differences in the sample and the national average were significant, the Mann-Whitney-Wilcoxon (MWW) (Clarifico & Perla, 2008). de Winter and Dodou (2012) conducted a study on five point Likert scales and whether the data should be analyzed with parametric statistics such as the \( t \) test or nonparametric statistics such as the rank-based MWW. de Winter and Dodou concluded that “the \( t \) test and MWW generally have equivalent power” (p.6). The hypotheses to be tested by the MWW are listed below.

1. **Transformational Leadership**:

   A. Bass (1999) stressed that Transformational Leadership is the process of influencing in which leaders change their associates’ awareness of what is important, and move them to see themselves and the opportunities and challenges of their new environment in a new way. In the MLQ, this type of leadership is quantified using five Likert scales: Idealized Attributes (IA), Idealized Behaviors (IB), Inspirational Motivation (IM), Intellectual Stimulation (IS), and Individual Consideration (IC). The metric used to quantify the study participants’ perception of their leaders with respect to this type of leadership is the average of all of the responses on these five scales. This average is then compared to the National Average for the same scales.

   B. The Hypotheses are:

   \[ H_0: \text{Mean of the Sample} = \text{National Mean} \]

   \[ \text{vs. } H_a: \text{Mean of the Sample} < \text{National Mean} \]

2. **Transactional Leadership**
A. Bass (1999) argued that Transactional Leaders display behaviors associated with constructive and corrective transactions. In the MLQ, this type of leadership is quantified using two Likert scales: Contingent Reward (CR) and Management by Exception (MBEA). The metric used to quantify the study participants’ perception of their leaders with respect to this type of leadership is the average of all of the responses on these two scales. This average is then compared to the National Average for the same scales.

B. Hypotheses to be Tested are:

\[ H_0: \text{Mean of the Sample} = \text{National Mean} \]
\[ \text{vs. } H_a: \text{Mean of the Sample} > \text{National Mean} \]

3. Passive Avoidant Behavior

A. Bass (1999) stated that Passive/Avoidant Behavior is characterized by a leadership style that is more “passive” and reactive in nature. In the MLQ, this type of leadership is quantified using two Likert scales: Management by Exception: Passive (MBEP), and Laissez-Faire (LF). The metric used to quantify the study participants’ perception of their leaders with respect to this type of leadership is the average of all of the responses on these two scales. This average is then compared to the National Average for the same scales.

B. Hypotheses to be Tested are:

\[ H_0: \text{Mean of the Sample} = \text{National Mean} \]
\[ \text{vs. } H_a: \text{Mean of the Sample} \neq \text{National Mean} \]

4. Outcomes of Leadership
A. Bass (1999) wrote that Transformational and transactional leadership are both related to the success of the group. In the MLQ, success is measured by how often the raters perceive their leader to be motivating, how effective they perceive their leader to be interacting at different levels of the organization, and how satisfied they are with their leader’s methods of working with others. In the MLQ, this type of leadership is quantified using three Likert scales: Extra Effort (EE), Effectiveness (EFF), and Satisfaction with the Leadership (SAT). The metric used to quantify the study participants’ perception the Outcomes of Leadership is the average of all of the responses on these two scales. This average is then compared to the National Average for the same scales.

B. Hypotheses to be Tested are:

\[ H_0: \text{Mean of the Sample} = \text{National Mean} \]
\[ \text{vs. } H_a: \text{Mean of the Sample} \neq \text{National Mean} \]

Statistical Methodology for the MWW U Test

de Winter and Dodou (2012) suggested that Likert scales are, by nature, non-parametric. That is, they do not correspond directly to a statistical parameter. In spite of this, there are a number of well-developed tests that can be used in this situation. Specifically, the Mann-Whitney U, the Wilcoxon rank-sum test, or the Wilcoxon-Mann-Whitney test is used here. The Mann-Whitney U test the null hypothesis that two populations have the same set of measures versus the alternative that one population tends to have larger (or smaller) values. Once the null and alternative hypotheses have been tested with this procedure, a z-test will be used to further investigate any specific differences found in the two populations (since the distributions under
the null hypotheses for the components of the MLQ are well documented, including extensive data regarding the respective standard deviations, the z-test can be used here) (de Winter and Dodou 2012).

Calculations:

dé Winter and Dodou (2012) asserted that this test requires the calculation of a statistic, called U that has a distribution under the null hypothesis that is known. In this case, Minitab statistical software was used to calculate the U test statistic and to assign the relevant p-values. Assumptions:

1. Observations obtained from the two groups are independent of each other.
2. Responses are ordinal (that is for any two observations, one can say which is greater).
3. Under the null hypothesis, the distributions of both groups are the same.
4. Under the alternative hypothesis, the probability that one distribution is greater than another is greater than 0.5.

The next chapter will review the results from the interviews, MLQ Survey, and the MWW U Test. Scores that appeared to be significantly different from the National Average were subjected to a z-test to further investigate any specific differences found in the two samples.

Chapter IV

Results

Exit Interviews

Exit interviews were conducted by the Nursing Recruitment and Retention Specialist at the PH. She indicated that the hospital had only recently begun a retention program at the hospital. She also stated that, “We only began doing exit interviews this year. Many of them seem to indicate a problem with the nurse’s immediate manager” (Anonymous, personal
communication, January 30, 2013). After reviewing the eleven voluntary exit interviews, it was found that one nurse had gained new employment at another facility, one left due to unspecified health problems, one identified family issues for leaving the PH, one had relocated, and one had to leave because of the excessive drive to the PH.

Over fifty percent of the exit interviews identified management related problems including poor staffing practices, inability to communicate with manager, and concern about unprofessional behavior of staff and manager. The majority of the complaints about management came from RNs who had been at the PH for less than a year.

The former and current RNs for the PH were asked if they had experienced any effects of a nursing shortage. One nurse stated, “It was evident by our not being allowed to take vacation time. There was also too large of a nurse to patient ratio. It was very difficult to provide quality care because of the number of patients. I finally left when they refused to change my shift so I could care for my mother who had become ill” (Anonymous, personal communication, July 31, 2012).

One nurse stated during the exit interview that his supervisor was only available by text and

Had requested to be off for daughter’s graduation over a month in advance but not granted. Had concerns regarding preceptor but never had a chance to discuss with supervisor because preceptor was always present. Never received feedback or recognition and was ridiculed in front of peers by preceptor who was unprofessional (Anonymous exit interview 2013).

When asked to describe the emotional work environment the nurse wrote, “Stressful. Co-workers complained about schedule, a lot of negativity from other nurses, felt like it would never
get better, never staffed well, never received requested time off, nurses were overloaded to keep from calling in help and having to pay extra—more worried about budget than well-being of nurses at work” (Anonymous exit interview 2013).

The other five participants in the exit interviews wrote similar responses. The responses included concern about unprofessional behavior of staff/manager and:

- Scheduling conflicts, unable to communicate with manager.
- Stress, patient load, scheduling, co-worker dissatisfaction.
- Poor staffing by management.
- Understaffed unit and could confusing processes.

The work environment described in the exit interviews is completely opposite of what Cowden et al. (2011) described as a positive work environment. The positive work environment involves nurses employed in environments where they feel supported by their leaders and peers and are recognized and valued for their contributions, and encouraged to participate in decision making were “generally more likely to remain in their positions, were more satisfied and more committed to the organization” (p.475).

The exit interviews also indicated poor communication between the nurse and his manager. The nurses discussed their inability to communicate with their manager. Marshall (2011) indicated that, “listening is often more important and effective than speaking. Often problems are solved simply by listening. Successful listening simply requires that people feel heard” (p. 107).

_Nurse Educator Interviews_

Prior to conducting the survey, interviews were conducted with nursing educators, hospital nurses, and nurse retention specialist to validate information found in the review of the
literature. It was also important to measure the impact of the nurse retention problem on a local basis.

An interview was conducted with Roxanne Johnston, Assistant Professor at the Shorter University School of Nursing. Professor Johnston agreed that the nursing shortage is a real problem. Johnston stated, “The baby-boom generation is retiring and that includes a lot of nursing staff as well. Advances in the medical field have resulted in people living longer, older, and having other long-term illnesses that require more hospital treatment” (R. Johnston, personal communication, July 30, 2012).

According to Dr. Vanice Roberts, Dean of the Berry College School of Nursing located in Rome, GA., Egenes (2012) was correct that nursing schools are unable to meet the demand for nurses. Roberts stated,

Schools aren’t able to meet the demand needed to fill nursing jobs. It is difficult to get clinical placements because hospitals can take ten nursing students instead of twenty at a time. There is also a shortage of nursing school faculty who are qualified to teach the nursing students. A high level nurse instructor can make $90,000 a year at a large hospital or business as opposed to making $54,000 a year at a college (V. Roberts, personal communication, July 26, 2012).

The exit interviews also suggested that individual consideration from the manager was lacking for these nurses. Vanice Roberts indicated that nurse managers must get to know their nurses on an individual basis. Roberts stated, “It’s a must to know your nurses individually. You may have a nurse that has been an exceptional employee and suddenly her performance drops. If you know the nurse individually, you may have known that her husband had recently been
deployed by the military. By knowing your nurses as individuals you may be able to anticipate issues that could arise that affect job performance” (V. Roberts)

Roxanne Johnston agreed that nursing schools are unable to keep highly trained faculty. Mrs. Johnston stated in her interview, “Nursing schools are going to have to be more competitive in the future with salary in order to meet the demand that the medical community has for nurses. Without this the nurse retention problem will only increase especially as we see the baby-boom nurses retiring” (R. Johnston).

McGlynn, Griffin, Donahue, and Fitzpatrick, (2012) had indicated job satisfaction and respect were very important to the nurses in determining whether to stay at their current facility. Dr. Roberts stated, “I think the key factor in retaining a nurse is the hospital providing avenues for job satisfaction, respect, and good nurse/physician relationships” (V. Roberts). Professor Roxanne Johnston echoed the importance of job satisfaction and respect, “Job satisfaction certainly plays a role. A nurse wants to be respected and have good relationship with the physicians. A lot of tension can develop between a nurse and a physician. If the physician does not treat the nursing staff well this creates tension in the organizational climate” (R. Johnston).

Interviews were conducted with anonymous former nurses at the PH. They were asked why they left their position at the hospital. One RN responded, “The environment at the hospital was very rigid and controlling. The managers showed favoritism to some employees” (Anonymous, personal communication, July 31, 2012). Another RN stated, “There was no communication with upper management. The upper management was buffered from the floor nurses. We earned time off but could never take it due to the shortage. The only way to get a day off was to call in sick” (Anonymous, personal communication, July 31, 2012).
Below are the turnover rates provided by the PH. The PH has a much higher turnover rate than the national average.

Table 1

Nurse Retention Rates for Participating Hospital

<table>
<thead>
<tr>
<th>2012</th>
<th>jan</th>
<th>feb</th>
<th>mar</th>
<th>apr</th>
<th>may</th>
<th>jun</th>
<th>jul</th>
<th>aug</th>
<th>sep</th>
<th>oct</th>
<th>nov</th>
<th>dec</th>
<th>ytd totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>total rns</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
<td>640</td>
</tr>
<tr>
<td>rn terms</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>13</td>
<td>119</td>
</tr>
<tr>
<td>turnover</td>
<td>0.007</td>
<td>0.012</td>
<td>0.016</td>
<td>0.023</td>
<td>0.019</td>
<td>0.017</td>
<td>0.020</td>
<td>0.011</td>
<td>0.014</td>
<td>0.016</td>
<td>0.009</td>
<td>0.020</td>
<td>0.19%</td>
</tr>
</tbody>
</table>

The significance of this data is the fact that the national average retention rate for Registered Bedside Nurses is 11.2%. According to Colosi (2012) the average retention rate for the South East Region is 10.8%. The retention rate for the participating hospital is 19%.

Table 2

National/Southeast/PH Retention Rates

<table>
<thead>
<tr>
<th>Nurse Retention National Average</th>
<th>Nurse Retention South East Average</th>
<th>Participating Hospital Nurse Retention Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.20%</td>
<td>10.80%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Review of the Data

Data Analysis Calculation Methodology:

Using an Excel spreadsheet, the data was analyzed to sum the responses for each of the 45 questions by response (blank, zero, one, two, three, or four), and these responses were then summed into aggregate values corresponding to the correspondence of questions to Characteristic/Scale Name designations (IA, IB, IM, IS, IC, CR, MBEA, MBEP, LF, EE, EFF, and SAT) according to the mapping provided with the Multifactor Leadership Questionnaire documentation. The aggregate data for each Scale was then converted into mean scores by
dividing the aggregate score for each Scale by the total number of (non-blank) responses for all of the questions related to that Scale. The resulting value represents a mean response score on the scale of values ranging from zero to four. These values were then compared to the table of Percentiles for Individual Scores Based on the US National Average (Bass 1999). Percentile values for each Scale was then determined via linear interpolation using the table of values provided.

The graph below shows the national average scores for the MLQ (Bass 1999).

Table 3
MLQ National Average Scores

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Scale Name</th>
<th>Scale Abbr.</th>
<th>Score</th>
<th>Percentiles for Ind Scores (Higher Level Ratings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformational</td>
<td>Idealized Attributes</td>
<td>IA</td>
<td>2.63</td>
<td>25.2</td>
</tr>
<tr>
<td>Transformational</td>
<td>Idealized Behaviors</td>
<td>IB</td>
<td>2.62</td>
<td>24.8</td>
</tr>
<tr>
<td>Transformational</td>
<td>Inspirational Motivation</td>
<td>IM</td>
<td>2.82</td>
<td>44.7</td>
</tr>
<tr>
<td>Transformational</td>
<td>Intellectual Stimulation</td>
<td>IS</td>
<td>2.29</td>
<td>33.4</td>
</tr>
<tr>
<td>Transformational</td>
<td>Individual Consideration</td>
<td>IC</td>
<td>2.29</td>
<td>21.6</td>
</tr>
<tr>
<td>Transactional</td>
<td>Contingent Reward</td>
<td>CR</td>
<td>2.65</td>
<td>32.3</td>
</tr>
<tr>
<td>Transactional</td>
<td>Mgt by Exception (Active)</td>
<td>MBEA</td>
<td>2.15</td>
<td>67.7</td>
</tr>
<tr>
<td>Passive Avoidant</td>
<td>Mgt by Exception (Passive)</td>
<td>MBEP</td>
<td>1.17</td>
<td>66.4</td>
</tr>
<tr>
<td>Outcomes of Leadership</td>
<td>Laissez-Faire</td>
<td>LF</td>
<td>1.34</td>
<td>92.6</td>
</tr>
<tr>
<td>Outcomes of Leadership</td>
<td>Extra Effort</td>
<td>EE</td>
<td>2.28</td>
<td>28.5</td>
</tr>
<tr>
<td>Outcomes of Leadership</td>
<td>Effectiveness</td>
<td>EFF</td>
<td>2.70</td>
<td>24.0</td>
</tr>
<tr>
<td>Outcomes of Leadership</td>
<td>Satisfaction</td>
<td>SAT</td>
<td>2.74</td>
<td>24.8</td>
</tr>
</tbody>
</table>

Below are the results of the administered survey conducted for this study. These are the results obtained from the PH.

Table 4
MLQ Survey Percentiles
The participants in the survey rated their immediate supervisors in the 25.2 percentile compared to the MLQ scores from the national average. The national average scored 74.8% above this percentile.

I. Transformational Leadership:

<table>
<thead>
<tr>
<th>Category</th>
<th>SAMPLE</th>
<th>NATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>2.59</td>
<td>2.94</td>
</tr>
<tr>
<td>IB</td>
<td>2.56</td>
<td>2.77</td>
</tr>
<tr>
<td>IM</td>
<td>2.82</td>
<td>2.92</td>
</tr>
</tbody>
</table>
Performing the Mann-Whitney U-test on the above measures resulted in median values of:

Table 6

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>5</td>
<td>2.8500</td>
</tr>
<tr>
<td>Sample</td>
<td>5</td>
<td>2.5600</td>
</tr>
</tbody>
</table>

Point Estimate for National Mean – Sample Mean = 0.31

96.3% Confidence Interval for National Mean – Sample Mean:

(0.0301, 0.5599)

Test of:

Sample Mean = National Mean vs. Sample Mean < National Mean

Is significant (p=0.0184 level).

II. Transactional Leadership:

Table 7

<table>
<thead>
<tr>
<th>Category</th>
<th>Sample</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR</td>
<td>2.65</td>
<td>2.87</td>
</tr>
<tr>
<td>MBEA</td>
<td>2.19</td>
<td>1.67</td>
</tr>
</tbody>
</table>

Performing the Mann-Whitney U-test on the above measures resulted in median values of:

Table 8

<table>
<thead>
<tr>
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<th>N</th>
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</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>2</td>
<td>2.270</td>
</tr>
<tr>
<td>Sample</td>
<td>2</td>
<td>2.420</td>
</tr>
</tbody>
</table>
Point Estimate for National Mean – Sample Mean = -0.150

75.5% Confidence Interval for National Mean – Sample Mean:

(-0.980, 0.680)

Test of:

Sample Mean = National Mean vs. Sample Mean > National Mean

Is not significant (p=0.5000).

III. Passive Avoidant

Table 9

<table>
<thead>
<tr>
<th>Category</th>
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</thead>
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<tr>
<td>MBEP</td>
<td>1.17</td>
<td>0.75</td>
</tr>
<tr>
<td>LF</td>
<td>1.03</td>
<td>0.67</td>
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</table>

Performing the Mann-Whitney U-test on the above measures resulted in median values of:

Table 10

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>National</td>
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<td>0.8400</td>
</tr>
<tr>
<td>Sample</td>
<td>2</td>
<td>1.1000</td>
</tr>
</tbody>
</table>

Point Estimate for National Mean – Sample Mean = -0.2600

75.5% Confidence Interval for National Mean – Sample Mean:

(-0.5200, 0.0000)

Test of:

Sample Mean = National Mean vs. Sample Mean ≠ National Mean:

Is not significant (p=0.4142)

IV: Outcomes of Leadership
Table 11

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>3</td>
<td>3.0700</td>
</tr>
<tr>
<td>Sample</td>
<td>3</td>
<td>2.6800</td>
</tr>
</tbody>
</table>

Point Estimate for National Mean – Sample Mean = 0.38

91.9% Confidence Interval for National Mean – Sample Mean:

(0.0399, 0.7101)

Test of:

Sample Mean = National Mean vs. Sample Mean ≠ National Mean

Is significant (p=0.0808)

Follow-Up Analysis

Of the four sets of null and alternative hypotheses above, only the first (Transformational Leadership) null hypotheses: The mean of the sample will be equal to the national average mean vs. alternative hypotheses: The mean of the sample will be less than the national average mean, and the last (Outcomes of Leadership) null hypotheses: The mean of the sample will be the same as the national average mean vs. alternative hypotheses: The mean of the sample will not be equal to the national average mean, resulted in rejecting the null hypotheses. Once the test established the statistical likelihood of a different distribution in each of the two populations, a more detailed analysis of the individual components that constitute each of the aggregate measures was necessary to determine a significant difference. In this case, the z test was applied individually to each component of the aggregate measures for Transformational
Leadership and Outcomes of Leadership, comparing each of the components to the known National means and standard deviations.

Follow-Up Analysis of Transformational Leadership:

Table 12

<table>
<thead>
<tr>
<th>Component</th>
<th>Sample Mean</th>
<th>National Mean</th>
<th>National Std. Dev.</th>
<th>Z-Score</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>2.59</td>
<td>2.94</td>
<td>0.76</td>
<td>-3.63</td>
<td>0.0001</td>
</tr>
<tr>
<td>IB</td>
<td>2.56</td>
<td>2.77</td>
<td>0.72</td>
<td>-2.30</td>
<td>0.0108</td>
</tr>
<tr>
<td>IM</td>
<td>2.82</td>
<td>2.92</td>
<td>0.76</td>
<td>-1.04</td>
<td>0.1500</td>
</tr>
<tr>
<td>IS</td>
<td>2.29</td>
<td>2.78</td>
<td>0.71</td>
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<tr>
<td>IC</td>
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<td>2.85</td>
<td>0.78</td>
<td>-3.84</td>
<td>0.0001</td>
</tr>
<tr>
<td>CR</td>
<td>2.65</td>
<td>2.87</td>
<td>0.70</td>
<td>-2.47</td>
<td>0.0067</td>
</tr>
</tbody>
</table>

Analysis

All of the above measures show significant differences in the direction of the null hypothesis: The mean of the sample will be the same as the National Average Mean vs. alternative hypotheses: The mean of the sample will be greater than the National Average Mean, except for IM (Inspirational Motivation).

Research Question 1

“In a participating hospital, what are the nurses’ perceptions of their immediate nurse manager’s leadership style?” Based on the analysis presented in Table 12, the participants of the survey perceived their nurse managers’ as significantly less transformational in management style than the national average. The only exception was the scale for Inspirational Motivation.

Follow-Up Analysis of Outcomes of Leadership:

Table 13
<table>
<thead>
<tr>
<th>Component</th>
<th>Sample Mean</th>
<th>National Mean</th>
<th>National Std. Dev.</th>
<th>Z-Score</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>2.37</td>
<td>2.74</td>
<td>0.86</td>
<td>-3.39</td>
<td>0.0004</td>
</tr>
<tr>
<td>EFF</td>
<td>2.70</td>
<td>3.07</td>
<td>0.72</td>
<td>-4.05</td>
<td>0.0000</td>
</tr>
<tr>
<td>SAT</td>
<td>2.68</td>
<td>3.08</td>
<td>0.83</td>
<td>-3.79</td>
<td>0.0000</td>
</tr>
</tbody>
</table>

**Analysis**

All of the measures show significant differences in the direction of the null hypothesis (Sample Mean > National Mean).

**Research Question 2**

“Is nurse managers’ leadership style affecting nurse retention in the participating hospital?” Based on the analysis presented in Table 13, all of the measures show significant differences in the direction of the null hypothesis: The mean of the sample will be the same as the mean of the National Average Mean. The participants of the survey indicated significantly less satisfaction in the overall leadership of their nurse managers compared to the national average.

**Chapter V**

**Summary and Discussion**

The problem of management style and its effect on nurse retention in the hospital setting has been investigated in this research. This final chapter of the dissertation restates the research problem and the purpose of the study. This chapter also reviews the major methods and procedures utilized throughout the study. The major sections of this chapter summarize the results and discuss the implications of the study for the PH. Finally, limitations and recommendations for further research are presented.
Statement of the Problem

The research indicated that nurse retention is a costly problem. According to the American Association of Colleges of Nursing (2010), the United States is projected to have a nursing shortage that is expected to increase as the baby-boom generation age and the need for health care grows. With this problem looming, the importance of nurse retention in the hospital setting becomes substantial. The problem of nurse turnover in a hospital setting is costly. Jones and Gates (2007) stated, “Examples of direct costs of nurse turnover included advertising costs and those costs incurred by Health Care Organizations (HCOs) to market nursing positions in an attempt to recruit and hire nurses to fill turnover vacancies” (p. 1).

The purpose of this study was to gain insight into the problem of nurse retention and the importance of transformational leadership in the hospital setting. The goal was to find ways to empower nurses and create a better workplace. By creating a better work environment, hospitals may be able to retain more of their nurses. Retention would cut the cost of replacing nurses and assist hospitals with the ongoing nurse shortage. This study determined if the coaching and mentoring style of leadership affected nurse retention. This study has offered strategies that may provide guidance into reducing the turnover rate that exists among nurses in many hospitals across the country.

The research questions directing this study were as follows:

**Q1** “In a participating hospital, what are the nurses’ perceptions of their immediate nurse manager’s leadership style?”
Q2 “Is nurse managers’ leadership style affecting nurse retention in the participating hospital?”

Review of the Methodology

The sample for the study focused only on bedside Registered Nurses (R.N.s). The survey was completely voluntary and confidential. One hundred surveys were posted for the sample population, and the response rate was 100%. However, some participants chose not to answer particular questions. When a participant left an answer blank, the answer was not included as part of the results. Sixty-two registered nurses completed the survey.

This quantitative survey research design made use of The Multifactor Leadership Questionnaire (MLQ [5X-Short]) developed by Bass and Avolio (1999). This survey offered many advantages to this study and was used to rate and measure the nursing staff’s perception of the leadership style of the nurse managers at the PH. The results were also used to identify the range of management styles that are perceived by the nursing staff. The survey results were compared to the MLQ national average.

In order to test whether the differences in the sample and the national average were significant, the Mann-Whitney-Wilcoxon (MWW) (Clarifico & Perla, 2008) was administered. de Winter and Dodou (2012) conducted a study on five point Likert scales to determine whether or not the data should be analyzed with parametric statistics such as the t test or nonparametric statistics such as the rank-based MWW. de Winter and Dodou concluded that “the t test and MWW generally have equivalent power” (p.6).

Exit interviews and interviews with current and former nurses were also used for this study. The exit interview tool is not necessarily a valid and reliable research tool. It was devised
by the hospital and has not been tested for reliability or validity. However, the exit interviews were utilized as a means to gain further insight into the retention problem.

Discussion of the Results

Findings of the study

Previous researchers such as Bass (1998) have indicated that the effective leader achieves a balance between transformational and transactional behaviors. However, Marshall (2011) suggested that too much transactional leadership focuses on short term solutions. Transactional leaders are focused more on management while transformational leaders are focused more on leadership. Marshall (2011) indicated, “Managers do things right, and leaders do the right things. Managers are thought to control and maintain processes with a focus on the short term, relying on authority rather than influence, while leaders are visionary, insightful, and influential. Managers minimize risk and leaders maximize opportunity” (p.6). With the transactional leadership style relying on his or her authority, micromanagement can develop.

Consistent with Marshall’s findings, this study found that respondents perceived that their managers were relying on authority rather than influence. Over fifty percent of the exit interviews identified management related problems including poor staffing practices, inability to communicate with manager, and concern about unprofessional behavior of staff and manager.

The exit interviews also indicated poor communication between the nurse and his manager. The nurses discussed their inability to communicate with their manager. Marshall (2011) indicated that, “listening is often more important and effective than speaking. Often problems are solved simply by listening. Successful listening simply requires that people feel heard” (p. 107).
Exit interviews for this study also suggested that individual consideration from the manager was lacking for these nurses. Vanice Roberts indicated that nurse managers must get to know their nurses on an individual basis. Roberts stated, “It’s a must to know your nurses individually. You may have a nurse that has been an exceptional employee and suddenly her performance drops. If you know the nurse individually, you may have known that her husband had recently been deployed by the military. By knowing your nurses as individuals you may be able to anticipate issues that could arise that affect job performance” (V. Roberts)

Former nurses interviewed for this study agreed that, “The environment at the hospital was very rigid and controlling. The managers showed favoritism to some employees” (Anonymous, personal communication, July 31, 2012). Another RN stated, “There was no communication with upper management. The upper management was buffered from the floor nurses. We earned time off but could never take it due to the shortage. The only way to get a day off was to call in sick” (Anonymous, personal communication, July 31, 2012).

The MLQ scores appeared to agree with the interviews. Of the four sets of null and alternative hypotheses, only the first (Transformational Leadership) null hypotheses: The mean of the sample will be equal to the national average mean vs. alternative hypotheses: The mean of the sample will be less than the national average mean, and the last (Outcomes of Leadership) null hypotheses: The mean of the sample will be the same as the national average mean vs. alternative hypotheses: The mean of the sample will not be equal to the national average mean, resulted in rejecting the null hypotheses. Once the test established the statistical likelihood of a different distribution in each of the two populations, a more detailed analysis of the individual components that constitute each of the aggregate measures was necessary to determine a significant difference. In this case, the z test was applied individually to each
component of the aggregate measures for Transformational Leadership and Outcomes of Leadership, comparing each of the components to the known National means and standard deviations.

All of the measures show significant differences in the direction of the null hypothesis: *The mean of the sample will be the same as the National Average Mean* vs. alternative hypotheses: *The mean of the sample will be greater than the National Average Mean*, except for IM (Inspirational Motivation).

**Research Question 1**

“In a participating hospital, what are the nurses’ perceptions of their immediate nurse manager’s leadership style?” Based on the analysis presented in Table 12, the participants of the survey perceived their nurse manager’s as significantly less transformational in management style than the national average. The only exception was the scale for Inspirational Motivation.

**Research Question 2**

“Is nurse managers’ leadership style affecting nurse retention in the participating hospital?” Based on the analysis presented in Table 13, all of the measures show significant differences in the direction of the null hypothesis: *The mean of the sample will be the same as the mean of the National Average Mean*. The participants of the survey indicated significantly less satisfaction in the overall leadership of their nurse managers compared to the national average.

Of the four leadership styles measured by the MLQ, significant differences between the sample and the National Average were identified in Transformational Leadership ($p=0.0184$ level), except for IM (Inspirational Motivation). Significant differences were also identified in Outcomes of Leadership ($p=0.0808$). These significant differences in the sample and the
National Average Mean indicates that the PH is lacking in Transformational Leadership, and the overall satisfaction of the nurses surveyed is significantly lower than the National Average.

If the leadership style of the PH is not modified in a manner that encourages job satisfaction and retention, the patients residing in the community could experience a worsening nursing shortage. With the inevitable surge of Baby Boomers leaving the workforce for retirement, it is more urgent than ever to retain trained nursing professionals. Not only does the loss of nursing staff create a financial burden on the PH, but also on the community that it serves. The location of the PH has long been considered a medical hub in the Southeast. This location has been a huge selling point for families moving to the area. Without the implementation of more transformational leadership at the PH this loss of medical professionals could lead to a decrease in the growth of the community.

**Recommendations**

On August 30, 2013, a meeting was held at the PH to discuss with the Human Resources Department the results of the survey. After the results were reviewed, the staff in the HR Department stated, “We have made manager changes during the past few months. We found that a couple of managers were beginning to micromanage. Since this change, we have seen a dramatic decrease in the turnover rate” (Anonymous, personal communication, August 30, 2013). Goleman, et al. (2002) argued that often times managers think they are coaching when in reality they are creating a downward performance spiral. “Leaders who are also pacesetters—focused exclusively on performance—often think they’re coaching when actually they’re micromanaging or simply telling people how to do their jobs” (p. 61).
Recommendations for improving nurse manager transformational leadership behaviors include having administration collaborate more with the human resources department to develop leadership development training for those in nurse management positions. The development and implementation of a leadership development program must have complete organizational commitment in order to succeed. Hospital administration must support a leadership development program that is focused and has adequate resources for sustainable behavior change.

It is recommended that the PH implement a program such as Partners In Nursing (PIN). According to Cottingham, Dibartolo, Battistoni, and Brown (2011) PIN is a mentoring program that evolved from a national grant sponsored by the Robert Wood Johnson and the Northwest Health Foundations. The purpose of the program was to address problems associated to the nursing shortage in local communities. The program focused on partnering new nurse graduates with experienced RN mentors during the graduates’ first year of employment.

The PIN program has produced positive results in nurse retention by providing mentoring and coaching. Cottingham, Dibartolo, Battistoni, and Brown (2011) wrote, “By its second year, the retention goals were met for every partnering organization and feedback was extremely positive, especially in areas of motivation in the workplace and knowledge of career ladder systems” (p. 254). The program also cultivated leadership potential and provided opportunities for professional development.

Another program that has produced results is the Versant Residency Program. According to Ulrich et al., (2010) Versant is a residency program that also provides a one-on-one mentor for each new nurse graduate. Ulrich indicated that the program focuses on satisfaction, self-confidence, empowerment, group cohesion and organizational commitment, all traits of the transformational leadership style. This program has shown impressive results as well. Ulrich et
al., (2010) stated, “In one example, a general acute care hospital had a 35% new graduate turnover rate at 12 months prior to implementing the RN residency. The 12 month turnover rate in the first 3 years of the RN residency at that hospital was 5.36%” (p. 374).

The successful healthcare organization must recognize the need to develop transformational leaders for the future. It is recommended that the PH also explore a formal program for teaching transformational leadership to its managers. Marshall (2011) recommended the National Center for Healthcare Leadership (Davidson, Griffith, Sinioris, and Carreon 2005) which she stated, “offers a comprehensive lifelong, competency-based, and assessment-oriented leadership development program. Its focus is on leadership competencies, team effectiveness, organization climate, strategic human resource systems, governance alignment, cultural diversity practices, and organizational performance” (p.73).

On January 7, 2014, a letter was sent to the PH’s Institutional Review Committee to inform them that the study had been completed. The letter requested closure to this research project. A review of the methodology was provided along with a summary of the results.

Limitations of the Study

One of the limitations of the study relates to the generalizability of the sample. The sample is of a large regional medical center, located in the Southeastern United States, which may lead to an inability to generalize the data to other groups in others areas. In addition, the hospital is a not-for-profit organization, and this may impact the findings in relation to for-profit healthcare organizations. The study may also lead to an inability to generalize the findings to areas that have experienced the down turn of the economy in a much more severe fashion. It must also be mentioned that the exit interviews conducted by the PH may not be a reliable and valid research instrument.
Recommendations for Future Research

After concluding this study, further research should be conducted to aid in finding a solution to the nursing school issue. It appears that one of the biggest problems concerning the nursing shortage is finding qualified instructors. The American Association of Colleges of Nursing (2012) reported that U.S. nursing schools turned away 75,587 qualified applicants from baccalaureate and graduate nursing programs in 2011 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Almost two-thirds of the nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs (p. 1). Nursing schools will need to become more competitive in salary for the qualified instructors. Until nursing schools can adequately meet the demand for nurses, the nursing shortage will continue to be an issue for the medical community.

Future research is also recommended in the area of teaching basic leadership skills to all level of nursing students. The findings of this research indicated that nurses are promoted to leadership positions due to their clinical skills not leadership ability. Even the beginning nurse must work with support personnel to meet the needs of his patients. A basic introduction to leadership could assist the new nurse in avoiding frustration with managing support personnel and avoid turnover during that critical one year mark.

This same study should be conducted in a year at the participating hospital. The future study would be after the nursing retention program has been in effect for at least a year. A future study would also be a good measuring tool to see if the Preceptor program has had an effect. The Preceptor program should offer more training in mentoring and coaching. This study could measure the effectiveness of such a program.
Since this study focused only on the rater portion of the MLQ, it could be beneficial to conduct a study to measure the managers’ perception of their leadership styles. Doing both the self-assessment and the rater portion together could provide more enlightenment on the retention problem at this facility.
References


Dolan, T. B. (2011). Has the nursing shortage come to an end?. *ONS Connect, 26*(8), 8-12.


Retrieved from


Appendix A

Letter to the Hospital Institutional Review Committee
February 21, 2013

Institutional Review Committee

_______________________ Center

TITLE OF THE STUDY

Nurse Retention in the Hospital Setting

Researcher: Gary E. Silvers, BS, MA, PhD Candidate Tennessee Temple University

SPONSOR OF THE STUDY

_______________________ PhD, RN

RELEVANCE OF STUDY

The purpose of this study is to gain insight into the problem of nurse retention in the hospital setting. This study is relevant in light of the current nursing shortage. According to the American Association of Colleges of Nursing, “The United States is projected to have a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows” (American Association of Colleges of Nursing, 2010, p. 1). With this problem looming in the future, the importance of nurse retention in the hospital setting becomes substantial. The problem with nurse turnover in a hospital setting is costly. “Examples of direct costs of nurse turnover include advertising costs and those costs incurred by health care organizations (HCOs) to market nursing positions in an attempt to recruit and hire nurses to fill turnover vacancies” (Jones & Gates, 2007, p. 1).
In some markets the cost of losing a nurse is very costly. “Nurse retention has become a workplace priority in hospitals. Recent studies reporting the $65,000 cost to replace one nurse has caused hospitals to refocus energy and money to retain nurses” (Wieck, Dols, & Landrum, 2010, p. 7).

An article in Health Care Manager stresses, “Managers play a big role in employee satisfaction, and they are a major factor in an employee’s decision to stay or leave an organization. Often, managers in health care are promoted because of their clinical skills and have no formal management training. They feel helpless in their ability to keep staff from leaving. According to McNeese-Smith, recognition by a manager is directly related to an employee’s job satisfaction and commitment to the organization. To provide meaningful recognition, a manager needs to have positive interpersonal relationship skills” (McGuire, Houser, Jarrar, Moy, & Wall, 2003, p. 43).

SURVEY INSTRUMENT

This study will explore the importance of mentoring and coaching and the work-related outcomes of job satisfaction and organizational commitment. The sample for this study will be registered nurses at a regional hospital located in the Southeastern United States. The Multifactor Leadership Questionnaire (MLQ [5X-Short]) developed by Bass and Avolio (1999) will be used to measure the nursing staffs perception of the leadership style of the nurse managers.

Once completed, the study can point to a leader’s performance on a variety of leadership styles and give directions on how he or she may become a more effective leader.
The information obtained can assist in developing a retention program for nursing staff. By using this full range model, links can be made to each leadership style to the expected performance outcome, which has been used in hundreds of prior studies to support this connection (see for example, Dum dum, Sivasubramaniam and Avolio, 2002).

RESEARCH QUESTION

Does the management style of nurse managers affect nurse retention. Specifically coaching/mentoring behavior.

SUBJECT SELECTION

• Sample Size: One hundred registered nurses will be targeted for the online survey.

• Inclusion criteria: registered nurses who work at the bedside.

• Participation will be completely voluntary.

• Confidentiality of participants is insured.

• The hospital will remain anonymous in the dissertation.

This study has been approved by the Dissertation Committee at Tennessee Temple University.
Appendix B

Letter to Potential Nursing Participants
Dear Nursing Professional,

Your knowledge and expertise are needed! As a nursing professional you have information that is critical in understanding the problem of nurse retention in a hospital setting. Please participate in the survey located at the link below. This research is directed at gaining insight into job satisfaction, mentoring and its effects on nurse retention.

As a doctoral candidate at Tennessee Temple University, I am currently in the process of collecting data for my dissertation and would like to ask you for your help. Research such as this is intended to provide insight into the challenging work environment of the hospital nurse. Information collected could help to improve leadership training, developing nurse leaders, and impact hospital nurses’ job satisfaction.

Your participation in this survey is completely confidential. It has also been approved by the administration at your hospital. The study will require less than 20-25 minutes to complete. The survey will ask you to rate the management style of your immediate nurse manager. No names will be listed on the survey. The survey is being conducted electronically. A coding system will be used to protect the confidentiality of the volunteers.

To access the survey, click on the link. Alternatively, copy and paste the entire address into your browser bar. Once on the page click on the participant tab.

http://www.mindgarden.com/survey/11584
I thank you in advance for your time to participate in this important study. If you have any questions about my research or wish to discuss this study, feel free to contact either myself and/or my faculty advisor:

Gary E. Silvers
Doctoral Candidate
Tennessee Temple University
University
706-266-6235
silverg@tntemple.edu

Lori Robertson, PhD
Committee Chair
Tennessee Temple
robertsl@tntemple.edu
Appendix C

Mind Garden Permission to Use the Multifactor Leadership Questionnaire
To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her research:

Instrument: Multifactor Leadership Questionnaire

Authors: Bruce Avolio and Bernard Bass

Copyright: 1995 by Bruce Avolio and Bernard Bass

Five sample items from this instrument maybe reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published material.

Sincerely,

Robert Most Mind Garden, Inc. www.mindgarden.com
Appendix D

Participating Hospital Permission letter
March 12, 2013

Gary E. Silvers, PhD (c), RN (Principal Investigator)
Tennessee Temple University
1815 Union Avenue
Chattanooga, TN 37404

Dear Mr. Silvers:

IRC#: 20130227

TITLE OF PROPOSAL: Nurse Retention in the Hospital Setting, Principal Investigator – Gary E. Silvers, PhD (c), RN

This letter is to officially notify you of the approval of your project by the Institutional Review Committee (IRC) by expedited review.

You are authorized to implement this study as of today, March 12, 2013. This approval is valid until March 11, 2014.

This project should be conducted in full accordance with all applicable sections of the IRC Policy. Any proposed changes to your study protocols should be submitted for IRC approval before they are implemented. Please notify the committee immediately if you encounter any unanticipated problems. If it is necessary to continue the study beyond the expiration date, a request for continuation approval should be submitted about 6 weeks prior to the expiration date March 11, 2014. Please advise the IRC when this study is finished or discontinued by written report to the IRC.

Sincerely,

[Signature]
Chairman
Institutional Review Committee

gt

c: [Redacted] PhD, RN (Sponsor)
  Lori Robertson, PhD (Dissertation Committee Chair, Tennessee Temple University)
Appendix E

Sample of Exit Interviews
<table>
<thead>
<tr>
<th>Unit</th>
<th>Hire date</th>
<th>Term date</th>
<th>Interview date</th>
<th>Interview method</th>
<th>Reason for leaving</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6/18/2012</td>
<td>1/15/2013</td>
<td>1/18/2013</td>
<td>phone</td>
<td>relocation</td>
<td>enjoyed and co-workers</td>
</tr>
<tr>
<td></td>
<td>9/6/2011</td>
<td>1/3/2013</td>
<td>1/3/2013</td>
<td>face to face</td>
<td>personal; other job has own home care business</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/15/2012</td>
<td>6/24/2012</td>
<td>1/25/2013</td>
<td>phone</td>
<td>termed-performance concern about unprofessional behavior of staff/manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3/5/2012</td>
<td>09/28/12</td>
<td>1/25/2013</td>
<td>phone</td>
<td>location</td>
<td>moved further away from FMC; staffing was a concern</td>
</tr>
<tr>
<td></td>
<td>11/7/2011</td>
<td>12/13/12</td>
<td>1/25/2013</td>
<td>phone</td>
<td>other</td>
<td>scheduling conflicts, unable to communicate with mgr, staffing</td>
</tr>
<tr>
<td></td>
<td>10/15/2012</td>
<td>1/27/2013</td>
<td>2/21/2013</td>
<td>phone</td>
<td>other</td>
<td>stress, patient load, scheduling, coworker dissatisfaction</td>
</tr>
</tbody>
</table>
Appendix F

MLQ Raw Data Scores
| Blanks  |  6.0% | Blanks  |  11.7% | Blanks  |  4.4% | Blanks  |  8.1% | Blanks  |  8.7% | Blanks  |  4.8% | Blanks  |  11.1% | Blanks  |  6.9% | Blanks  |  6.5% |
|---------|-------|---------|--------|---------|-------|---------|-------|---------|-------|---------|-------|---------|--------|-------|--------|-------|
| Zeros   |  8.5% | Zeros   |  8.9% | Zeros   |  4.4% | Zeros   |  11.7% | Zeros   |  9.1% | Zeros   |  6.9% | Zeros   |  9.8% | Zeros   | 39.9% | Zeros   | 47.6% |
| Ones    | 13.3% | Ones    |  8.9% | Ones    |  8.5% | Ones    | 12.1% | Ones    | 15.9% | Ones    | 12.5% | Ones    | 17.2% | Ones    |19.4%  | Ones    |16.5%  |
| Twos    | 16.5% | Twos    |16.9%  | Twos    |18.1%  | Twos    |20.6%  | Twos    |17.2%  | Twos    |16.5%  | Twos    |23.8%  | Twos    |17.3%  | Twos    |13.7%  |
| Threes  | 25.8% | Threes  | 31.0% | Threes  | 33.5% | Threes  | 32.7% | Threes  | 22.4% | Threes  | 29.0% | Threes  | 22.1% | Threes  |11.3%  | Threes  |10.5%  |
| Fours   | 29.8% | Fours   | 22.6% | Fours   | 31.0% | Fours   |14.9%  | Fours   |27.2%  | Fours   |29.8%  | Fours   |16.0%  | Fours   | 5.2%  | Fours   | 5.2%  |
Appendix G

Individual Scores for Idealized Attributes
Below are the individual scores given for Idealized Attributes

IA Distribution

The participants of the survey rated their managers’ in the 24.8 percentile compared with the MLQ scores from the national average. 75.2% of the national average scored higher than this percentile.
Appendix H

Individualized Scores for Idealized Behaviors (IB)
Below are the individualized scores for Idealized Behaviors (IB)

IB Distribution

The participants of the survey rated their managers’ in the 44.7 percentile compared with the MLQ scores from the national average. 55.3% of the national average scored higher than this percentile.
Appendix I

Individualized Scores for Inspirational Motivation (IM)
Below are the individualized scores for Inspirational Motivation (IM)

IM Distribution

The participants of the survey rated their managers’ in the 33.4 percentile compared with the MLQ scores from the national average. 66.6% of the national average scored higher than this percentile.
Appendix J

Individualized Scores for Intellectual Stimulation (IS)
Below are the individualized scores for Intellectual Stimulation (IS).

IS Distribution

The participants of the survey rated their managers’ in the 21.6 percentile compared with the MLQ scores from the national average. 78.4% of the national average scored higher than this percentile.
Appendix K

Individualized Scores for Individual Consideration (IC)
Below are the individualized scores for Individual Consideration (IC).

IC Distribution

The participants of the survey rated their managers’ in the 32.3 percentile compared with the MLQ scores from the national average. 67.7% of the national average scored higher than this percentile.
Appendix L

Individualized Scores for Contingent Reward (CR)
Below are the individualized scores for Contingent Reward (CR)

CR Distribution

The participants of the survey rated their managers’ in the 67.7 percentile compared with the MLQ scores from the national average. Only 32.3% of the national average scored higher than this percentile.
Appendix M

Individualized Scores for Management by Exception: Active (MBEA)
Below are the individualized scores for Management by Exception: Active (MBEA).

MBEA Distribution

The participants of the survey rated their managers’ in the 66.4 percentile compared with the MLQ scores from the national average. Only 33.6% of the national average scored higher than this percentile.
Appendix N

Individualized Scores for Management by Exception: Passive (MBEP)
Below are the individualized scores for Management by Exception: Passive (MBEP).

MBEP Distribution

The participants of the survey rated their managers’ in the 92.6 percentile compared with the MLQ scores from the national average. Only 7.2% of the national average scored higher than this percentile. This indicates that this leadership trait is not an issue at the PH.
Appendix O

Individualized Scores for the Laissez-Faire (LF) leadership Style
Below are the individualized scores for the Laissez-Faire (LF) leadership style.

**LF Distribution**

The participants of the survey rated their managers’ in the 28.5 percentile compared with the MLQ scores from the national average. 71.5% of the national average scored higher than this percentile.
Appendix P

Individualized Scores for Extra Effort (EE)
Below are the individualized scores for Extra Effort (EE).

EE Distribution

The participants of the survey rated their managers’ in the 24.0 percentile compared with the MLQ scores from the national average. 76% of the national average scored higher than this percentile.
Appendix Q

Individualized Scores for Effectiveness (EFF)
Below are the individualized scores for Effectiveness (EFF)

EFF Distribution

The participants of the survey rated their managers’ in the 24.8 percentile compared with the MLQ scores from the national average. 75.2% of the national average scored higher than this percentile.
Appendix R

Individualized Scores for Satisfaction with the Leadership (SAT)
Below are the individualized scores for Satisfaction with the Leadership (SAT).

SAT Distribution