PERCEPTIONS OF NURSE MANAGERS' LEADERSHIP STYLE BY NURSE MANAGERS AND RN STAFF: JOB SATISFACTION AS PERCEIVED BY RN STAFF

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by

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ABSTRACT

The nursing profession is changing rapidly due to changes in healthcare such as: shifting social values, downsizing, and federal regulations. Despite re-engineering and integration of initiatives occurring in the business world today, the healthcare industry rarely recognizes the danger of continuing to use outmoded business practices. Most nurse managers are ill prepared for changes associated with their role today. Effective nursing leadership is essential to meet the challenges that these complex changes present to the healthcare profession.

This descriptive, comparative, exploratory and correlational study was conducted to compare perceptions of leadership style of nurse managers as perceived by nurse managers and their RN staff using Hersey and Blanchard's (1991) Situational Leadership Model. A convenience sample of 11 nurse managers and 79 Registered Nurse staff from one hospital setting was used to compare perceptions of nurse managers' leadership styles. A second purpose of the study was to determine if RN staff perceptions of leadership style effectiveness and leadership flexibility of their nurse managers were predictive of job satisfaction using Stamps (1997) Index of Work Satisfaction.

Information on gender, age, educational level was obtained using the Social Demographic Form. All nurse manager respondents were female, with an average age of thirty-one. The majority had a master's degree in nursing, had between 6-10 years of experience in their position and had been on their assigned unit for more than five years. The majority of RN staff were female, had a Bachelor of Science degree in nursing and had worked in their current unit for 1-5 years. The average age of RN staff was 36.

RN staff perceived the leadership style effectiveness of the nurse manager as being significantly less effective than did the nurse managers. Nurse managers and RN staff did not differ significantly in regard to perceptions of leadership flexibility. The leadership effectiveness style of nurse managers as perceived by RN staff were predictive of two components of job satisfaction: nurse-nurse interaction and total interaction (nurse-nurse and physician-nurse interaction combined)

Further findings from the secondary analysis revealed that, with the exception of organizational policies, nurse managers and RN staff differed in their perceptions of the importance of all aspects of job satisfaction.

Assessing leadership styles provides a means for identifying strengths and weaknesses in nurse managers' leadership style and improve the quality of care. Comparing the perceptions of the nurse managers' with those of their RN staff will help the nurse managers identify areas that may improve their leadership ability in various situations.

This study used a convenience sample of nurse managers and RN staff were employed in one hospital setting. Thus, findings must be viewed in regard to these limitations and can only reflect the hospital staff studied.

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CHAPTER I

Introduction

The nursing profession is changing rapidly and by all indications this acceleration will continue as the profession moves into the millennium. Shifting social values, the media, federal regulations, rapid technology changes, cost containment, downsizing, changes in labor force values, staffing, HMO's, and patient acuity are but a few issues that make health care an increasingly competitive business.

Despite re-engineering and integration initiatives of the past decade, the healthcare industry rarely recognizes the dangers of outmoded business practices (Moss, 1999). Most skilled nurse managers are ill prepared for the changes associated with their role (Ingersoll, Cook, Fogels, Applegate, & Frank, 1999; Mathena, 2002; Noyes, 2002, and Squires, 2001). Effective nursing leadership is essential to meet the challenges that these complex changes present to the healthcare profession.

Effective leadership is the process of influencing the activities of an individual or a group in efforts toward goal achievement in a given situation (Hersey, Blanchard, & Johnson, 1996). Effective leaders encourage others to behave in certain ways to facilitate achievement of desired goals or objectives. For example, Fox, Fox, and Wells (1999) found that an increase in leadership activities by 5% would increase staff productivity by 3.4%. Effective leaders inspire and encourage innovation, assist the staff in the self-actualization process, promote and facilitate patient care delivery (Simms, 1991).

The leadership style of individuals is exhibited by their behavior pattern when attempting to guide activities of others (Hersey et al., 1996). The leadership style of the nurse manager is an important determinant of nurses' reactions to their work, and has been measured by monitoring job satisfaction, turnover, health complaints, absenteeism, and indicators of (non) well-being (Boumans & Landeweerd, 1993). Hersey et al. (1996) reported that by adding the component of effectiveness to task and relationship behavior dimensions, the concepts of leadership style can be integrated with situational demands of a specific environment. Time, experience, education, and training influence the development of a leadership style.

Research indicates that effective leaders do not rely on only one leadership style, but adjust their leadership style to specific situations as they occur (Goleman, 2000; Hutton, 1995; Kouzes & Posner, 1995). Effective leaders, therefore, are flexible and adopt styles that are situationally appropriate to motivate the individuals involved. Changes in leadership style by a nurse manager allows subordinates to mature through the promotion of the subordinates' self-esteem and confidence (Goleman, 2000).

Nurse managers who exhibit a variety of leadership behaviors have employees who report significantly higher levels of job satisfaction, productivity, and organizational commitment than managers who do not (McNeese-Smith, 1995, 1996). However, leaders who are controlling, use economic, political, or psychological incentives to produce desired goals have been reported to contribute to greater job dissatisfaction (Duxbury, Armstrong, Drew, & Henley, 1984). Attendance records reveal that motivated and

satisfied employees have fewer days off, fewer physical complaints, and progressively take on more difficult objectives within the constraints of their job (Stamps & Piedmont, 1986).

Purpose

The purpose of this study was twofold: (1) to describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of nursing staff. The six components of job satisfaction include pay, professional status, task requirement, interaction, autonomy, and organizational policies.

Research Questions

The research questions posed in this study were as followed:

Research Question 1

Is there a difference in (a) educational level, (b) gender, (c) age, (d) length of time as an RN, (e) length of time employed in current hospital, and (f) length of time nurse managers and RN staff worked on current unit?

Research Question 2

What is the leadership style flexibility of nurse managers as perceived by the nurse managers on the LBAII-Self instrument as compared to the leadership style of flexibility of nurse managers as perceived by their nursing staff members on the LBAII-Other instrument?

Research Question 3

What is the leadership style effectiveness of nurse managers as perceived by the nurse managers on the LBAII-Self instrument as compared to the leadership style of effectiveness as perceived by their nursing staff members on the LBAII-Other instrument?

Research Question 4

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse managers on the LBAII-Self instrument?

Research Question 5:

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse managers' nursing staff on the LBAII-Other instrument?

Research Question 6

Are leadership style effectiveness, and leadership flexibility of nurse managers as perceived by RN staff predictive of satisfaction with (1) pay, (2) professional status, (3) task requirements, (4) interaction, (5) autonomy, and (6) organizational policies?

Conceptual Framework

The Situational Leadership Model (SLM), as developed by Hersey and Blanchard (1972), revised (1988, 1991) was used to guide this study (Figure 1). The SLM was developed originally as the Life Cycles Theory to help leaders be more effective in their daily interactions with others. Since its development, the LBA II has been used in a wide variety of research studies. Areas include the fields of Business, Nursing, Education and the Military. Maslow's Hierarchy of Needs, Hertzbergs Motivational-Hygiene theory,

Likert's Management System, and Mouton's Managerial Grid theory have been integrated within the SLM (Cook, 1992). The SLM is concise, understandable, and easily implemented on an individual basis (Hersey & Blanchard, 1988, p.191).

Basic Components of the SLM Model

There are three basic components to the model: task behavior, relationship behavior, and the development level/motivation of the follower. The SLM is based on an interplay among the following elements:

1. The amount of guidance and direction (task behavior) a leader gives.
2. The amount of socio-emotional support (relationship behavior) a leader provides.
3. The development/readiness level (maturity level) that followers exhibit (Hersey & Blanchard,1988).

Task and relationship behavior. Hersey and Blanchard (1988) define task behavior as "The extent to which the leader engages in spelling out the duties and responsibilities of an individual or a group" (p. 191). Task behavior is characterized by one-way communication. The leader tells the follower what, how, when, and where to do the task and with whom to do it. Task behavior is directive and is related to an autocratic leadership style. With task behavior, the leader sets the goal, controls the situation by constructing a step-by-step plan to accomplish the goal, and solve the problem (Fluker, 1995, p. 35).

Relationship behavior is defined by Hersey and Blanchard (1988) as "the extent to which the leader provides socio-emotional support, shares responsibility of goal setting, allows the follower to make decisions, and engages in two-way or multiple-way

communication with the follower" (p.191). The following activities are required in relationship behavior: listening, facilitating, and supporting. Relationship behaviors tend to increase a follower's self-confidence and motivation (Blanchard, Zigarmi, & Zigarmi, 1985).

Task and relationship behavior refer to the leader. The amount of task and relationship behavior must vary in every situation or the effectiveness of the leader will diminish. The more the leader is able to use the correct combination of task and leadership behavior the more effective will he or she be in influencing others (Hersey & Blanchard, 1988).

In the SLM model, leader behavior is placed on two axises at right angles of each other forming four quadrants. Each of the four quadrants represents a leadership style. Each leadership style is a combination of task and relationship behavior. The four leadership styles are Directing, Coaching, Supporting, and Delegating. In the Directing style (S1), the leader plans the task, tells the follower how do it, and closely supervises the task. In the Coaching style (S2), the leader explains decisions, solicits the followers' suggestions, and provides support. In the Supporting style (S3), the leader shares decision making, provides support, and encouragement. In the Delegating style (S4), the follower is the decision maker.

The four leadership styles are as follows:

S1 - High directive and low supportive behavior

S2 - High directive and high supportive behavior

S3 - High supportive and low directive behavior

S4 - Low supportive and low directive behavior

Based on their research, Hersey, Blanchard, and Johnson (1996) found that most leaders have a primary and secondary leadership style. A primary leadership style is defined as the behavior pattern used most often by leaders when attempting to influence the behavior of others. Secondary leadership style is the style that the leader tends to use on occasion to influence the behavior of others.

The development level. The third component of the model is the development level (maturity level) of the follower. The development level refers to "the extent to which a person has mastered the skills necessary for the task at hand and has developed a positive attitude toward the task" (Blanchard, Zigarmi, and Nelson, 1993, p. 27). This level considers maturity and readiness of the followers. Development, maturity, and readiness are used interchangeably to indicate the follower's extent of preparedness for a given task (Fluker, 1995). It is the goal of the leader to advance the development levels of the followers (Hutton, 1995). The revised SLM refers to competence and willingness as two dimensions of the development level of the followers (Zigarmi, Edeburn, & Blanchard 1997). The four development levels view the follower as:

D1 - High commitment and low competence

D2 - Some competence and low commitment

D3 - High competence and variable commitment

D4 - High competence and high commitment

A follower's development level varies with any given task. If the follower's development level is high for the assigned task, he or she will require less structure. The underlying theme of Situational Leadership Theory contends that there is interplay

between (1) the number of tasks assigned, (2) the degree of emotional support provided by the leader (3) the development level of the follower for the particular assigned tasks (Hersey et al., 1996). Figure 1 shows the relationship of leadership style, task behavior, supportive behavior and development level. The development levels show the degree of competence, and commitment of the followers to perform a particular task without supervision (Hutton, 1995).

Competence can be developed by using the appropriate leadership style (Figure 2). Commitment is a combination of competence and motivation (Hutton, 1995, p. 44). Once the follower has developed to the fourth level, he or she is able to perform without supervision. Nurses in general are satisfied when they are working independently (Blegen, 1993). A conceptual model (Figure 1) illustrates this theory. Figure F2 is a Chart of Development Levels matched with Appropriate Leadership Styles.

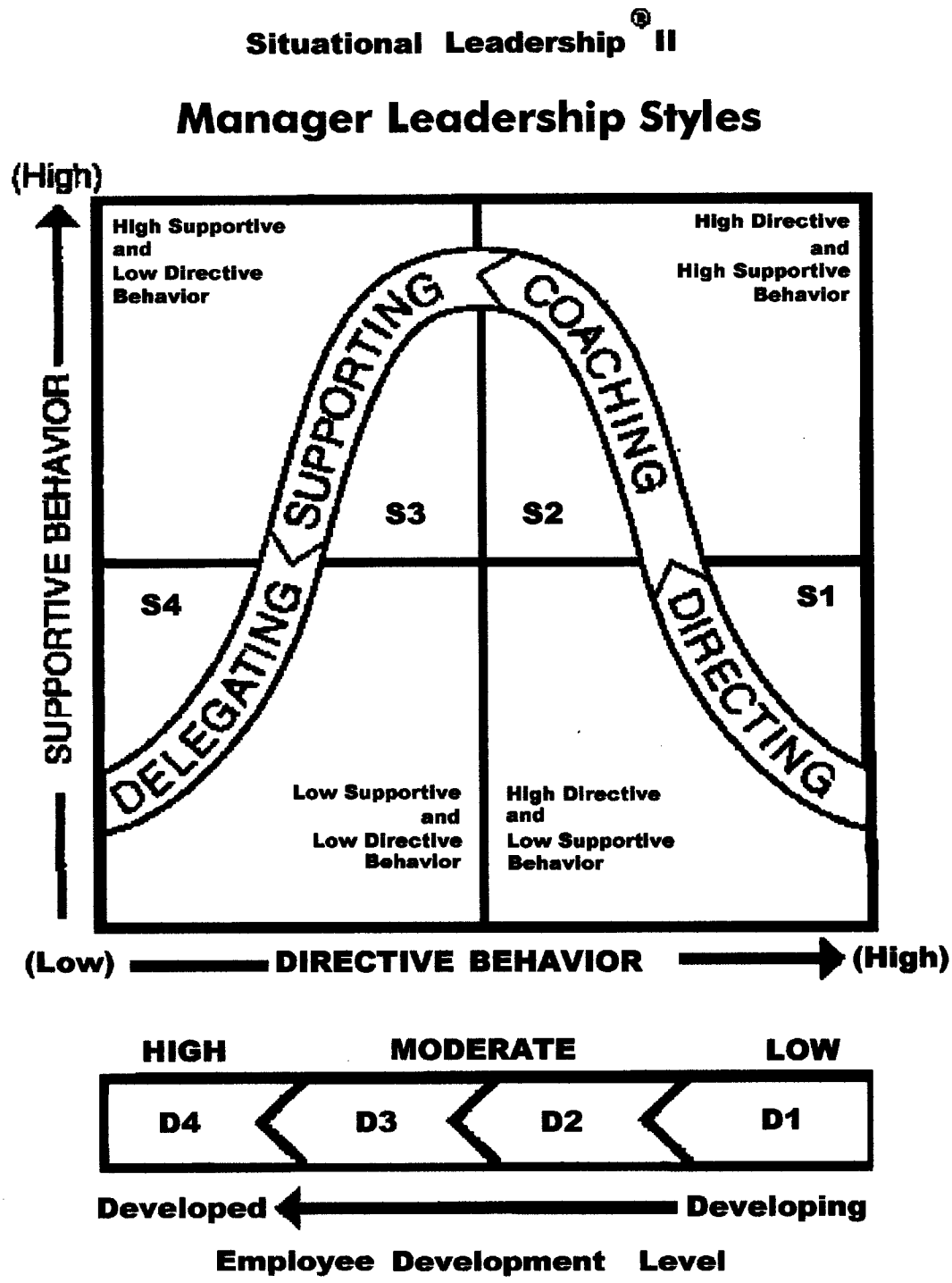

Figure 1
Situational Leadership Model
Blanchard Training and Development, Inc.

Chart of Development Levels Matched with Appropriate Leadership Styles

Development Level	Appropriate Leadership Style
D1 Low Competence * High Commitment	S1 Directing Structure, control, and supervise
D2 Some Competence * Low Commitment	S2 Coaching Direct and Support
D3 High Competence * Variable Commitment	S3 Supporting Provides support and encouragement
D4 High Competence * High Commitment	S4 Delegating Relinquish decision making to the follower

Figure 2

Relationship of the Model to the Study

The SLM was the framework chosen for the current study since nurse managers' leadership styles was analyzed using all aspects of this model. In this study the nurse managers' leadership styles were analyzed using one of the four quadrants (S1, S2, S3, or S4) noted in the SLM. The nurse managers' behavior was examined in terms of the two dimensions of supportive and directive behavior. The different combinations of developmental levels were matched with the nurse managers' leadership styles.

The use of the SLM is further validated as the appropriate framework for this study since the LBAII-Self and the LBAII-Other instruments to be used in collecting data were specifically designed to obtain information relevant to the SLM (Zigarmi, Edenburn &

Blanchard,1997). Zigarmi et al. state that the roots of these instruments are based on the observable and verifiable managerial behavior of two types: Directive and Supportive behavior. The authors further state that the LBAII instruments are congruent with the SLM model. Data on job satisfaction were obtained in order to determine if managerial styles of nurse managers are predictive of job satisfaction of nursing staff.

The data obtained from the LBAII-Self and LBAII-Other instruments were used to answer research questions 2 - 6 posed in this study. The research questions were specifically designed to obtain data which are directly related to the SLM.

Definition of Terms

Nurse Manager

Theoretical. One who oversees a total operational unit or division, including all functional activities of the unit (Mosley, Pietri, & Megginson, 1996, p. 27).

Operational. A registered nurse with 24 hour responsibilities for planning, organizing, leading, and evaluating followers in order to achieve the goals of a nursing unit in the selected hospital in this study. Responsibilities include, but are not limited to, hiring/firing, working with financial resources, planning, organizing, leading, and controlling.

RN Nursing Staff

Theoretical. Individuals who are especially prepared in the scientific basis of nursing and who meet certain prescribed standards of education and clinical competence to be licensed as a registered nurse (Friel, 1994, p. 909).

Operational. Registered nurses, licensed by the state from which respondents in this study have been selected where they practice professional nursing, not holding a middle

management, executive nurse, or educational nursing position, and who routinely provides care.

Hospital

Theoretical. An institution that provides medical, surgical, or psychiatric care and treatment for the sick or injured (Soukhanov, 1996, p. 1243).

Operational. Any nursing area in the hospital setting selected for this study in which two or more staff nurses are providing direct patient care.

Job Satisfaction

Theoretical. The fulfillment or gratification of a desire or expectation of the employer, job, and position (Soukhnaov, 1996, p. 1604).

Operational. The scores obtained on the Index of Work Satisfaction (IWS). This scale reports six satisfaction scores: pay, job status, interaction, (subdivided into nurse-nurse interaction and physician-nurse interaction), autonomy, task requirements, organizational requirements, and a total satisfaction score (Stamps, 1997).

Selected Demographic Characteristics

Theoretical. The demographic characteristics of human populations as age, and income (Merriam-Webster, 1990, p. 338).

Operational. Subjects' responses to the Selected Demographic Characteristics Form (SDCF) such as education, sex, age, position, years as a nurse, years employed at the hospital.

Leadership Style

Theoretical. The behavior pattern as perceived by others, that a person exhibits when attempting to influence the activities of others (Hersey et al., 1996, p. 134).

Operational. The actual leadership style exhibited by responses obtained from the LBAII-Self and LBAII-Other instruments.

Leadership Effectiveness

Theoretical. A numerical representation of the respondent's appropriate use of the chosen style in light of the situation described in the LABII instruments (Zigarmi et al., 1997).

Operational. The scores of respondents developed from statistical analysis representing leadership effectiveness obtained from the LBAII-Self and LBAII-Other instruments.

Flexibility Leadership Style

Theoretical. The extent to which a leader is able to vary her or his leadership style (Hersey, et al, 1996, p. 299).

Operational. A numerical indicator of how often the respondent uses a different style (S1, S2, S3, and S4) to solve each of the twenty situations in the LBAII-Self and LBAII-Other instruments.

Primary Leadership Style

Theoretical. The behavior pattern used most often when attempting to influence the activities of others (Hersey, et al, 1996, p. 299).

Operational. The frequency counts of the number of times a respondent chooses one major leadership style (S1, S2, S4, or S4) as noted in responses on the LBAII-Self and LBAII-Other instruments.

Secondary Leadership Style

Theoretical. The leadership style that a person tends to use on occasion (Hersey, et al, 1996, p. 299).

Operational. Frequency counts of the number of times a respondent chooses a second most likely leadership style(s) from (S1, S2, S3, and S4) used by the nurse manager from the 20 situations noted in the LBAII-Self and LBAII-Other instruments.

Developmental Leadership Style

Theoretical. Managers are engaged in the developmental cycle any time they attempt to increase the task-relevant readiness of an individual or group beyond the level that an individual or group has previously reached (Hersey, et al, 1996, p. 265).

Operational. Frequency counts of the number of times a respondent chooses the developmental level associated with S1, S2, S3, and S4 leadership styles (D1 - low competence, high commitment, D2 - some competence, low commitment, D3 - high competence, variable commitment, and D4 - high competence and high commitment.

Assumptions

The following assumptions were made:

1. Nurse managers have perceptions about their own leadership styles.
2. RN staff nurses have perceptions about the leadership styles used by nurse managers.

3. The respondents will answer questions truthfully.
4. Leadership styles can be measured.
5. Satisfied employees are motivated and productive.
6. Job satisfaction of nurse managers and their RN staff is desirable.
7. Attitudes about leadership style and perceptions of nurse managers and RN staff can be measured accurately.

Limitations

1. The findings cannot be generalized to the total population of RN staff members due to the use of a convenience sample drawn from the target population of a non-profit hospital located in a Southern state. However, the findings in this study may be generalized to the nurse managers in the study setting since all but one nurse manager participated in the study.
2. Only nurse managers and their RN staff employed in one general hospital were participants in this study.
3. The respondents may respond to the questions in a manner that they believe the researcher wants.
4. Job satisfaction is a perception that could change from one situation to the next.

Significance of Study

The purpose of assessing leadership styles was to provide a means for identifying strengths and weaknesses in nurse managers' leadership styles, and to improve the quality of nursing leadership in the work setting. Comparing the nurse managers' own perceptions

of effectiveness, flexibility, primary, secondary, and developmental leadership styles with that of their RN staff members may be helpful in providing information for nurse managers' overall growth in terms of identifying areas that may improve their leadership ability in various situations. Further, the results of this study may be useful for nurse administrators and nurse educators to develop effective leadership behaviors. Finding that leadership effectiveness and flexibility, if predictive of job satisfaction indices of RN staff, may also play an important part for nursing management.

By identifying the best style of leadership, nurse educators may design management courses dealing with the importance of using appropriate leadership styles in nursing practice, thus increasing productivity and job satisfaction. Additionally, further research may be beneficial in identifying the effects of nurse managers' use of appropriate leadership styles on job satisfaction of their nursing staff.

CHAPTER II

Literature Review

The study of leadership styles, employee satisfaction, and selected social characteristics of a hospital based personnel guided the literature review. The review was organized into three sections. In the first section, a background of leadership theory is presented. In the second section, literature is reviewed related to nursing leadership style. In the final section, a review of the literature related to leadership style and employee satisfaction is presented. Leadership and employee satisfaction studies included in the review have the most direct effect on this study.

Background of Leadership Theory

For the purpose of this review, historical leadership theories were classified as trait, scientific management, behavioral, and contingency-situational.

Trait Theories

Early researchers on leadership centered around the individual. A trait theorist believed that an effective leader was born with certain traits or characteristics that distinguished the leader from the follower. Gibb (1954), Mann (1959), Jennings (1960), Bass (1981), and Stogdill (1974) wrote extensively on what traits or characteristics were used by effective leaders. The trait theorist identified a variety of traits in leaders. A few of these were: height, looks, knowledge and intelligence, self-confidence, fluency of speech, drive, and courage. However, Jennings (1961, p.2) stated that "fifty years of study has failed to produce one personality trait or set of qualities that can be used to discriminate between leaders and non-leaders."

Mosley, Pietri, and Megginson (1996) believed that the identification of characteristics of effective leaders brought a restoration of the trait theory in the 1980's. Some researchers take the position that characteristics of successful leaders can be identified, and that these characteristics can be developed in others who aspire to be leaders (p. 397). Researchers who have identified characteristics in effective leaders are Bennis (1989), and Kouzes and Posner (1995). Bennis (1989) identified seven characteristics of effective leadership performance: business literacy, people skills, concept skill, track record, taste, judgement, and character. Kouzes and Posner (1995), in their studies on leadership, found that the leader should be able to adapt the five fundamental practices of exemplary leadership (challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart) and be versatile enough to adapt a style appropriate to each situation.

Scientific Management

A major turning point in the history of leadership occurred in the late 1800's when researchers changed their focus from identifying leadership traits to identifying ways to improve efficiency. A leader in the scientific management movement was Frederick W. Taylor. Taylor began looking at ways to improve efficiency in the steelworks in Philadelphia. In 1976, Koontz & O'Donnell stated that no other person has had a greater impact on the development of management than Frederick W. Taylor (p. 34). Taylor's (who is considered to be the father of efficiency engineering) enlightened approach to management advocated increasing productivity, while improving employees' working conditions and earnings (Mosley et al., 1996).

Behavioral Theories

While Scientific Management focused on ways to improve performance efficiency, in the 1930's, researchers began to shift their focus to favorable treatment of employees. The psychologist, Mayo (1932), brought the behavioral school to the forefront. Mayo's studies were conducted at the Western Electric plant in Hawthorne, Illinois, from 1927 to 1932. The purpose of these studies was to determine ways to improve productivity. Mayo found that employees worked harder when they believed that management was concerned about their welfare and paid attention to them. This phenomenon became known as the Hawthorne Effect.

Further development of behavioral theories in the 1960's occurred when McGregor introduced his Theory X and Theory Y. McGregor proposed that organizational leadership was based on two contrasting theories: Theory X and Theory Y. McGregor believed that behind every managerial decision or action were assumptions about human nature and human behavior (McGregor,1960, p.33). Theory X is based on the assumption that human beings dislike work. They must be coerced, controlled, threatened, and directed to achieve organizational objectives. Theory Y assumed that the average human being does not dislike work, seeks responsibility, and exercises self-direction and self-control to achieve organizational objectives.

The most important contribution to the behavioral approach has been our increased understanding of human motivation, worker behavior in groups, personal relationships at work, and the satisfaction derived from work over and above monetary reward (Pearce & Robinson, 1989, p. 42). Likert (1967) conducted research on the general patterns of

management used by high producing managers in different work settings. Likert posits that every aspect of a firm's activities is determined by the competence, motivation, and general effectiveness of the human organization. Likert concluded that the management of the human component is the central and most important task of management (p.1).

Likert's most important contribution to behavioral theory was the identification of four management systems operating in the actual organizations he studied (Mosley et al.,1996, p. 400).

These systems are:

System 1 (exploitative - authoritative) management primarily uses an autocratic leadership style.

System 2 (benevolent - authoritative) focuses on procedures and outcomes, and management makes most of the decisions.

System 3 (consultant) ideas are solicited from followers.

System 4 (participative) best decisions are made through a participative group structure between leaders and followers.

General, rather than close supervision, is more often associated with a high level of productivity rather than a low level of productivity (Likert, 1961, p. 9). In System 1 and System 2, the manager is in control and uses mainly an autocratic style of leadership, producing subservient attitudes in the followers. Likert proposed and demonstrated that moving an organization away from System 1 and 2, and toward System 3 and 4, would, given sufficient time for effects to take place, increase both employee productivity and

satisfaction (Bass, 1981, p. 302). The closer the organization is to System 4, the closer the organization is to achieving its goals.

Blake and Mouton (1985) proposed a managerial grid as a leadership model that focuses on tasks (productivity) and employee orientation to managers, as well as combinations of concerns between the two extremes (Mosley et al., 1996, p. 401). It is based on two dimensions termed "concerns for production" and "concerns for people." The manner in which these two concerns are expressed by a leader defines the use of authority (Blake & Mouton, 1985, p. 13). These dimensions were depicted in grid form. Concern for productivity was placed on the vertical axis and concerns for people on the horizontal axis. The grid was divided into four quadrants, and the dimensions were plotted from 1 to 9. One represented low concern, five an average amount of concern, and nine was high concern.

Blake and Mouton (1985) identified five benchmark leadership styles that displayed significant differences in characteristic actions and outcomes that were readily identified in leaders. The five types of leaders identified by Blake and Mouton (1985) were:

9,1 style maximum concern for production combined with minimal concern for people. A manager concentrates on maximizing production by exercising power and authority.

1,9 style minimum concern for production and maximum concern for people. Primary concern is placed on employees and avoids the use of pressure to get the work done.

1,1 style minimum concern for both production and people.

The manager does as little as possible.

5,5 style "middle of the road theory" or "go along to get along."

The manager conforms to the status quo.

9,9 style integrates production and people concerns.

Interdisciplinary approach that works toward gaining optimum results.

The important point is, in order to increase managerial competence and productivity in people, a leader must know alternative leadership styles, and be prepared to use the soundest style based on the work to be done and the individuals to do it (Blake & Mouton, 1985, p. 13).

Content Theories of Motivation for Leaders

Approximately ten years after behavioral researchers began looking at favorable treatment of employees, a second group of researchers began looking at the effects of motivation on employees. Content theorists addressed the question of what caused motivation to occur and to stop (Pearce & Robinson, 1989; Mosley, Pietri, & Megginson, 1996). Two major content theorists were Maslow and Herzberg. Maslow, the father of humanistic psychology, conducted research in a myriad of areas. Maslow is most remembered for his hierarchy of needs and the concept of self-actualization as the highest motivating force (Maslow, 1998). His theory of hierarchy of needs was developed in the 1940's and was based on his concept of five basic human needs. These needs are ranked in order of importance: physiological, safety, social, esteem, and self-actualization.

Physiological and safety needs are considered primary needs. Lower level needs form a foundation on which the higher level needs are built. The higher level needs are the needs which serve to motivate individuals (Fluker, 1995, p. 30). Social, esteem, and self-actualization needs are referred to as secondary needs. After the lower level need has been met, and remains stable, it no longer motivates behavior, and the person can move to a higher level. In order for the manager to motivate the employee, he or she must first determine at what level the individual is presently motivated. Pierce and Robinson (1989) noted the following criticisms with Maslow's theory:

1. Most people reorder the levels of hierarchy at some time in their lives.
2. It is extremely difficult to determine at what level of need the individual is currently motivated.
3. It is difficult to determine the person's needs.
4. Individuals differ in the extent to which they feel needs have been sufficiently satisfied.

Maslow's theory should be regarded as a general guide by managers, because it is a theoretical concept, not an absolute explanation for human behavior (Mosley et al.,1996, p. 366).

Another well known motivational researcher, Frederic Herzberg, developed a theory that supports Maslow's hierarchy of needs. Herzberg's Two-Factor Theory was derived from field research involving 200 employees at a large paint company. He found that the employees had two basic categories of needs which he labeled as hygiene factors and motivators. These two sets of factors parallel Maslow's concept of a hierarchy of needs,

where hygiene factors relate to the lower level needs (primarily security needs), and motivators relate to the highest levels (Mosley et al., 1996). Hygiene factors included policy, supervision, salary, relationship with peers, personal life, relationship with other employees, status, and job security (Pearce & Robinson, 1989, p. 457). Meeting hygiene needs prevented dissatisfaction, but did not increase motivation or job satisfaction. These factors have value only in the sense of being external rewards that occurred after the job was done.

Motivators included achievement, recognition, the nature of the work itself, responsibility, advancement, and the work itself (Pearce & Robinson, 1989, p. 458). The nature of motivators, as opposed to hygiene factors, is that they have a more long-term effect on employee attitudes (Herzberg 1968, p. 63). Workers expect certain conditions on the job, but it is not until their hygiene and motivating needs are met that they become productive. The only way to motivate an employee is to provide challenging work with increasing responsibility (Herzberg, 1968, p. 53).

Critics of Herzberg's theory pointed out that his findings might apply to professionals, but not to other groups of employees. Ondrack (1974) performed a construct replication of Herzberg's findings using the semi-structured Occupational Values Scale. A majority of the incidences failed to yield a two-factor pattern (p. 79).

Contingency-Situational Leadership Model

Each of the previous described theories is associated with highly respected theorists and has been studied in many different settings. None seem to resolve the linkage between leadership and such performance indicators as production, efficiency, and satisfaction

(Creamer, 1990). Contingency-situational theories are leadership theories based on such factors as the situation, the people, the task, the organization, and other environmental factors (Mosley et al., 1996, p. G-2). Virtually all leadership theories introduced in the past decade are contingency or situational theories (Creamer, 1990).

Fiedler (1965), the father of contingency theory, suggests that there are three major situational variables that seem to determine whether a given situation is favorable to leaders. These variables are as follows:

1. Leader-member - The leader's personal relationship with the group.
2. Task Structure - The degree of structure in the task to which the group has been assigned.
3. Position of Power - The power and authority the position provides.

Power plays an important role in leadership. Hersey and Blanchard (1996) note that it is not sufficient for the leader to have either position or personal power alone, but must work at obtaining both. They emphasize the importance for the leader to have both types of power in order to influence peers and subordinates alike. Different situations will require different approaches. Positional power may be effective in one situation, but in another, personal power would be more effective. Power is affected by the situational variables (Cook, 1992). Fiedler (1965) defined leadership as "an interpersonal relationship in which power and influence are unevenly distributed so that one person is able to direct and control the actions and behaviors of others" (p. 11).

An example of the contingency-situational theory is Hersey and Blanchard's "Life-Cycle" model. In 1977, Hersey and Blanchard changed the title of their model from

"Life-Cycle" to "Situational Leadership." Cook (1992) noted that Maslow's Hierarchy of Needs, Herzberg's Motivational-Hygiene theory, Likert's Management System, and Blake and Mouton's Managerial Grid theory, are all found in the Situational Leadership model. An important concept of the Situational Leadership Model is that a leader uses the appropriate leadership style for any given situation (Hersey et al.,1996).

Nursing Leadership Styles

Leadership style, as perceived by others, is the behavior pattern that a person exhibits when attempting to influence the activities of others (Hersey et al.1996, p. 134). An appropriate style is important because of its effect on employee morale and productivity (O'Donovan,1975). Recognizing leadership styles may help nurse managers adapt a style to meet the needs of the employee and the situation. The purpose of looking at leadership styles is to provide a means for identifying strengths and weaknesses in nurse managers' leadership styles, and to improve the quality of nursing leadership in the work setting.

Primary Leadership Styles

Leadership styles include two primary scores reflecting effectiveness and flexibility. Effectiveness is the appropriate use of a leadership style in a given situation (Hersey et al 1996, p. 135). Mosley, Pietri, and Mosley (1996) defined effectiveness as the managerial ability to set and achieve proper objectives. The more the nurse manager is capable of adapting his or her style of leadership behavior to the demands of the situation and the needs of the subordinates, the more effective he or she will be in reaching personal and organizational goals (Darby, 1989, p.22).

Flexibility is the ability to change the leadership style based on a new situation and is determined by how often the nurse manager uses a particular style to solve problems in different situations. Gresham and Brown (1997) referred to flexibility as the degree to which one is able to vary one's style to fit the maturity level of the followers in a specific situation.

Sharrow (1989) conducted a descriptive study to examine the perceived effectiveness of the leadership styles of deans of baccalaureate nursing programs. Effectiveness was measured by the LEAD instrument, and information, pertaining to global questions on faculty-perceived effectiveness and faculty supervision, was obtained from the Job Description Index. Twenty-nine deans and 294 faculty participated in the study. Findings showed that the deans perceived their leadership effectiveness as above average, while their staff perceived them to be at the low range of positive. On the global questionnaire, the staff perceived the deans to be above average to very effective. Further, findings indicated that in both studies, the deans had high task/high relationship effective dominant leadership style.

Adams (1990) conducted three studies on different perspectives of chief nurse executives' (CNE) leadership styles. The first study, was a descriptive study using the leadership effectiveness and adaptability description questionnaire developed by Hersey and Blanchard (1988). The purpose of the research was (1) to determine the primary leadership styles used by hospital CNEs, (2) determine the effective of the CNEs were in tailoring their style to fit the situation, and (3) determine if there was a significant relationship between selected demographic characteristics of CNEs and their leadership

effectiveness. Subjects were CNEs in acute care hospitals in a five-county San Francisco Bay area. Findings of the study showed that the CNEs used Selling (Coaching) and Participating (Supporting) Styles exclusively. The Coaching Leadership Style reflects the CNE's concern for both task and relationship. The group mean effectiveness score was averaged and was shown to improve with experience and education. Increased effectiveness with experience is consistent with Situational Leadership (p.38). The results of the study indicated that there was no relationship between experience and effectiveness.

In 1991, Sonkin conducted a descriptive study to examine the relationship between nurse managers' perception of situational leadership styles. The subjects consisted of ninety-two nurse managers from a regional medical center. LBA II, and Power Base Inventory questionnaires developed by Thomas and Boone in 1985 were used to collect data. Findings showed the leadership styles were closely grouped with the Supporting Leadership style noted as being the primary style, followed by the Coaching and Delegating Leadership Styles. The Supporting Leadership Style involves the employee in the decision making process. It permits the employee to participate in determining the basis upon which their efforts will be judged. Furthermore involvement of employees in the planning process increases their commitment to the goals and objective. The success of this style depends on the situation.

Adams (1993) conducted a correlational study to determine if CNEs and chief executive officers (CEOs) in the same hospital have the same problem-solving styles and how tenure of the CNE related to the problem-solving styles of the CNE/CEO. Sixty-six CNE/CEO pairs were given an adaptation-innovation questionnaire developed to measure

problem-solving styles. Sixty-seven percent of the pairs had the same problem solving-style. There was a significant relationship between problem-solving styles of the CNE/CEO pairs and tenure of the CNEs. Two-thirds of the CEOs employed CNEs with the same problem-solving style. A CNE/CNO pair who share the same problem solving style use the same thinking process to solve problems, they hold similar views on ways to achieve goals, and they respond similarly to change and crisis, and adopt innovations at a similar rate. High performance teams are essential to a hospital efficiency, effectiveness, and success.

In 1994, Adams conducted a descriptive study that addressed the problem-solving styles of hospital nurse executives and the relationship between problem-solving style and leadership effectiveness. Sixty-six hospital nurse executives in a five county urban area in California participated in the study. The Kirton Adaption-Innovation Inventory (KAI) and the Leadership Style Effectiveness Adaptability Descriptive-Self (LEAD-Self) questionnaires were used to collect data. Findings showed that the majority of the nurse executives were innovators. There was no difference in the effectiveness scores of adaptors and innovators.

Conflict Management Style of Nurse Managers and Staff Nurses

Thomas-Kilmamn's (1974) Measure of Differences (MODE) questionnaire was used by Cavanagh (1991) to determine the conflict management style of 142 staff nurses and 82 nurse managers in twenty urban hospitals. The study investigated the conflict management style of RN staff nurses and nurse managers in the hospital setting. The conflict management style is described in terms of five predominant types: accommodation,

avoidance, collaboration, competition, and compromise. Findings of the descriptive study suggested that avoidance is the most common used conflict management style used by nurse managers with competition being the least favored. It was noted that nurse managers' using the avoidance style was noted to have difficulty taking a stand on issues, unlikely to be assertive, efficient or effective. The findings show that nurse managers vary their leadership style to resolve conflict. Findings also showed that the nurse managers' had a primary and secondary leadership style.

Leadership Behavior

A descriptive study was conducted by Johnson and D'Argenio in 1991 to measure the effectiveness of a management training program on the leadership behavior of a group of new managers. Lead-Self and Other (Blanchard & Blanchard, 1973) were used in this study to collect the data. Eleven nurse managers, and at least three of their respective staff from a 178-bed community hospital, participated in the study. Findings indicated that the managers used both dominating, and supportive leadership styles, and had low effectiveness.

In conclusion, the results of the study showed that it is possible to obtain short-term changes in leadership behavior through involvement in a leadership training program. The leadership styles used by the managers did not foster growth and development of followers, and would not be effective in a nursing department striving to establish a professional practice climate.

Darby (1989) conducted a study to determine if a relationship exists between female nursing administrators' needs for affiliation and administrative effectiveness. The subjects

were 274 nursing administrators in an acute care hospital in the state of Missouri. The Jackson Personality Form (Jackson, 1984) was used to evaluate the need for affiliation and the Leadership Behavior Analysis II-Self (Blanchard, Hambleton, Zigarmi, & Forsyth, 1991) was used to measure leadership effectiveness. The findings of the study showed no correlation between need affiliation and effectiveness.

Ciesla (1992) used the Leadership Behavior Analysis II Questionnaire (Hersey & Blanchard, 1988) to determine if there were any differences in the use of leadership styles and leadership effectiveness between deans of schools of nursing and deans of schools with programs in management. Effectiveness, as defined by Hersey & Blanchard (1988), indicates the ability to choose the appropriate leadership style for a particular situation.

Fifty-five deans from nursing programs and 55 deans from management programs participated in the study. The majority of the deans reported the use of low-directive and high supportive leadership style. This style is effective with highly professional, independent, educated, and motivated individuals. Findings showed no significant differences in the use of leadership styles, or leadership effectiveness, between the deans of the two programs, and was an appropriate style for use with their followers.

Leadership Styles and Job Satisfaction

Research in nursing related to job satisfaction dates back approximately twenty-eight years. The first study relating to components of work satisfaction in nursing, was conducted by a nurse, and published in 1953 (Stamps & Piedmonte, 1986). This study indicated that the hospital setting provided the least amount of job satisfaction for nurses (Gustin, 1988, p. 10). Research in industry and nursing have consistently demonstrated an

inverse relationship between satisfaction, turnover, and absenteeism. Results of recent studies indicate a relationship between job satisfaction and leadership style.

In 1984, Duxbury, Armstrong, Drew, and Henley evaluated various leadership styles as they related to burnout and job satisfaction of 283 nurses employed in fourteen Neonatal Intensive Care Units. Findings indicated that a leadership style of low consideration and high structure was most deviant. Head nurse structure had no significant effect on satisfaction and burnout. Head nurse structure did have an effect when combined with consideration. Nurse managers could promote growth and professionalism by displaying a leadership style that discouraged burnout and promoted job satisfaction. The findings were correlated to results of a previous study by Duxbury, Henley, and Armstrong (1982) in which it was determined that nurse managers held a pivotal role within a Neonatal Intensive Care Unit. Nurse managers who provided a leadership style that was supportive of staff nurses were found to have a moderate effect on the environment and promote job satisfaction.

Rhoton (1985) studied the relationship of charge nurses' leadership style dimensions of consideration and structure with staff nurses' job satisfaction. Fifteen charge nurses, and 77 staff nurses in two U.S.A.F. Medical Centers, participated in the study. Charge nurses were given the Leadership Opinion Questionnaire (LOQ) developed by Fleischman (1969). The LOQ was used to measure leader dimensions of consideration and structure. The Minnesota Satisfaction Questionnaire (MSQ) was used to measure job satisfaction of staff nurses. The charge nurses and the staff nurses completed a demographic questionnaire. The results of a Pearson correlation procedure indicated a positive

association between staff nurses' overall job satisfaction and charge nurse structure, and between staff nurse satisfaction with supervision and charge nurse consideration. The findings indicate that the charge nurse's leadership behavior does affect job satisfaction. Demographic characteristics were not significantly correlated with job satisfaction.

Gustin (1988) conducted a study to compare job satisfaction of hospital nurses who utilize a shared governance management structure to job satisfaction of hospital nurses in a traditional management structure. Three-hundred-forty-six nurses from two hospitals participated in the study. One-hundred-ten nurses from a 300-bed religious based hospital with shared governance, and 236 nurses from a 700-bed urban hospital with traditional management structure participated in this study. The I W S (Stamps & Piedmonte, 1986) was used to measure job satisfaction, and a demographic questionnaire was completed by the participants. In this study, job satisfaction was significantly higher in the shared governance hospitals as compared to the traditional hospitals.

A non-experimental survey design used by Williams in 1990 to determine the difference between job-satisfaction of RN's in medical/surgical units and RN's in critical care units. Thirty-seven RN staff participated in the study. The IWS (Stamps & Piedmonte, 1986) was used to measure job-satisfaction. No significant differences in levels of satisfaction between RN staff in medical/surgical units and RN staff in critical care units were noted. None of the RN staff in (medical surgical or critical care) were not satisfied with their jobs. The components ranked most important were pay and autonomy. Those ranked least important were organizational policies and task requirements. Pay was found to be the most single most important dissatisfying component.

Lucas (1991) conducted a correlational descriptive design study to determine nurses' perceptions of the current and desired management styles of hospital units, and to investigate the relationship of management style on satisfaction. Subjects consisted of 505 staff nurses in two private and two public acute care general hospitals in a southeastern metropolitan area. Management style was measured using the Profile of Organizational Characteristics (Renis Likert Associates, Inc., 1978). Job satisfaction was measured using an instrument developed by Munson and Heda in 1974. In this study, management style and job satisfaction were significantly correlated. Job satisfaction was found to be related to years employed in the hospital. The staff nurses perceived that the managers used a benevolent-authoritative style. The desired management style of the staff nurses was participative. A participative management style was associated with job satisfaction.

Boumans and Landeweerd (1993) surveyed 561 nurses to determine if a correlation existed between the leadership style of the head of the unit, the reaction of nurses (job satisfaction, experienced meaningfulness, and health complaints). Did the nurse's need for autonomy play a moderate role in the reaction the nurse had and the leadership style used by the head nurse? It was noted that the nurse manager occupied an important position within the framework of the nursing unit. Leadership styles of consideration and structure/productivity were correlated with job satisfaction, health complaints, and absenteeism. Findings indicated that a social leadership style contributed positively to nurses' job satisfaction, and reduction of health complaints. A highly structured leadership style was associated with increased health complaints and decreased work satisfaction. In terms of satisfaction and complaints, nurses with a need for autonomy required a different

leadership style than those with little need for autonomy. Based on the analysis of combinations of leadership styles, it appears that nurses are more satisfied if the nurse manager pays attention to both dimensions of leadership. It becomes clear that nurses with a great need for autonomy prefer a different type of leadership from nurses with little need of autonomy. The findings from this study supports the need to vary one's leadership style to meet the situation and the individual needs of the individuals involved.

McNeese-Smith (1993) conducted a correlational descriptive study to measure the amount of time managers used leadership practices as perceived by manager and as perceived by their staff. McNeese-Smith was interested in determining if a correlation existed between the manager's leadership behaviors and the employees' productivity, job satisfaction, and commitment. The five leadership practices, identified by Kouzes and Posner, were the behaviors used in this study. They are: (1) challenging the process, (2) inspiring a shared vision, (3) enabling others to act, (4) modeling the way, and (5) encouraging the heart. Forty-one department managers and 471 staff members, in two suburban, acute care hospitals, participated in the study. Fifty percent of the participants were from nursing departments, and fifty percent of the remaining participants were from other clinical and non-clinical areas. The following questionnaires were used to collect data: Leadership Practices Inventory for Self and Others (Kouzes & Posner, 1990), Job-in-Denial Scale (Smith, Kendall, & Hulin, 1975), Organizational Commitment Scale (Lyman et al., 1974), and Productivity Scale (McNeese-Smith, 1991). Results show that leaders utilize the behavior of "Enabling Others to Act" most frequently and "Inspiring a Shared Vision" the lest often. The McNesse-Smith concluded that behaviors nursing

managers utilize can make a significant impact on employee productivity, job satisfaction, and commitment.

Kovner, Hendrickson, Knickman, & Finkler (1994), conducted an experimental study to assess the impact of various nursing care delivery models and management interventions on nurse satisfaction. Eight hundred fifty-eight RNs form 68 pilot units, and 335 RNs from 35 companion units in 35 acute care hospitals participated in the study. The IWS (Stamps & Piedmonte, 1986) was used to measure job satisfaction. The authors concluded that changing the work environment seems to bring about significant changes in elements of satisfaction. They were not able to determine the impact that these changes in satisfaction had on turnover.

A descriptive study was conducted by Drews and Fisher (1996) which focused on management style, intent to stay, job satisfaction, and selected individual and organizational characteristics. Subjects consisted of 43 nurses who were randomly selected from a Midwest, acute-care, public university children's hospital. Job satisfaction was measured by the IWS(Stamps & Piedmonte, 1986). The leadership questionnaire was a 18-item questionnaire divided into six categories: leadership, motivation, communication, decision making, goals, and control. Findings indicated that a significant relationship existed between perception of leadership style and RN job satisfaction. A one-way ANOVA analysis showed no significant relationship between perceived job satisfaction and intent to stay. A higher level of satisfaction existed when the supervisor used the participative style. The study also showed that the staff nurses with a higher level of satisfaction were likely to stay in their job for the next three years.

Gresham and Brown (1997) used a correlational design to examine the interplay between job satisfaction, leadership style, and leadership adaptability. Twenty-two chief nurse executives, and 87 middle nurse managers (MNM), participated in the study. The Lead-Self and the Lead-Other questionnaires, developed by Hersey and Blanchard (1997), were administered to determine the perceived leadership style and leadership adaptability of the MNM. The "Satisfaction with my Supervisor Scale" was administered to assess workers' satisfaction with their supervisors. Findings indicated that the MNMs preferred selling and participating styles of management. Congruence in perceived leadership adaptability was not significantly related to satisfaction with supervision. In addition, a possible relationship between congruence of perceptions and satisfaction with supervision was found.

Acorn, Ratner and Crawford (1997) conducted a study to test a structural model delineating decentralization and its relationship to perceived autonomy, job satisfaction, and organizational commitment to first-line nurse managers. Two hundred first line nurse managers in 41 acute care hospitals of more than 100 beds in a providence in Canada participated in the study. The Index of Centralization (Hage & Aiken, 1967) was used to measure decentralization; Job Characteristics Inventory (Sims, Szilagi, & Keller, 1976) was used to measure autonomy; and The McCloskey/Muller Satisfaction Scale (Muller & McCloskey, 1990) was used to measure job satisfaction. Findings indicated that job satisfaction was an important predictor of organizational commitment. Decentralization was found to be more important, because it affected organizational commitment directly, and indirectly, through professional autonomy and job satisfaction.

McNeese-Smith (1997) conducted a research study to identify staff nurses' perception of what their managers do to increase job satisfaction, productivity, and commitment to organizational, as well as their job dissatisfaction, or lack of commitment to the organization. Thirty nurses from a large Los Angeles county hospital participated in the study. McNesse-Smith concluded that receiving recognition or thanks from the Nurse Manager (NM) contributed to job satisfaction, productivity, and to a lesser degree, to organizational commitment. Job satisfaction was related to meeting the personal needs of the staff, accommodating scheduling needs where possible, and giving professional advice. There was higher nurse satisfaction and productivity when the NM met unit needs, facilitated the nurses in doing their job, organized the work, and followed-up on problems.

Morrison, Jones, and Fuller (1997) examined the relationship among leadership style, empowerment, and job satisfaction, for the staff nurses of a regional medical center. Two hundred seventy-five nursing department personnel participated in the study. The following questionnaires were used in the study: Bass Multi-factor Leadership Questionnaire (Bass, 1985, 1995), Spreitzer's Psychological Empowerment Instrument (Spreitzer, 1995), and Warr's Job Satisfaction Questionnaire (Warr, Cook, & Wall, 1979). The authors concluded that transformational leadership had no effect on empowerment, although it does have a direct effect on job satisfaction.

Moss and Rowels (1997) investigated the relationship between head nurses' management style and staff nurses' job satisfaction. Six hundred twenty-three nurses in three Midwestern hospitals participated in the study. Likert's Profile of Leadership Behavior (Form LB) (Likert &Likert, 1986), and the Prince and Muller's Job Satisfaction

Survey (Prince & Muller, 1981), were used to collect data. The author concluded that staff nurses' job satisfaction clearly improves as the management style moves toward a participative management style.

Fung-kam (1998) used a cross sectional design to obtain a comprehensive understanding of job satisfaction of Hong Kong nurses and obtain direction for effective improvement on nurses' job satisfaction. A secondary purpose was to assess the need for autonomy of Hong Kong nurses, and to examine the relationship between nurses' job autonomy and their individual need for autonomy. One hundred ninety registered nurses, employed by general hospitals, participated in the study. The IWS (Stamps & Piedmonte, 1986) was used to measure job satisfaction. Findings indicated that the RNs were dissatisfied more than satisfied. The nurses valued the components of autonomy, professional status, and pay. There was no significant relationship between their satisfaction with job autonomy and their individual need for autonomy.

Bratt, M., Broome, M., Kelber, S., and Lostocco, L. (2000), conducted a cross-sectional survey designed to explore the influence of nurses' attributes, unit characteristics, and the work environment on the job satisfaction of nurses in pediatric critical care units to determine stressors that are unique to nurses working in pediatric critical care. The sample consisted of 1,973 staff nurses in pediatric critical units in 65 institutions in the United States and Canada. The following predictor variables were measured using self-reported questionnaires: job stress, nursing leadership, group cohesion, and nurse-physician collaboration. Significant associations were found between stress, group cohesion, professional job satisfaction, nurse-physician collaboration, nursing

leadership behaviors, and organizational and work satisfaction. Organizational work satisfaction was positively collaborated with group cohesion, professional job satisfaction, nurse-physician collaboration, and nursing leadership behaviors. Job stress, group cohesion, job satisfaction, nurse-physician collaboration, and nursing leadership explained 52% of the variance in organizational work satisfaction. The author's conclusion was that job stress and leadership behaviors are the most influential variables in the explanation of job satisfaction.

Ingersol, G., Olsan, T., Drew-Cates, J., and Devinney, D., and Davies, J. (2002) conducted research in order to define the characteristics of the nursing work force of a mixed urban/rural region of New York state and to determine the nurse level of job satisfaction and commitment to the work setting. One-thousand-eight-hundred-fifty-three of the nurses who received questionnaires returned usable forms. The IWS (Stamps & Piedmonte, 1986) was used to determine job satisfaction. Findings in this investigation suggest that organizational environment, education preparation, and personal characteristics of currently employed registered nurses affect their current job satisfaction, organizational commitment, and plans for continuing in nursing.

Summary

Leadership and leadership theory have evolved from the concept that certain traits distinguished the leader from the follower, to ways to improve the follower's performance, and finally to relationships between the leader, follower, situation, and maturity level of the follower. Scholars have not been able to identify a set of traits common to all leaders or identified a set of leadership behaviors appropriate for all situations because of

heterogeneity. However, leaders are finding success in adapting a leadership style to fit each situation.

Research findings in nursing literature reflect that nursing leadership is unique due to the rapid changing healthcare profession, nursing shortage, and that the majority of the nursing leaders are women. Nursing is in an era of rapid change; an era that requires its leaders to be prepared, effect change, and not just maintain the status quo.

Recent studies indicate that the manager's leadership styles affect job satisfaction. Determining which leadership styles are used by the nurse manager will give the nurse manager insight into their strengths and weaknesses, and may provide the nurse managers with new innovative approaches to managing their followers in order to adapt to the changing healthcare profession, improve the followers performance, increase job satisfaction, and reduce absenteeism.

CHAPTER III

Methodology

The purpose of this study was twofold: (1) to describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of nursing staff. The six components of job satisfaction include pay, professional status, task requirement, interaction, autonomy, and organizational policies. The study design, sample and setting, independent and dependent variables, protection of human subjects, instruments, procedure for data collection, and data analysis plan are presented in this chapter.

Design

The design of this study was descriptive, comparative, exploratory, and correlational in nature. Descriptive and exploratory studies are designed to describe variables and to gain more information about characteristics within a particular field (Burns & Grove, 1993, p. 294). The purpose of conducting descriptive research is to "accurately portray a population that has been targeted because of some specific characteristics" (Wilson, 1989, p. 150). A comparative design is used to compare or contrast samples from two or more groups of subjects in relation to certain designated variables (Wilson, 1989, p. 150). Correlational designs examine relationships between variables of interest. In descriptive

correlational designs, no attempt is made to control or manipulate the variables. The purpose of this design is to examine the relationship that exists in a situation (Burns & Grove, 1993).

Sample and Setting

The target population for this study were full-time managers and RN staff members. The convenience sample for this study consisted of 11 full time nurse managers and 79 RN staff from a non-profit acute care hospital meeting the following criteria:

1. Male and female registered nurses licensed by the state to practice professional nursing.
2. Employed full time.
3. Actively employed in the selected setting for at least six months prior to the onset of the study.
4. RN staff members will have worked with their nurse manager for at least six months.

The setting for this study was a 406 bed not for profit acute care hospital, accredited by the Joint Commission for the Accreditation of Health Organizations, Medicare Certified, located in a southern geographic region of the United States. The nursing service population consisted of 483 full-time nursing staff as follows: 12 nurse managers, 297registered nurses, 40 licensed practical nurses, 74 nursing assistants, and 58 clerical staff.

Protection of Human Subjects

Approval for this study was obtained from the Chief Operational Officer (Appendix A) and the Institutional Review Board (IRB) at the study site (Appendix B) as well as the Institutional Review Board of Louisiana State University Health Sciences Center (LSUHSC) (Appendix C). Potential participants were provided with a packet that included an explanation and a description of the purpose of the study, the procedure, consent forms, and instruments. Privacy, anonymity, and confidentiality were guaranteed. Participants were not identified in any way. Coded numbers were assigned to questionnaires to protect the identity of the participants. No physical, psychological and/or social risks or discomfort to the participants were anticipated as a result of participating in the study. Participation in the study was voluntary, and subjects had the right to refuse to participate without prejudice.

Participants who participating were asked to read the enclosed consent form in the packet and, were asked to sign the consent form per LSUHSC consent guidelines (Appendix D). Participants were instructed to follow the procedure for data collection. All data obtained from this study was stored in a locked filing cabinet at the investigator's home. The researcher, statistician, and major advisor were the only individuals with access to the data.

Instruments

Four instruments were used in the study: A Selected Demographic Characteristics Form (SDCF) developed by the researcher, the Leadership Behavior Analysis II-Self (LBAII-Self) the Leadership Behavior Analysis II-Other (LBAII-Other) revised by

Zigarmi, Edeburn, and Blanchard (1997) and the Index of Work Satisfaction (IWS, Part A and B) developed by Stamps and Piedmont (1986, 1997).

SDCF

The SDCF was used to identify institutional and personal variables. The institutional variables consist of area of employment, shift, years of service, years as an RN and type of employment (full time).

Other demographic variables included age, educational level, and gender (Appendix E). The variables noted in the SDCF were used to describe the sample and to determine if any of these variables were potential intervening variables that may affect the results of the study.

LBAII-Self and LBAII-Other

In developing the instrument, consideration was given to the use of words and phrases associated with directive and supportive leadership behaviors. The instrument was designed to depict situations that describe and support the leadership behaviors (styles). There are six different styles (Zigarmi et al., 1997). These include:
Style 1-High Direction/Low Support; Style 2-High Direction/High Support; Style 3-Low Direction/High Support; Style 4-Low Direction/Low Support; Style 5-Leadership Style Effectiveness; and Style 6-Leadership Style Flexibility (Appendixes F and G). The cumulative style scores reflect the amount of direction and support used by the leader at the time the data is collected. The typical job situations noted in the LBAII-Self and LBAII-Other are exactly the same and include identical behavior choices. The only

differences in the two instruments is that the LBAII-Self is used for leaders (nurse managers), and the LBAII-Other is used for employee (RN staff) rating of perceived leadership styles of their nurse managers. Two principal scores of the LBAII instruments are the Leadership Flexibility and Effectiveness Scores. Other scores represent the frequency in which primary, secondary, and developmental leadership styles are chosen (Zigarmi et al., 1997, p. 7). Permission to use the LBAII-Self, and the LBAII-Other was granted by Dr. Drew Zigarmi, the Research Coordinator for Blanchard Training and Development, Inc. (Appendix H).

Leadership flexibility style scores. The leadership flexibility style score is a numerical indicator of how often a respondent uses a different style (S1, S2, S3, and S4) in solving each of the 20 job situations in the LBAII. A high score indicates high style flexibility, which means the respondent uses all of the four styles more or less equally. The leadership flexibility style scores range from 0 to 30. (Zigarmi et al. 1997, p. 7).

Leadership effectiveness style scores. The leadership effectiveness style score is a numerical indicator reflecting the degree to which the leader (manager) or his subordinate (staff member) perceives the leadership style as the most appropriate style to use for each of the specific 20 job situations presented in the LBAII instrument. A value is assigned to excellent, good, fair, and poor responses as follows (4, 3, 2, and 1 respectively). The potential score ranges from 20 to 80. The leadership effectiveness score represents the diagnostic skill of the manager in selecting the appropriate style advocated by the Situational Leadership Mode. For subordinates (RN staff members), the

leadership effectiveness score represents the perceived behavior of the manager (Zigarmi et al., 1997, p. 8).

Primary, secondary, and developmental leadership styles. The 20 questions noted in the LBAII-Self and LBAII-Other represent Primary, Secondary, and Developmental Leadership Styles which are "extracted" subscores of Leadership Effectiveness and Leadership Flexibility styles. The Primary Leadership style is the leadership style(s) a manager uses most often and is indicated by scores calculated from responses noted on the LBAII instruments. Secondary Leadership Style is the second most likely style employed by the manager. The Developmental Leadership Style is the style a manager needs to develop as indicated by low scores.

Internal Consistency Reliability of LBAII-Self and LBAII-Other. Since 1983, numerous dissertations (unpublished) masters theses (unpublished), and research papers have been written using these instruments. In 1987, Blanchard Training and Development, Inc. strengthened the instrument that is used to measure the Situational Leadership concepts of Style, Flexibility, and Effectiveness in terms of internal consistency reliability (Haley, 1983).

Reliability is defined as how consistently an instrument measures the concept of interest (Burns & Grove, 1993, p. 778). Hersey and Blanchard developed one of the most reliable methods of "measuring impression, perceptions, or expectations of or about the leader" (Chemers & Ayman, 1993, p. 139).

The internal consistency reliability coefficients of the LBAII-Self are adequate for self-reporting instruments ranging from a low of 0.43 to a high of 0.60 (Zigarmi et al.,

1997, p. 94). Zigarmi et al. (1997) averaged the reliability data from five different studies and reported Cronbach's alpha coefficient for the LBAII-Self as 0.53. The authors also stated that the internal consistency reliability of the LBAII-Other was "extremely good," ranging from a low of 0.54 to a high of 0.86 (p. 94). Zigarmi, Edeburn, and Blanchard. (1993) also averaged reliability data of eight different studies and obtained an internal reliability alpha coefficient of 0.74 for the LBAII-Other instrument.

Construct validity of LBAII-Self and LBAII-Other. Validity determines the extent to which the instrument actually reflects the amount of construct being examined (Burns & Grove, 1993, p. 782). In other words, it is the ability of the instrument to measure what it claims to measure. Construct validity of the LBAII-Other was obtained by examining relationships of a Leadership Style instrument [Multi-Level Management Survey (MLMS)] that had already been tested. A statistically significant relationship ($p < .0001$) was evidenced in all but one of the comparisons. The authors state that the validity results of LBAII-Other can be, for all practical purposes, applied to the LBAII-Self (Zigarmi et al., 1997, p. 20).

Index of Work Satisfaction (IWS).

The IWS was developed in an effort to produce a practical job satisfaction questionnaire that could provide an accurate measure of the occupational satisfaction of nurses. The scale is based on Herzberg's (1959) and Maslow's (1970) theories of job satisfaction. Six components of job satisfaction related to health care occupations were identified: pay, autonomy, professional status, interaction, task requirements, and organizational policies (Stamps, 1997).

The IWS is composed of two parts (Appendix I). Part A measures the relative importance of various aspects of components of job satisfaction to the participant. Part A of the IWS is used to allow participants to choose between all possible combinations of 15 pairs of the six components. Participants are asked to choose the member of each of the pairs that they consider more important to them as a contributor to their own level of job satisfaction. The relative importance of each component is then weighed and a scale value is computed for each component.

Part B is a 44-item attitude scale that measures current levels of satisfaction for each of the six components. The items are arranged randomly throughout the questionnaire in order that the participant would not become aware of the particular component being studied. The IWS is scored on a 7-point Likert scale ranging from strongly disagree to strongly agree with a neutral point. Half of the items with each component are phrased negatively and half positively. A total weighted score is calculated from Parts A and B. The weighted score reflects both the level of importance and evident satisfaction.

Internal consistency reliability of the IWS. The IWS was first given to two samples of nurses in rural hospitals in 1972. The IWS was administered to 336 nurses. Eighty-three percent of the nurses responded. The internal consistency reliability alpha coefficient was 0.912. The IWS was also administered in seven other settings over an eight-year period. Stamps (1997) states that revisions of the IWS were made after each administration. Cronbach's alpha and Kendall's tau were used to establish internal consistency reliability. The alpha coefficients for each of the components ranged from 0.69 to 0.90 with an overall coefficient of 0.85.

Construct validity of the IWS. Factor analysis was used to verify construct validity of Part B of the IWS. A principal component analysis with a varimax rotation produced factors that accounted for 62% to 82% of the variance. The questions were grouped into seven to fifteen components of work satisfaction that were closely related to the original six components of pay, autonomy task requirements, administration, interaction, and professional status. Further analysis revealed overlapping and similar factors.

A final validation study was conducted in 1985 on a sample of 246 completed questionnaires. Internal consistency reliability testing resulted in an alpha coefficient of 0.82 for the overall IWS instrument. Intra scale reliability for the six components ranged from 0.52 to 0.81 indicating that each item within a subscale measured that particular aspect of job satisfaction. The strength of the correlation between weighted and unweighted summed scores of Part B was tested using Kendall's tau resulting in a high coefficient of 0.92. This final validation phase produced the 44-item questionnaire that was published in 1986 (Stamps, 1997). Permission to use the IWS was obtained from Paula L. Stamps through Market Street Research, Inc. (Appendix J).

Independent and Dependent Variables

Research Questions 2 - 5

The two groups of participants (nurse managers and RN staff) are independent variables and the scores reflecting perceptions of leadership style flexibility and leadership style effectiveness are the dependent variables

Research Question 6

The dependent variables are scores of the six components of Part B of the IWS (pay, professional status, task requirements, interaction, autonomy, and organizational policies). The independent variables are scores reflecting the perceptions of leadership style: leadership style flexibility and leadership style effectiveness.

Procedure for Data Collection

The procedure for data collection pertaining to this study was as follows:

1. Obtained permission to conduct the study from the Chief Operations Officer at the selected setting.
2. Obtained permission from the Blanchard Training and Development, Inc. to use the LBAII-Self and the LBAII-Other instruments.
3. Obtained permission from Paula Stamps/Market Street Research, Inc. to use the IWS instrument.
4. Obtained approval from the Institutional Review Boards (IRBs) at Louisiana State University Health Sciences Center and the university affiliated with the selected hospital setting.
5. Selection of Participants - A list of nurse managers, the number of RN staff, and their units was provided by the Assistant Administrator of the selected hospital. All nurse managers and RN staff who were full-time employees, and who were employed a minimum of six months, were asked to participate in the study. Questionnaires and consent forms were coded with a number representing whether the participant was a nurse manager or an RN staff member.

Example: Questionnaire coded "1" represents the nurse manager and Questionnaire coded "2" represents RN staff. The rationale for the coding system was that it provided anonymity and confidentiality and was also essential for analyzing the data representing nurse managers separately from the RN staff.

6. Each packet contained a cover letter explaining the study (Appendixes K and L), Information regarding anonymity and confidentiality, the right to refuse to participate at any time without jeopardizing any relationship with the employing institution, the consent form, the SDCF, the LBAII-Other, the IWS instruments, two large envelopes labeled "Consent Forms Only" and "Questionnaires Only." The researcher's telephone number was also included in the packet.
7. RN staff members participating in the study were instructed to (1) signed the consent forms, placed them in the envelope labeled for that purpose, and sealed the envelopes, and (2) completed the three questionnaires, placed the three completed questionnaires in the envelope labeled "Questionnaires Only," and sealed the envelopes.
8. Participants were instructed to place their envelope labeled "consent form" into a sealed slotted box labeled "Consent Forms Only," and to place their envelope labeled "questionnaires only" into a sealed slotted box labeled "Questionnaires Only - For Richard McElhaney, RN, MSN" were provided for this purpose and were located in Nursing Services Office.
9. The researcher collected the slotted sealed boxes one week following disposition of the packets to the RN staff members. Consent forms and completed

questionnaires were kept separately in a locked file at the researcher's home. Data were available for analysis only to the researcher, major professor, and statistician.

10. The researcher met with the nurse manager group at a pre-arranged time and explained the study to them. Packets were distributed and the same procedure as noted for the RN staff in regard to voluntary participation will be followed.

Research Questions and Data Analysis

The Statistical Package of the Social Sciences (SPSS) Version 10 (1999) and Sigma Stat Statistical Software (1995) were used to perform the data analysis. The data obtained from the Social Demographic Form were used to describe the sample and explore when potential differences existed in demographic characteristics between nurse managers and RN staff. Internal consistency reliability of the LBAII-Self, the LBAII-Other, and Part B of the IWS were computed using Cronbach's Alpha.

Normality of scores representing the six components of the IWS, leadership effectiveness, and leadership flexibility were tested using the Kolmogorov-Smirnov (K-S) test. A p value > .05 indicates that the data are considered to be normally distributed (Seigal, 1956). The homogeneity of variance for the same variables was tested using Bartlett's F Box test. A p value > .05 indicates that the variances of the two groups are not significantly different.

Estimated Power Analysis for Independent t-test and Correlation Procedures

Originally a power analysis for the independent t-test was conducted using the SigmaStat statistical software program (Jandel Scientific, 1995). The estimated power of the

independent t-test with an expected difference in means of the two groups with $n = 13$ (nurse manager group) and $n = 130$ (RN staff group) and a standard deviation = 0.06 yielded a power of 0.812 at alpha = 0.50. The estimated power of the independent t-test with a difference in means of the two groups = 5.00 and standard deviation = 4.50 yielded a power = 0.967 at alpha = 0.05.

The estimated power for the correlation procedure with a correlation coefficient as low as 0.25 yielded a power of 0.81 based on a sample of 130 RN staff members. However, it is noted that a second power analysis was conducted based on the actual sample size of nurse managers and RN staff in this study. Results were reported in the analytical phase of this study. The following research questions guided the data analysis of this study.

Research Question 1

Is there a difference in the (a) educational level, (b) gender, (c) age, (d) length of time as an RN, (e) length of time employed in current hospital, and (f) length of time worked on current unit, of nurse managers and their RN staff?

Cross tabulation (including frequencies, percentages, means, medians, and standard deviations) of social characteristics were used to compare nurse managers and RN staff.

The original plan to use the chi-square test as an exploratory measure to determine if there were significant differences in the gender of the two groups was discarded since the assumption of less than five responses in more than 20% of the cells was violated. Additionally the independent t-test which was originally planned as an exploratory measure to ascertain it there were significant differences in the remaining social

characteristics, with the exception of age, was also discarded since these characteristics were listed as frequency distributions (nominal data) instead of actual year (ratio data.)

Research Question 2

What is the leadership style flexibility of the nurse managers as perceived by the nurse managers on the LBAII-Self instrument as compared to the leadership style flexibility of nurse managers as perceived by their RN staff on the LBAII-Other instrument?

Research Question 3

What is the leadership style effectiveness of nurse managers as perceived by the nurse managers on the LBAII-Self instrument as compared to the leadership style effectiveness as perceived by their RN staff on the LBAII-Other instrument?

Research questions 2 and 3 were analyzed using frequencies, percentages, means, medians, and standard deviations. The independent t-test was used as an exploratory measure to determine if significant differences exist between the nurse managers and RN staff in regard to their perceptions of nurse managers, leadership style flexibility, and effectiveness.

Research Question 4

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse managers on the LBAII instrument?

Research Question 5

What are the primary, secondary, and developmental leadership styles of nurse mangers as perceived by the nurse managers' RN staff on the LBAII-Other instrument?

Research questions 4 and 5 were combined in order to compare the primary, secondary, and developmental leadership styles of nurse managers as perceived by nurse managers and RN staff. Frequency counts of the number of times a respondent chooses one particular style out of four (S1, S2, S3, or S4) from the twenty job situations noted on LBAII-Self and LBAII-Other were obtained. The chi-square statistical test was used as an exploratory measure to determine if significant differences exist between perceptions of nurse managers and perceptions of RN staff in regard to primary, secondary, and developmental leadership style of nurse managers indicated by responses on the LBAII-Self and the LBAII-Other instrument. A p value $\leq .05$ was used to determine if there were significant differences in perceptions of primary, secondary and developmental leadership styles of nurse managers and RN staff.

Research Question 6

Are leadership style effectiveness, and leadership flexibility of nurse managers as perceived by RN staff predictive of their satisfaction with (1) pay, (2) professional status, (3) task requirements, (4) interaction, (5) autonomy, and (6) organizational policies.

Research question 6 was not analyzed since none of the IWS dependent variables were significantly correlated with the independent variables (leadership effectiveness and leadership flexibility (p's $>.05$) for the RN staff group.

CHAPTER IV

Data Analysis

The purpose of this study was to (1) describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers was predictive of job satisfaction of nursing staff. The statistical analysis is presented in this chapter. It is noted that all percentages are reported to the nearest whole number.

Internal Consistency Reliability (ICR) of the LBAII-Self and LBAII-Other Instrument

Zigarmi et al., (1997) reported that the internal consistency reliability of the LBAII-Self ranged from alpha = 0.43 to alpha = 0.60, and that the internal consistency reliability of the LBAII-Other ranged from an alpha = 0.54 to an alpha = 0.86. Zigarmi et al. reported these alpha coefficients were adequate for self-reporting instruments. Stamps et al., (1978) reported that the Cronbach's alpha on most of the components of the IWS ranged within the acceptable range for internal consistency reliability (alpha ranging from 0.52 to 0.81). Therefore, on the basis of this information, the minimal alpha coefficient acceptable for instruments in this study was set at 0.43.

Alpha coefficients were used to measure the internal consistency reliability of the LBAII-Self and the LBAII-Other instruments in regard to style flexibility and style effectiveness. The findings for nurse manager and RN staff follow.

Alpha coefficient for the four dimensions of the LBAII-Self were well within the range of alpha coefficients noted by Zigarmi et al. (1997). The alpha coefficients for the four

dimensions for the LBAII-Other ranged between $a = .61$ and $a = .75$. Data are presented in table 1.

Table 1

Internal Consistency Reliability of the LBA-II Self and LBAII-Other

	Nurse Managers $n = 11$	RN Staff $n = 79$
LBAII- Dimensions	LBAII-Self *alpha*	LBAII-Other *alpha*
S1	0.64	0.75
S2	0.50	0.61
S3	0.80	0.69
S4	0.64	0.73

Internal Consistency Reliability (ICR) of the IWS Instrument

ICR of the IWS for the nurse managers

The alpha coefficient for the total IWS administered to Nurse Managers did not meet the acceptable criteria of alpha = 0.43 (alpha = 0.23). However several subscales did meet the criterion. Subscales that met the criterion for acceptable internal consistency reliability of alpha $\geq$ 0.43 included (a) pay, (b) professional, (c) nurse-nurse interaction, (d) physician-nurse interaction, (e) total interaction (nurse-nurse and physician-nurse combined), and (f) organizational policies. Subscales that had an alpha coefficient < 0.43 included autonomy, and task requirements.

ICR fo the IWS for RN staff

The alpha coefficients that met criteria of $a \geq 0.43$ for RN staff included the total IWS ($a = 0.50$), and subscales of the IWS (a) task requirements, (b) professional status,

(c) nurse-nurse interactions, and (d) overall interaction. Subscales of the IWS that had an alpha coefficient below the acceptable criteria ($a < 0.43$) included (a) autonomy, and (b) organizational policies. Data are presented in Table 2.

Table 2

Reliability of the IWS Instrument by Nurse Managers and RN Staff

IWS Instrument and Subscales	Nurse Managers $n = 11$	RN Staff $n = 79$
	alpha	*alpha*
Total IWS	0.23**	0.54*
Pay	0.50*	0.46*
Autonomy	0.28**	0.24**
Organizational Policies	0.45*	0.32**
Task Requirements	0.18**	0.43*
Professional Status	0.48*	0.56*
Nurse-Nurse Interaction	0.46*	0.84*
Physician-Nurse Interaction	0.62*	0.43*
Overall Interaction	0.85*	0.50*

* alpha $\geq$ 0.43
** alpha < .043

Analysis of Research Questions

Research Question 1

Is there a difference in (a) gender, (b) age, (c) educational level, (d) length of time as a nurse manager, (e) length of time RN staff were RNs, (f) length of time employed in

current hospital, and (g) length of time nurse manager and RN staff worked on current unit?

Statistical procedures. The descriptive statistical procedures used to describe the ages of nurse managers and RN staff included frequencies, percentages, medians, and mode. Additional descriptive statistics for nurse managers included means and *sds* since the frequency distributions of the ages of this group passed the K-S test (K-S $Z = 1.769$, $p = .80$. Means and *sds* were not noted for RN staff since the frequency distribution of age did not pass the K-S test (K-S $Z = 1.331$, $p = .04$). The Mann-Whitney test was substituted for the independent t-test to determine if there were significant differences in ages of nurse managers and RN staff since the frequency distribution of the ages of RN staff did not pass the normality test.

Educational levels, length of time in current position, and length of time in current hospital unit of nurse managers and RN staff were analyzed using frequencies, percentages, and mode since these variables were at the nominal level of measurement (categories).

Comparison of gender of nurse managers and RN staff. All of the 11 nurse managers were female. Fifty-seven of the of the 79 RN Staff were female (72%). Twenty-two (28%) of the RN staff were male.

Comparison of the ages of nurse managers and RN staff. The ages of nurse managers ranged between 26 to 57 years. The mean, median and modal age 41.8, 42, and 43 years respectively, with a sd = 8.16. The K-S test passed (K-S $Z = .563$, $p = .91$).

The ages of the RN staff ranged from 23 to 59 years. The median age was 35, and the modal age was 28 years. However, the Bartlett-F test for homogeneity of the two groups of respondents passed ($F = 0.28$). The Mann-Whitney non parametric test was substituted for the independent t-test as an exploratory measure to determine if there were significant differences in ages of nurse mangers and RN staff since the assumption of normality was violated for RN staff group. No significant differences in the ages of the two groups were noted ($Z = 1.769, p = 0.08$). Data are presented in Table 3.

Table 3

Comparison of Ages of Nurse Manages and RN Staff

	Nurse Managers $n = 11$		RN Staff $n = 79$	
Age in Years	*f*	%	*f*	%
23 - 29	1	9.0	0.46*	33.0
30 - 39	*2*	18.0	0.24**	32.0
40 - 49	6	55.0	0.32**	20.0
50 - 59	2	18.0	0.43*	15.0
	41.8/42/43		na/35/na/28	
—W test	$Z = 1.769, p$ .08*			

Comparison of educational level of nurse managers and RN staff. The highest educational level reported by the nurse manager group was a Masters degree (6, 55%). The second highest level of education reported by this group was the baccalaureate degree

(4, 36%). One (9%) of the 11 nurse managers reported their highest level of education as an Associate Degree in Nursing.

The highest educational level reported by the RN staff group was a BS degree (62, 78%). Seven (9%) of the RN staff had a Associate Degree in Nursing and (7, 9%) held a Masters degree. Two members (3%) of the group reported their highest educational level as MBA and BS degrees. One (1%) RN staff member held a Associate Degree in Nursing. Substantially more nurse managers had Masters degree, while substantially more RN staff held a BS degree. The chi-square test to determine if significant differences were noted in regard to education level was not applicable since more than 20% of cells had expected frequencies of < than 5. Data are presented in Table 4.

Table 4

Comparison of Highest Educational Level of Nurse Managers and Rn Staff

Educational Level	Nurse Managers *n = 11*		RN Staff *n = 79*	
	f	%	*f*	%
Associate Degree	1	09.0	7	09.0
Diploma	-----	-----	1	01.0
BS	4	36.0	62	78.0
Masters	6	55.0	7	09.0
MBA/BS	-----	-----	2	03.0
X^2 test	NA- more than 20% of cells with expected fx of < than 5			

Comparison of length of time as nurse Manager and RN staff. The overall length of time that the11 nurse managers were in their position ranged from 1 and 6 years. Three (27%) of nurse managers had held this position for 1 year, one (9%) had held a nurse managers position for 2 years, one member (9%) was a nurse manager for 5 years, and 6 members (55%) of this group were nurse managers for more than 5 years._

The overall length of time that the 79 RN staff had been RNs ranged from less than 1 year to 20 years. Seven (9%) of the RN staff had been RNs for less that 1 year. Nineteen (24%) of this group reported they had between 1 and 5 years of RN experience. Twenty-three (29%) had been RNs between 6 and 10 years. Sixteen members (20%) of this group had their RN license between 11 and 15 years. Eight (10%) between 16-20 years, and six (8%) had their RN license greater than 20 years. It is noted that the majority of the 11 nurse managers (7, 55%) had practiced as nurse managers between 6 and10 years, while the majority of the 79 RN staff (23, 29%) had practiced as RNs between 6 and 10 years. The chi-square test was not appropriate to use to determine if significant differences in regard to length of time the respondents in this study had been nurse managers or RNs since more than 20% of the cells for this test had fewer than 5 responses. Data are presented in Table 5.

Table 5

Comparison of Total Length of Time Practiced as a Nurse Managers and as RN Staff

Years in Position	Nurse Managers *n = 11*		RN Staff *n = 79*	
	f	%	*f*	%
< 1 year	3	27.0	7	09.0
1 - 5 years	1	18.0	19	24.0
6 - 10 years	7	55.0	23	29.0
11 - 15 years	----	----	16	20.0
16 - 20 years	----	----	8	10.0
> 20 years	----	----	6	08.0
X^2 test	NA- more than 20% of cells with expected fx of < than 5			

Comparison of nurse managers' and RN staffs' length of time in current hospital unit. The number of years the 11 nurse managers worked in their current hospital units are as follows: (a) three (27%) - one year, (b) one (9%) - 5 year, (c) seven (64%) - more than 5 years. The number of years the 79 RN staff members worked in their current hospital units are as follow: (a) nine (11%) - less than 1 year, (b) seven (9%) - 1 year, (c) nine (11%) - 2 years, (d) three (4%) - 3 years, (e) four (5%) - 4 years, (f) 22 (28%) - 5 years, (g) 25 (32%) - more than 5 years. It is noted that the majority of the 11 nurse managers (7,64%) had practiced in their current hospital unit as a nurse manager for a period greater than 5 years. The majority of the 79 RN staff (45, 57%) had practiced in their current hospital unit between 1 and 5 years. Data are presented in Table 6.

Table 6

Comparison of Nurse Managers and RN Staff in Regards to Years in Current Unit

Years in Current Unit	Nurse Managers $n = 11$		RN Staff $n = 79$	
	f	%	*f*	%
< 1 year	3	27.0	9	11.0
1 - 5 years	1	18.0	45	57.0
> 5 years	7	55.0	25	32.0
X^2 test	NA- more than 20% of cells with expected fx of < than 5			

Research Question 2

What is the leadership style flexibility of nurse managers as perceived by the nurse managers on the LBAII-Self instrument as compared to the leadership style flexibility of nurse managers as perceived by the nursing staff members on the LBAII-Other instrument?

The leadership style flexibility scores for nurse managers ranged between 10 and 24 with a mean = 16.46, a median = 16.0, and a sd = 4.87. The leadership style flexibility scores for the RN staff ranged between 3 and 30 with a mean = 18.01, a median = 20.00, and a sd = 4.79. The Bartlett-F test for homogeneity of variances passed ($F = 1.03, p = .85$). The normality test for the nurse manager and RN staff groups passed (K-S Z = 0.486, $p = 0.97$ and K-S Z = 1.000, $p = 0.27$ respectively).

Nurse managers and RN staff did not differ significantly in perceptions of the leadership style flexibility of nurse managers [$t(88) = 1.66, p = .10$]. It is noted that the power of test = 0.45. However, this is not surprising since the differences in the mean scores was only 1.55 indicating the Nurse Managers and RN staff had similar perceptions

of nurse managers' leadership flexibility. Power of the test is defined as finding a significant difference when it really exist (Gravetter & Wallnau, 2000, p. 271). Data are presented in Table 7.

Table 7

Comparison of Nurse Managers and RN Staff Perceptions of Leadership Flexibility

Leadership Flexibility Scores	Nurse Managers $n = 11$		RN Staff $n = 79$	
	f	%	*f*	%
3 - 9	----	---	1	01.0
10 - 20	8	73.0	53	67.0
> 20	3	27.0	25	32.0
Mean\Median\sd	16/45/16/00/4.87		18.01/20.00/4.79	
t-test	$t(88 = 1.66, p = .10$ (not significant)			

Research Question 3

What is the leadership style effectiveness of nurse managers as perceived by the nurse manager on the LBAII-Self instrument as compared to the leadership style of effectiveness as perceived by their RN staff members on the LBAII-Other?

The leadership style effectiveness scores for nurse managers ranged between 53 and 66 on a scale of 20 - 80 with a mean = 57, a median = 57, and a sd = 4.29. The leadership style for RN staff ranged between 36 and 65 with a mean = 52.05, a median = 52.00, and a sd = 4.78. The Bartlett F-test for homogeneity of variance for the two groups passed ($F = 1.82$, $p = 0.30$). The normality test for nurse managers and RN staff passed (K-S Z =

.62, $p = 0.83$ and K-S Z = 1.038, $p = 0.23$ respectively). RN staff perceived style effectiveness of nurse managers as being statistically less effective than did nurse managers [$t(88) = 2.73, p = 0.008$]. The power of the test = 0.80. Data are presented in Table 8.

Table 8

Comparison of Nurse Managers and RN Staff Perceptions of Leadership Effectiveness

	Nurse Managers $n = 11$		RN Staff $n = 79$	
Leadership Effectiveness Scores	*f*	%	*f*	%
36 -46	---	---	14	18.0
47 - 57	7	63.0	54	68.0
58 - 68	7	55.0	11	14.0
M/Med/sd	57.00/57.00/4.29		52.05/52.00/4.78	
t-test	$t(88) = 2.73, p = 0.008$ (significant)			

Research Question 4

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse manager on the LBAII-Self instrument?

Research Question 5

What are the primary, secondary, and developmental leadership styles of nurse manages' as perceived by the nurse managers' RN staff on the LBAII-Other instrument?

Research Questions 4 and 5 were combined in order to compare the primary, secondary, and developmental leadership styles of nurse managers as perceived by nurse managers and by RN staff. A frequency count of primary and secondary leadership styles of nurse managers as perceived by nurse managers and RN staff and developmental levels

was conducted. Data showing the association of the leadership styles and developmental levels are presented in Table 9.

Table 9

Developmental Levels Associated with Leadership Styles

Leadership Style	Developmental Level
S1	D1
High Directive, Low Supportive Behavior	Low Competence, High Commitment
S2	D2
High Directive, High Supportive Behavior	Some Competence, Low Commitment
S3	D3
High Supportive, Low Directive Behavior	High Competence, Variable Commitment
S4	D4
Low Supportive, Low Directive Behavior	High Competence, High Commitment

Comparison of Perceptions of Nurse Managers Primary and Secondary Leadership Styles with Developmental Levels as Perceived by the Nurse Managers and RN Staff

The results of the analysis of perceptions of nurse managers and RN staff follow: None of the nurse managers perceived S1 (high directive, low supportive behavior leadership style) as their primary or secondary leadership style. Nine (12%) of the RN staff perceived the primary leadership style of nurse managers as S1 (high directive, low supportive). Twelve (15%) of RN staff respondents also perceived the secondary leadership style of

nurse managers as S1. The developmental level associated with S1 is low competence and high commitment.

. The highest percentage (37%) of the 11 nurse managers perceived their primary leadership style as S2 (high directive and high supportive behavior). The highest percentage (5, 45%) of the 11 nurse managers also perceived their secondary leadership style as being S2.

The results of the analysis of perceptions of RN staff indicated that 31 (39%) of this group of respondents perceived that the nurse managers' primary leadership style as S2 (high directive and high supportive behavior). Twenty-four percent of the RN staff also perceived the nurse managers' secondary leadership style as S2. The developmental style of nurse managers as perceived by nurse managers and RN staff is associated with the S2 leadership style and involves some competency and low commitment.

Three (35%) of the 11 nurse managers perceived their primary leadership style as S3 (high supportive and low directive behavior). Five (45%) of this group of respondents also perceived their secondary leadership style as S3.

Twenty-seven (35%) of the RN staff also perceived the primary leadership style of the nurse managers as S3. Twenty-five (32%) of the 79 RN staff respondents also perceived the secondary leadership style of nurse managers as S3. The development style associated with S3 is high competence and variable commitment.

One (9%) nurse managers perceived her primary leadership style as S4. None of the the nurse managers indicated the use of a secondary leadership style for S4. Four (5%) RN staffs' perceptions of the primary leadership style of nurse managers as S4. The

developmental style associated with S4 involves highly supportive and low directive behavior.

One (9%) nurse manager perceived her primary leadership style as S1 and S2. One (9%) nurse manager perceived her secondary leadership style as S1 and S2. Two (3%) RN staff respondents perceived the primary leadership style of nurse managers as a combination of S1 and S2. One (1%) RN staff respondents also perceived the secondary leadership style of nurse manager as a combination of S1 and S2. The developmental style associated with a combination of S1 and S2 includes (a) low competence and high commitment, and (b) some competence and low commitment.

One (1%) Rn staff respondent perceived the primary leadership style of nurse managers as a combination of S1 and S3. One (1%) RN staff respondent also perceived the secondary leadership style of nurse managers as being a combination of S1 and S3. The developmental styles associated with this combination of primary leadership styles includes (a) low competence and high commitment, and (b) high competence and variable commitment.

One (1%) RN staff respondent perceived the use of two primary leadership styles by nurse managers, namely S1 and S4. The developmental styles used with S1 and S4 include (a) low competence and high commitment, and (b) high competence and high commitment.

One (9%) nurse manager perceived the use of S2 and S3 as her primary leadership styles. One (1%) of the RN staff respondents also perceived the use of S2 and S3 as primary leadership styles. The developmental styles used by nurse managers that are

associated with these two primary styles are (a) some competence and low commitment, and (b) high competence and variable commitment.

One (1%) RN staff respondent perceived that nurse managers used a combination of S2 and S4 primary leadership style. One (1%) RN staff respondent also perceived that nurse managers used the same combination of leadership styles as secondary leadership styles. The developmental styles associated with these two leadership styles includes (a) some competence with low commitment, and (b) high competence with high commitment.

One (1%) RN staff respondent perceived that nurse managers used a combination of S2, S3, and S4 primary leadership styles. These three combinations of leadership styles are associated with developmental styles reflecting (a) some competence with low commitment, (b) high competence with variable commitment, and (c) high competence with high commitment.

One (9%) nurse manger perceived that she used a combination of S3 and S4 as primary leadership styles. One (1%) RN staff respondent perceived that nurse managers used the same combination of primary leadership styles (S3 and S4)..

Three (4%) of RN staff respondents perceived the nurse managers used the same combination of styles (S3 and S4) as secondary leadership styles. Developmental styles associated with these two combinations of leadership styles include (a) high competence with variable commitment, and (b) high competence with high commitment. Data are presented in Table 10.

Table 10

Comparison of Primary, Secondary, and Developmental Leadership Styles of Nurse Managers as Perceived by Nurse Manages and RN Staff

	Nurse Manages			RN Staff		
Leadership Styles*	Primary *n*=11	Secondary *n*=11	Develop**	Primary *n*=79	Secondary *n*=79	Develop**
	f(%)	*f(%)*	Type	*f(%)*	*f(%)*	Table
S1	------	------	------	9(12.0)	12(15.0)	D1
S2	04(37.0)	05(45.0)	D2	31(39.0)	19(24.0)	D2
S3	03(27.0)	05(45.0)	D3	27(35.0)	25(32.0)	D3
S4	01(09.0)	------	D4	04(05.0)	14(18.0)	D4
S1 & S2	01(09.0)	01(10.0)	D1 & D2	02(03.0)	01(01.0)	D1 & D3
S1 & S3	------	------	------	01(01.0)	01(01.0)	D1 & D3
S1 & S4	------	------	------	01(01.0)	------	D1 & D4
S2 & S3	01(09.0)	------	D2 & D3	01(01.0)	------	D2 & D3
S2 & S4	------	------	------	01(01.0)	04(05.0)	D2 & D4
S2,S3,S4	------	------	------	01(01.0)	------	D2,D3,D4
S3 & S4	01(09.0)	------	D3 & D4	01(01.0)	03(04.0)	D3 & D4

* S1 = High Directive, Low Supp. Behavior/ S2 = High Directive, High Supp. Behavior
* S2 = High Supp., Low Directive Behavior/ S4 = Low Supp., Low Directive Behavior
** D1 = Low Competence, High Commitment
** D2 = Some Competence, Low Commitment
** D3 = High Competence Var. Commitment /** D4 = High Competence, High Commitment

Research Question 6

Are perceptions of leadership style effectiveness, and flexibility of nurse managers as perceived by RN staff predictive of satisfaction with (1) pay, (2) professional status, (3) task requirements, (4) interaction, (5) autonomy, and (6) organizational policies.

Pearson Correlation Procedure Analysis

The Pearson Correlation was used to determine if the independent variables (leadership style effectiveness and leadership style flexibility) were significantly associated with the dependent variables (pay, autonomy, task requirements, organizational policies, physician-nurse interaction, nurse-nurse interaction, and interaction; physician-nurse and nurse-nurse interaction combined) for the (a) nurse manager group and (b) RN staff group. Based on the results of the correlation, nurse-nurse interaction and total interaction were the only dependent variables significantly correlated with leadership style effectiveness for nurse managers.

No significant correlations were noted between any of the dependent variables and perceptions of leadership effectiveness or leadership flexibility for the RN staff group. Therefore analysis of research question 6 was not conducted. Data are presented in Tables 11 and 12.

Table 11

Comparison of Perception of Nurse Managers and RN Staff-Pearson Correlation Coefficients Between Dependent Variables of the IWS and Independent Variable Leadership Effectiveness

Dependent Variables	Leadership Effectiveness			
	Nurse Managers $n = 11$		RN Staff $n = 79$	
	r	*p*	*r*	*p*
Pay	.055**	> .05	.148**	> .05
Autonomy	.581**	> .05	.151**	> .05
Task Requirements	.599**	> .05	.068**	> .05
Organizational Policies	.556**	> .05	.009**	> .05
Professional Status	.506**	> .05	.254**	> .05
Physician/Nurse Interaction	.444**	> .05	.111**	> .05
Nurse/Nurse Interaction	.897*	.001	.254**	> .05
Total Interaction (Physician & Nurses)	.793*	.01	.210**	> .05

* significant at $p < .05$
** not significant ($p > .05$)

Table 12

Comparison of Perception of Nurse Managers and RN Staff-Pearson Correlation Coefficients Between Dependent Variables of the IWS and Independent Variable Leadership Flexibility

Dependent Variables	Leadership Flexibility			
	Nurse Managers $n = 11$		RN Staff $n = 79$	
	r	*p*	*r*	*p*
Pay	.502**	> .05	.220**	> .05
Autonomy	.055**	> .05	.023**	> .05
Task Requirements	.086**	> .05	.001**	> .05
Organizational Policies	.075**	> .05	.156**	> .05
Professional Status	.463**	> .05	.019**	> .05
Physician/Nurse Interaction	.444**	> .05	.111**	> .05
Nurse/Nurse Interaction	.897**	.001	.014**	> .05
Total Interaction (Physician & Nurses)	.231**	.01	.062**	> .05

** not significant at $p > .05$

Secondary Analysis

Based on the significant correlations (p's < .05) between leadership effectiveness and (1) nurse-nurse interaction, and (2) total interaction (combined nurse-nurse and physician-nurse interaction) a secondary analysis was conducted to determine if leadership effectiveness as perceived by nurse managers was predictive of their satisfaction with nurse-nurse interaction and total interaction.

Results of the simple linear regression procedure regarding perceptions of leadership effectiveness as perceived by nurse managers and nurse-nurse interaction. The assumption for use of linear regression for leadership effectiveness and nurse-nurse interaction passed (Durbin-Watson Statistic = .001, Normality Test, $p = 0.649$, and Constant Variance Test, $p = 0.283$). The power of the test at alpha = 0.05 and was 0.985. The results of the analysis were significant ($F = 37.085$, $p = 0.001$) nurse-nurse interaction was predictive of leadership effectiveness. Seventy-eight percent of the variance in nurse-nurse interaction based on the adjusted R^2 was explained by perceptions of leadership effectiveness of nurse mangers. Data are presented in Tables 13 and 14.

Table 13

Linear Regression-Analysis of Variables Results for Nurse Manager Leadership Effectiveness and Nurse-Nurse Interaction

	DF	*SS*	*MS*	*F*	*p*
Regression	1	204.543	204.543	37.086	< .001
Residual	9	49.638	5.515		
Total	10	254.182	25.418		

Table 14

Variables in the Regression Equation for Nurse Managers Leadership Effectiveness and Nurse-Nurse Interaction

	Coefficient	St Error	*t*	*p*
Constant	-33.371	9.894	-3.37	< .008
Nurse-Nurse Interaction	1.054	0.173	6.09	< .001

The predicted regression equation used for Leadership Effectiveness was: Y (predicted score) = (-33.371 + (1.054* nurse-nurse interaction) +/- SE (2.35).

Results of the simple linear regression regarding leadership effectiveness and interaction (nurse-nurse and physician-nurse interaction combined). The assumptions for use of the liner regression procedure for leadership effectiveness and interaction passed (Durbin-Watson Statistics = 1.675 Normality Test, $p = 0.436$ and Constant Variance Test, $p = 0.557$). The power of the test at alpha = 0.05 was 0.86. The results of the analysis were significant ($F = 15.236$, $p = 0.004$) indicating that 63% of the variance in interaction (combined nurse-nurse and physician-nurse interaction) based on the adjusted R^2 was explained by leadership effectiveness of nurse managers. Data are presented in Tables 15 and 16.

Table 15

Linear Regression Analysis of Variance Results for Nurse Manager Leadership Effectiveness and (nurse-nurse/physician-nurse combined) interaction

	DF	*SS*	*MS*	*F*	*p*
Regression	1	115.672	115.672	15.236	< .004
Residual	9	68.328	7.592		
Total	10	184.000	18.400		

Table 16

Variables in the Equation

	Coefficient	St Error	*t*	*p*
Constant	36.551	5.304	6.89	< .001
Physician-nurse Interaction	1.054	0.173	6.09	< .001

The predicted equation for leadership effectiveness is Y (predicted score) = 36.551 + (1.054 * physician-nurse interaction) +/- SE (2.35).

Results of Eta Correlation Procedure for Nurse Managers and RN Staff

The Eta Correlation procedure was substituted for the original multiple regression procedure for the remaining dependent and independent variables since it indicates "the degree of relationship between two variables regardless whether the relationship is linear or nonlinear" (Jaeger, 1999, p. 71). Eta squared is defined as a sample statistic or population parameter that represents the proportion of the variance of a dependent variable that is predicted by an independent variable. "Eta squared represents the total predictability of a dependent variable, whether based on a linear model or a nonlinear model." (Jaeger, 1990, p.371).

All dependent and independent variables were included in the analysis using Eta Correlation procedure. A substantial amount of variance in all dependent variables was explained by perceived leadership effectiveness and perceived leadership flexibility of nurse managers.

A much lower percentage of variance in all dependent variables was explained in regard to RN staff perceptions of nurse manager leadership effectiveness and leadership flexibility than that noted by nurse managers perceptions of their leadership effectiveness and leadership flexibility.

It is also interesting to note that 78% of the variance in nurse-nurse interaction was found as a result of the nurse managers' perceived leadership effectiveness using the linear regression procedure, while 86.8% of the variance in nurse-nurse interaction was found as

a result of the nurse managers' perceived leadership effectiveness using eta correlation procedure. This indicates that 8.8% of the variance in nurse-nurse interaction explained by the nurse managers' perceptions of their leadership effectiveness was due to non-linear association between perceived leadership effectiveness and nurse-nurse interaction.

It is also noted that 63% of the variance in total interaction was found as a result of the nurse managers' perceived leadership effectiveness using the linear regression method, while 87% of the variance in total interaction was noted as a result of the nurse managers perceived leadership effectiveness due to non-linear association between perceived leadership effectiveness and total interaction. This indicates that 24% of the variance in total interaction explained by nurse managers' perceptions of their leadership effectiveness was due to non-linear association between perceived leadership effectiveness and total interaction.

It is also noted that the Pearson Correlations Coefficients between the dependent and independent variables, with the exception of nurse-nurse interaction and total interaction, were not significant, however, the majority of the eta coefficients indicated that the relationship between these variables was mainly due to a non-liner relationship. It is also noted that the amount of variance in the components of the IWS explained by perceptions of nurse managers in regard to their (1) leadership effectiveness, and (2) leadership flexibility was substantially greater than that perceived by RN staff. Data are presented in Table 17 and 18.

Table 17

Eta Correlation Coefficients and Eta Squared Results related to Amount of Variance Explained in Dependent Variable by Independent Variable for Leadership Effectiveness by Nurse Managers and RN Staff.

	Leadership Effectiveness			
	Nurse Managers $n = 11$		RN Staff $n = 79$	
Dependent Variables	Independent Variables			
	eta coeff	eta^2 % explained	eta coeff	eta^2 % explained
Pay	.86342	74.5	*.60862*	37.0
Autonomy	.86509	74.8	.64262	41.3
Task Requirements	.97245	72.9	.49798	24.8
Organizational Policies	.69852	48.8	.55014	22.3
Professional Status	.93367	87.2	.60025	36.0
Nurse-Nurse Interaction	.93177	86.8	.55614	30.9
Phys-Nurse Interaction	.51573	66.5	.51248	26.3
Total Interaction	.93367	87.2	.55608	31.0

Table 18

Eta Correlation Coefficients and Eta Squared Results related to Amount of Variance Explained in Dependent Variable by Independent Variable for Leadership Flexibility by Nurse Managers and RN Staff.

	Leadership Flexibility			
	Nurse Managers $n = 11$		RN Staff $n = 79$	
Dependent Variables	Independent Variables			
	eta coeff	eta^2 % explained	eta coeff	eta^2 % explained
Pay	.91424	83.6	.61610	22.1
Autonomy	.93041	86.6	.64262	41.3
Task Requirements	.90238	81.4	.47246	22.3
Organizational Policies	.94229	88.8	.50858	25.9
Professional Status	.78728	61.9	.42541	18.1
Nurse-Nurse Interaction	.95883	91.9	.56127	31.6
Phys-Nurse Interaction	.97368	94.8	.44827	20.0
Total Interaction	.95735	85.9	.53299	28.4

Secondary Analysis of the IWS Questionnaire

A secondary analysis of the IWS questionnaire was conducted to determine the nurse managers and RN staff perceptions of the rankings of importance of the six components of part A of the IWS and the perceived rankings of the six components of part B of the IWS. The procedures in scoring the IWS questionnaire identified by Stamps (1997) include the creation of (a) a frequency of paired comparison of the IWS, (b) a proportion matrix which converts the frequencies to a proportion (percentage), (c) a matrix of *Z* values

which place the weights of each component on the IWS on a normal distribution, and (d) obtaining the Component Weighting Coefficient (CWC). The CWC represents the scale value for each component of the IWS in terms of its deviation from the mean of the scale values. Statements with negative values are considered to be less important that the average of the scale values of all statements, and statements with positive values were identified as being more important that the average. (Stamps, 1997).

The CWC was used to assess the level of importance of each of the components for the nurse manager and RN staff respondents using Part A of the IWS (paired comparison). This information was used to rank the components in order of importance for each group of respondents. The information obtained from this step allows the computation of the Index of Work Satisfaction (IWS) which was used to determine the level of current work satisfaction of the two groups of respondents

Analysis of IWS-Part A (Paired Comparison)

Part A of the IWS was analyzed using the same method described by Stamps (1997). Part A of the scale was used to determine which component of a pair (pairs of the six components of the IWS) was considered to be more favorable in terms of work satisfaction.

Frequency Matrix of Paired Comparison of the IWS for Nurse Managers and RN Staff

A paired comparison analysis of the respondents to the IWS was conducted to determine the number of times nurse managers and RN staff respondents favored one component over another. The most important components of the IWS are shown in the

columns of the frequency matrix. The diagonals shown in the tables are blank, which is the results of comparing the components to themselves.

Findings from the frequency matrix for nurse managers. The findings for the 11 nurse managers follow: The following components of the IWS were found to be more important than pay: (a) autonomy ($n = 7$ vs $n = 4$); and (b) interaction ($n = 7$ vs $n = 4$). Task requirements were noted to be more important than (a) pay ($n = 7$ vs $n = 4$); (b) autonomy ($n = 10$ vs $n = 1$); (c) interaction ($n = 9$ vs $n = 2$); and (d) professional status ($n = 8$ vs n=3). Organizational policies were noted to be more important than (a) interaction ($n = 11$ vs $n = 0$); (b) pay (n=10 vs $n = 1$); (c) professional status (n =10 vs $n = 1$); (d) autonomy ($n = 9$ vs $n = 2$); and (e) task requirements ($n = 7$ vs $n = 4$). Professional status were found to be more important than (a) autonomy ($n = 9$ vs $n = 2$) and (b) pay ($n = 7$ vs $n = 4$).

It is interesting to note that organizational policies were judged by nurse managers as most important in regard to all components of the IWS and task requirements were judged as most important in regard to all but one component of the IWS, namely organizational policies by nurse managers. Data are presented in Table 19.

Table 19

Frequency Matrix of Paired Comparison of the IWS for the 11 Nurse Manager Respondents

	Most Important					
Least Important	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	4	7	10	7	4
Autonomy	7	----	10	9	9	8
Task Req	4	1	----	7	3	2
Org. Policies	1	2	4	----	1	0
Prof. Status	4	2	5	10	----	6
Interaction	7	3	9	11	5	----

Findings from the frequency matrix for RN staff. The findings for the 79 RN staff follow: Organizational policies was judged to be more important than (a) pay (n = 69 vs n = 10); (b) interaction (n = 66 vs n= 13); (c) autonomy (n = 63 vs n = 16); and (d) task requirements (n = 57 vs n = 22). Task requirements were judged to be more important than (a) pay (n = 59 vs n = 20); (b) autonomy (n = 60 vs n = 19); (c) professional status (n = 56 vs n = 23); and (d) interaction (n = 40 vs n = 39). Professional Status was judged to be more important than (a) organizational policies (n = 64 vs n = 15); (b) pay (n = 62 vs n = 17); and (c) autonomy (n = 49 vs n = 30). Interaction was noted to be more important than (a) pay (n= 64 vs n = 15); (b) autonomy (n = 55 vs n= 24); and (c) professional status (n = 52 vs n = 27). Data are presented in Table 20.

Table 20

Frequency Matrix of Paired Comparison of the IWS for the RN Staff Respondents

	Most Important					
Least Important	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	47	59	69	62	64
Autonomy	32	----	60	63	49	55
Task Req	20	19	----	57	23	39
Org. Policies	10	16	.22	----	64	13
Prof. Status	17	30	56	15	----	52
Interaction	15	24	40	66	27	----

Proportion Matrix of Paired Comparisons of the IWS

The proportion matrix of the IWS is converted from the frequency matrix by dividing each cell in the frequency matrix by the number of respondents. Results of the proportion matrix indicates the percentage of respondents that chose a specific IWS component as being more favored over other IWS components. Stamp (1997) states that percentages noted in the proportion matrix are expressed by 3 decimal points.

Proportion matrix of paired comparison of the IWS for nurse managers. The results showed that (1) pay was favored over interaction by 27.2%, (2) autonomy was favored over pay by 27.2%, (3) task requirements were favored over (a) pay by 27.2% (b) autonomy by 91.8%, (c) professional status by 27.2% and (d) interaction by 63.6%, (4) interaction was favored over autonomy by 45.4% and (5) organizational policies were favored over professional status by 81.8%. Data are presented in Table 21.

Table 21

Proportion Matrix of Most Favored and Least Favored Responses of Nurse Manger Respondents

	Most Important					
Least Important	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	.364	.636	.909	.636	.364
Autonomy	.636	----	.909	.818	.818	.727
Task Req	.364	.091	----	.636	.273	.182
Org. Policies	.091	.182	.364	----	.091	.001
Prof. Status	.364	.182	.727	.909	----	.545
Interaction	.636	.273	.818	1.000	.455	----

Proportion matrix of paired comparisons of the IWS for RN staff respondents.

Findings from the proportion matrix for RN staff respondents showed that autonomy was favored over pay by 19%. Task requirements were favored over (a) pay by 49.4%, (b) autonomy by 50.6%, (c) professional status by 41.8%, and (d) interaction by 1.2%. Organizational policies were favored over (a) pay by 65.8%, (b) autonomy by 67%, (c) task requirements by 51%, and (d) interaction by 66.7%. Professional status was favored over (a) pay by 66%, (b) autonomy by 24%, and (c) organizational policies by 62%. Interaction was favored over (a) pay by 62%, (b) autonomy by 39.2%, and (c) professional status by 31.6% respectively. Data are presented in Table 22.

Table 22

Proportion Matrix of Paired Comparison of the IWS for RN Staff Respondents

Least Important	Most Important					
	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	.595	.747	.785	.785	.810
Autonomy	.405	----	.759	.759	.620	.696
Task Req	.253	.241	----	.722	.291	.494
Org. Policies	.127	.203	.278	----	.810	.165
Prof. Status	.125	.380	.709	.190	----	.658
Interaction	.190	.304	.506	.835	.342	----

Matrix of Z values. The Table of Normal Deviates *Z* (Appendix M) was used to convert the proportion matrix to a matrix of *Z* values. This process was used to place the weights for each component of the IWS on a normal distribution. The proportions for each components of the IWS were summed and the mean of each of proportions for the components was obtained. A Standard value of 3.100 has been added to each mean value in order to eliminate negative values (Stamp, 1997). The Component Weighting Coefficients (CWC) were obtained by adding the mean values to the standard values.

The CWC represents the scale value for each component of the IWS in terms of its deviation from the mean of all scale values. Using this method, the CWC for each component of the IWS is derived from its comparison with all other components (Stamps, 1997). Negative scale values are considered to be less important that the average and positive scale values are considered more important that the average.

Rankings of IWS Components for Nurse Managers.

Rankings of the IWS component for nurse managers from most important to least important were as follows: (1) Organizational Policies (CWC = 3.738), (2) Task Requirements (CWC = 3.351, (3) Pay (CWC = 2.978, (4) Interaction (CWC = 2.947), (5) Professional Status (CWC = 2.936, and (6) Autonomy (CWC = 2.856). Data are presented in Table 23.

Table 23

Matrix of Z-Values for Nurse Managers

	Most Important					
Least Important	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	0.350	0.348	0.135	0.348	-0.348
Autonomy	0.348	----	1.335	0.908	0.908	0.604
Task Req	-0.350	-1.341	----	0.348	-0.604	-0.908
Org. Pol.	-1.341	-0.908	-0.429	----	-1.335	-0.001
Prof. Status	-0.348	0.908	0.604	1.335	----	-0.113
Interaction	0.348	-0.604	0.908	3.090	-0.113	----
Sum	-1.343	-1.129	2.766	7.016	0.822	-0.766
Mean	0	-0.244	0.251	0.638	-0.164	-0.153
Standard	3.100	3.100	3.100	3.100	3.100	3.100
CWC	2.978	2.856	3.351	3.738	2.936	2.947

Rankings of IWS Components for RN Staff

Rankings of the IWS components for RN staff from most important to least important were as follows: (1) Organizational Policies (CWC = 3.535), (2) Professional Status (CWC

3.471), (3) Task Requirements (CWC = 3.375), (4) Interaction (CWC = 3.265), (5) Autonomy (CWC = 2.358), and (6) Pay (CWC = 2.357). Dat are presented in Table 24.

Table 24

Matrix of Z-Values for Staff Respondents

	Most Important					
Least Important	Pay	Autonomy	Task Req	Org. Pol	Prof Status	Interaction
Pay	-----	0.240	0.697	0.789	0.789	0.878
Autonomy	-0.240	----	0.703	0.703	0.305	0.513
Task Req	-0.665	-0.703	----	0.589	0.550	-0.015
Org. Pol.	-1.141	-0.831	-0.589	----	0.878	-0.001
Prof. Status	-0.348	0.908	0.604	1.335	----	-0.974
Interaction	0.878	-2.112	0.015	0.974	0.435	----
Sum	-3713	-3.711	1.376	2.177	1.857	0.809
Mean	0	-0.742	0.275	0.435	0.371	0.162
Standard	3.100	3.100	3.100	3.100	3.100	3.100
CWC	2.978	2.856	3.351	3.738	2.936	3.262

Comparison of Rankings for CWC -Part A

Organizational policies was ranked as most important by nurse managers. Organizational policies, task requirements and interaction were ranked as most important by RN staff. Task requirements were ranked as second in importance by nurse managers. Professional status was ranked as second in importance by RN staff. Professional status, interaction and pay were ranked third in importance by nurse managers. Autonomy was

ranked third in importance by RN staff. Autonomy was ranked as least important by nurse managers while pay was ranked as least important by RN staff. Data are presented in Table 25.

Table 25

Comparison of Rankings by Perceptions of Importance of the IWS Components by Nurse Managers and RN staff

	Nurse Managers	RN Staff
	$N = 11$	$N = 79$
Components of the IWS	Rankings	Rankings
Organizational Policies	1	1*
Task Requirements	2	1*
Pay	3*	4***
Interaction	3*	1*
Professional Status	3*	2
Autonomy	4***	3**

* Org policies, task requirements and interaction were tied for first in importance for RN staff.
** Pay, interaction and professional status were tied for third in importance for nurse managers
*** Autonomy was ranked as least important for nurse managers and pay was ranked as least important for RN staff.

Computation of the Components Adjusted IWS Score for Part B of the IWS

Stamps (1997) states that the first step in calculating the overall value of IWS involve multiplying the CWC for each of the six components of the IWS by the mean score for each component. The results of the computation is the Component Adjusted IWS Score

which weighs the satisfaction of each component by the level of importance placed on each component by the respondents.

The second step in the analysis includes the computation of the index of work satisfaction value by summing the Component Adjusted Scores for each component of the IWS and dividing by six (the number of total components in the IWS). The results is the summary figure-the Index of Work Satisfaction representing the level of importance and the current level of satisfaction.

Findings of Nurse Managers and RN Staff Using the Component Adjusted Scores (Index of Work Satisfaction)

Based on the information pertaining to the weighted component adjusted scores, nurse managers perceived professional status as most important, followed by interaction, organizational policies, autonomy, and pay with task requirement as least important. Based on this information using the weighted component adjusted scores, RN staff also perceived professional status as most important followed by interaction, organizational policies, task requirements, autonomy with pay as least important.

The index of work satisfaction (IWS) was 12.6 for nurse managers and 12.4 for RN staff. Stamps (1997) states that a IWS of around 12 indicates that it is at the lower end of second quartile which is below 50th percentile. Stamps also states that "most studies obtain a value of around 12, out of a maximum of 37, which is clearly at the lower end of the second quartile." (P. 25).

The total scale scores for nurse managers and RN staff were similar (182.2 and 181.0 respectively out of a possible score of 308). These findings indicates that the overall

satisfaction rate for nurse managers is only 59.2% of the total possible score of 308. The total satisfaction rate for RN staff is only 58.8% of the total possible score of 308. Stamps and Piedmonte (1986) state that a total satisfaction score below 50 percent (155) should be viewed as a warning about lower levels of satisfaction. In this study the total scale scores for both groups of respondents were above 50%, but below 60% indicating some job satisfaction.

It is also noted that the component mean score for nurse managers and RN staff was exactly the same (4.1). The component mean score falls in the middle of the range from 1 to 7 indicating a neutral response in regard to degree of satisfaction. The results of the findings for nurse managers RN staff are displayed in Tables 26 and 27.

It is interesting to note some important differences between the findings of part A of the IWS using CWC and the findings of part B of the IWS using the component adjusted scores (CAS). The CWC relates to which components are deemed more important than other components, while the CAS relates to level of current job satisfaction.

Discrepancies between rankings of importance and level of current job satisfaction for nurse managers and RN staff.

The differences in rankings of the CWC and CAS for nurse managers are as follows:

1. Organizational policies are ranked 1st in importance, but third in terms of level of current work satisfaction.
2. Task requirements are ranked 2nd in importance, but least important in terms of level of current work satisfaction.
3. Pay is ranked 3rd in importance, but 5 in levels of current work satisfaction.

4. Interaction is ranked 3rd in importance, but 2nd in level of current work satisfaction.
5. Professional status is ranked 3rd in importance, but1st in level of current work satisfaction.
6. Autonomy is ranked as least in importance, but 4th in level of current work satisfaction.

The differences in ranking between CWC and CAS for RN Staff are as follows:

1. Organizational policies are ranked 1st in importance, but 3rd in level of current satisfaction.
2 Professional status is ranked 2nd in importance, but 1st in level of current satisfaction.
3. Task requirements is ranked 1st in importance, but 4th in level of current satisfaction.
4. Interaction is ranked 1st in importance, but 2nd in level of current satisfaction.
5. Pay is ranked in the same position (least important) in regard to level of current satisfaction
6. Autonomy is ranked 3rd importance, but (5th) in regard to level of current satisfaction.

Data are presented in Tables 26 and 27.

Table 26

Numerical Values for the IWS Questionnaire for Nurse Managers

Component	Component Weighting Coefficient (Part A)	Component Scale Score	Component Mean Score	Component Adjusted Scores
Pay	2.98	22.46	3.74	11.14
Autonomy	2.86	33.64	4.21	12.04
Task Requirements	3.35	19.36	3.22	10.79
Org. Policies	3.74	23.82	3.40	12.72
Professional Status	2.94	35.00	5.00	14.70
Interaction	2.95	47.91	4.79	14.13
Nurse-Nurse	-----	21.19	4.24	-----
Nurse-Physician	-----	26.72	5.34	-----
Total Scale Score: 182.2 (range: 44-308)		Mean Scale Scores: 4.1 (range: 1 - 7)		Index of Work Satisfaction: 12.6 (range: 09 - 37.1)

Table 27

Numerical Values for the IWS Questionnaire for RN Staff

Component	Component Weighting Coefficient (Part A)	Component Scale Score	Component Mean Score	Component Adjusted Scores
Pay	2.36	19.86	3.31	7.81
Autonomy	2.36	35.49	4.44	10.47
Task Req	3.38	20.70	3.45	11.66
Org. Policies	3.54	23.22	3.32	11.75
Pro. Status	3.47	35.51	5.07	17.59
Interaction	3.26	46.47	4.65	15.16
Nurse-Nurse	-----	23.17	4.63	-----
Nurse-Physician	-----	23.29	4.66	-----
Total Scale Score:181.0 (range: 44-308)		Mean Scale Scores: 4.1 (range: 1 - 7)		Index of Work Satisfaction: 12.4 (range: 09 - 37.1)

Note: Interaction Component is not subdivided in calculating the Component Weighting Coefficient from Part A of the IWS.

Summary

The data obtained in this study were analyzed in this chapter in order to describe, compare and explore nurse managers' perceptions of their leadership styles vs perceptions of the RN staff' perceptions of the leadership style of nurse managers. Research questions 4 and 5 were combined in order to compare the leadership styles as perceived by nurse managers and RN staff members. None of the nurse managers perceived their primary leadership style as high directive and low supportive (S1).Twelve percent of the 79 RN staff perceived their nurse managers' primary style as S1. Fifteen percent of the RN staff

also perceived the secondary leadership style of their nurse managers as S1. The developmental level of S1 is noted as low competence, and high commitment.

A second purpose of the study was to determine if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of RN staff. Cronbach's alpha was used to determine the internal consistency reliability of the LBAII-Self and the LBAII-Other as well as the internal consistency reliability of the IWS questionnaire and the six components. Demographics characteristics of both groups of respondents were analyzed. Exploratory statistical test were used to determine if significant differences existed in these characteristics.

Six research questions were analyzed in regard to perceptions of nurse managers: leadership style vs RN staff members perceptions of the nurse managers' leadership style styles in terms of primary, secondary, and developmental leadership styles. Descriptive statistics and exploratory statistical test were used to answer the research questions. Assumptions for the use of the exploratory independent t-test included the Kolmogorov-Smirnov test for normality, and the homogeneity of variance test.

The non-parametric test (Mann-Whitney U) was substituted for the independent t-test when the assumptions for the independent t test were violated. The Pearson Correlation procedure was used to ascertain if there were linear correlations between the independent variables consisting of the six components of the IWS and the independent variables consisting of leadership flexibility and leadership effectiveness. Two simple regression procedures were used to ascertain if (a) leadership effectiveness and (b) leadership flexibility were predictive of nurse-nurse interaction and total interaction (nurse-nurse

interaction and physician-nurse interaction combined) since these were the only variables that were significantly and linearly correlated.

The eta correlation procedure was substituted for the Pearson Correlation to determine the association between the remaining dependent and independent variables. This procedure indicates the degree of the relationship between two variables whether the relationship is linear or non-linear. Eta squared was used to determine how well the independent variables predicted the dependent variables in this study (a combination of linear and non-linear relationship).

A secondary analysis on the IWS questionnaire was conduced to determine and compare the nurse managers and RN staff perceptions of the rankings of importance of the six components of the IWS. A total IWS scale score, a mean score, and the Index of Work Satisfaction were obtained. These variables were used to compare the nurse managers and RN staff perceptions of the rankings of importance given each of the six components of the IWS and to compare the level of current work satisfaction. The steps used in this secondary analysis followed the recommendations of Stamps (1997).

CHAPTER V

Conclusions and Recommendations

The information in this chapter includes a discussion of the methodological issues, limitations, major findings and conclusions, and relationship to the conceptual framework and nursing implications. Recommendations are also noted for nursing administration, nursing research, and nursing education. A summary of the chapter is also presented.

Methodological Issues

This study was designed to describe to compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse manager' leadership styles, and to ascertain if leadership style effectiveness of nurse managers was predictive of job satisfaction of nursing staff. A convenience sample of 79 RN staff and 11 nurse managers in one hospital setting was used in this study. It was noted that the total population of nurse managers in this setting = 12. The overall response rate for nurse managers was 92% . Out of the 235 questionnaires sent to RN staff members, 79 (34%) usable questionnaires were returned.

The criterion for internal consistency reliability of the three instruments, LBAII-Self, LBAII-Other, and the IWS, used in this study was set to alpha $\geq$ 0 .43. This criterion was based on the alpha level noted as being adequate for the LBAII-Self and LBAII-Other (Zigarmi et al., 1997). The ICR of the LBAII-Self and the LBAII-Other and its subscales met the criteria for ICR (alpha $\geq$ 0.43) for both nurse mangers and RN staff.

The following subscales of the IWS met the criteria of ICR for both nurse managers and RN staff (pay, professional status, nurse-nurse interaction, physician interaction and

overall interaction. The total IWS and an additional subscale of the IWS (task requirements) met the criterion of alpha > 0.43 for RN staff but not for nurse managers (alpha < 0.43). The IWS subscale (organizational policies) met the alpha criterion for nurse managers (alpha > 0.43, but not for RN staff (alpha < 0.43). The IWS subscale (autonomy) did not meet the criteria for ICR for both nurse managers' and RN staff (alpha < 0.43).

Therefore findings pertaining to the total IWS and subscales that did not meet the ICR criterion of $\geq$ 0.43 should be viewed with caution. Normality tests of frequency distributions of the LBAII-Self subscales, LBAII-Other, subscales and the IWS subscales was conducted for nurse managers and RN staff using the K-S test. The K-S test of the LBAII-Self and LBAII-Other passed (K-S-Z > 0.05).

Limitations

Since this study was conducted using a convenience sample in only one setting, and represents only one moment in time, generalization of the results is limited. A major limitation was related to the small sample size of nurse managers. However, this is not surprising since the professional nursing population in hospital settings consists predominantly of RN staff with a much smaller number of nurse managers. Other studies noted in the literature also used small numbers of charge nurses with much larger number of staff nurses to determine the relationship of leadership styles with nurses' job satisfaction (Gresham & Brown; McNeese-Smith,1993; and Rhoton,1985).

A limitation in this study was that the power of statistical tests used in this study in some instances was < 0.80. However, further examination was conducted in those instances where the power of the test was < 0.80. In every instance the mean and standard

deviations related to findings for both nurse managers and RN staff were very similar. Additionally a further investigation using the same means and *sds* of the two groups with an estimated population of 100 in each group resulted in power that was still substantially lower than 0.80. It is noted that perceptions of nurse leadership styles were only examined at one point in time.

Further, the examination of nurse manager leadership styles included the educational levels, years of experience in present position, and years in current unit of nurse managers and RN staff as categorical (grouped-frequency distributions), instead of ratio data (actual years of education, and actual years in present position and actual years in current unit). Therefore the use of stronger statistical information (means and standard deviations) and the use of the independent t-test as an exploratory measure was not possible. An examination of the data at the ratio level of measurements may have yielded important findings. The use of chi-square tests was also precluded since the assumption of less than five responses in 20% of the cells was violated.

Therefore this study is seen as an exploratory effort that needs replication using (1) interval/ratio data instead of nominal data where appropriate and (2) additional questions pertaining to comparison of nurse leadership styles with number of years as (1) nurse manager, (2) number of years as RN staff, (3) educational levels of nurse managers and (4) educational levels of RN Staff.

Conclusions

Research Question 1

Is there a difference in (a) gender, (b) age, (c) educational level, (d) length of time as nurse manager, (e) length of time RN staff practiced as RNs, (f) length of time employed in current hospital, and (g) length of time nurse managers and RN staff worked on their current units?

Gender and age. There were no male nurse managers. Twenty-eight percent of the RN staff were male. The age range of nurse managers was 31 years compared to 36 years for RN staff. Nurse managers and RN staff did not differ significantly in regard to age. No direct conclusions were drawn in regard to the lack of male nurse managers. The smaller number of male RN staff members may be due to the prevalence of a higher percentage of females than males in the nursing profession in general.

Educational levels of nurse managers and RN staff. It is not surprising that the majority of nurse managers had a Masters degree in nursing since the position of nurse manager usually requires a higher educational level. However, it is noted that over one-third of nurse managers had a BS degree and that one nurse manager held an Associate degree. What was not analyzed was (1) the number of years in which the two latter groups of nurse managers had worked as RN staff members prior to being promoted to the nurse manager position and (2) whether they had received specific educational preparation for the position of nurse manager, possibly using mentors.

The majority of the RN staff (78%) had a Bachelor degree in nursing (BSN). The small percent of RN staff who hd less than a BSN may have perceived the nurse managers leadership style differently than RN staff who had a BSN.

According to Zigarmi et al. (1996), demographics are a non-factor in LBAII studies. However findings from studies in which the IWS instrument was used showed that demographic characteristics of participants (such as age, education, and gender) were highly correlated with job satisfaction (Stamps, 1997). Drews and Fisher (1996) found that educational preparation and age of participants were correlated with job satisfaction. Adams (1990) found that increased education was linked to increased levels of job satisfaction.

Length of time in the position as nurse managers and length of time in the position as staff members. The length of time in the nurse manager and RN staff positions varied to a large extent. It may be that nurse managers who were in their position for only one year may also have different leadership styles than do nurse managers who had substantially more years in this position. This possibility was not addressed in the study.

A majority of RN staff had considerable experience in this position. The remaining RN staff members had less than 1 year to 5 years in this position. The following questions were not addressed in this study: (1) Would RN staff members who had substantially fewer years of practice as RN staff members perceive the leadership styles of nurse managers differently than RN staff members who had substantially more years of practice as RN staff members? and (2) Would nurse managers perceptions of their own leadership styles differ for RN

staff members who have substantially fewer years of experience than RN staff members who have substantially more years of such experience.

Length of time working on the unit as nurse managers and length of time working on the unit as staff members. Nurse managers who had worked in their current unit for more than 5 years had the most experience in regard to managerial decisions in their current unit. The remaining nurse managers worked in their current unit from less than 1 year to 4 years.

The majority of RN staff had a substantial amount of experience in their current unit. A small percentage had less than one year, while less than 30% had between 1 and 4 years of experience.

It was concluded that information regarding years of experience for both nurse managers and RN staff would have been more useful if actual years of such experience had been obtained in this study thereby allowing the use of means, *sds* and the independent t-test or the Mann-Whitney test to determine if significant differences existed in years of experience as nurse managers and RN staff and in years of experience in current hospital units. The question that needs to be addressed is: Do nurse managers and RN staff with more years of experience differ from nurse managers and RN staff with fewer years of experience in their current units in regard to perceptions of style effectiveness leadership of nurse managers?

Research Question 2

How does the leadership style flexibility of nurse managers as perceived by the nurse managers responses on the LBAII-Self instrument compare to the leadership style flexibility

of nurse managers as perceived by RN staff members responses on the LBAII-Other instrument. Nurse managers and RN staff did not differ significantly in regard to perceptions of leadership flexibility styles of nurse managers. It is noted that the power of the test was below the criterion of 0.80 (a = .45). However this is not surprising since the differences in the mean scores was 1.55. The potential leadership flexibility style scores range from 0 to 30. The mean score of 16.46 for nurse managers represented 51% of the potential leadership flexibility score, while the mean score of 18.01 represented 60% of the potential leadership flexibility score. The mean scores of RN staff members (although not significant) showed a somewhat greater perception of leadership flexibility of their nurse managers than that perceived by nurse managers themselves.

This finding was supported by McNeese-Smith, (1995, 1996), who found that employees whose managers exhibit a variety of leadership behaviors report significantly higher levels of productivity and organizational commitment than do managers themselves. Boumans and Landeweerd (1993) also found that the leadership flexibility style of nurse managers was correlated with greater job satisfaction by RN staff. Goleman (2000); Hutton (1995) and Rosner (1995) noted that effective leaders adjust their leadership style to specific situations as they occur. Goleman also states that effective leaders are flexible and adapt their leadership styles that are situationally appropriate to motivate the individuals involved.

Goleman (2000) states that changes in leadership style allows subordinates to mature through the promotion of the subordinates-esteem and confidence. It may be that older RN staff members and those with more experience perceived their nurse managers as being

more flexible than younger RN staff with less experience. According to Gresham and Brown (1997) flexibility is the degree to which one is able to vary one's style to fit the maturity level of followers in specific situations.

Research Question 3

What is the leadership style effectiveness of nurse managers as perceived by the nurse manager on the LBAII-Self instrument as compared to the leadership style effectiveness as perceived by their RN staff members on the LBAII-Other?

RN staff members perceived the leadership style effectiveness of nurse managers as being significantly less effective than did nurse managers. According to Hersey, Blanchard and Johnson (1996), effective leaders encourage others to behave in certain ways to facilitate achievement of desired goals or objectives. According to Simms (1991), effective leaders inspire and encourage innovation, assist staff in the self-actualization process. Hersey et al. (1996) state that the concept of effectiveness when added to task and relationship behavior can be integrated with situational demands of a specific environment and that time, experience, education and training influence the development of a leadership style.

Based on Hersey (1995) and Hersey and Blanchard's (1998) definitions of effectiveness, it is concluded that RN staff members, in general, perceived the leadership style effectiveness of their nurse managers as not choosing the appropriate leadership style for their subordinates in terms of maturity and experience. Using Simms (1991) observation.

RN staff may also believe that their nurse managers in general need to use a more effective style in order to inspire and encourage innovation and facilitate a self-actualization process.

Research Question 4

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse managers on the LBAII-Self instrument?

Research Question 5

What are the primary, secondary, and developmental leadership styles of nurse managers as perceived by the nurse managers' RN staff on the LBAII-Other instrument?

Research questions 4 an 5 were combined in order to compare the leadership styles as perceived by nurse managers and RN staff members.

High directive and low supportive leadership style (S1). None of the nurse managers perceived their primary leadership style as S1. A small percentage of the 79 RN staff perceived their nurse managers' primary style as S1.

A small percentage of the RN staff also perceived the secondary leadership style of their nurse managers as S1. The developmental level of S1 is the lowest level of development noted as low competence, and high commitment. These RN staff members, therefore may have perceived their nurse managers as planning their tasks, directing RN staff how to complete the task and used close supervision in regard to their task behaviors. It is concluded that the RN staff members may have had less experience as an RN and/or less experience in the current unit and perceived that their nurse managers were using the correct leadership style for their situation.

Since none of the nurse managers perceived that they used the S1 high directive low supportive leadership style, they may have perceived that their RN staff members as having more maturity in regard to their educational level, experience as an RN and time in their unit than that perceived by the RN staff members and therefore did not perceive their leadership styles as S1.

Information as to the actual number of years (1) experience and (2) actual number of years of in the current unit with the same nurse managers may have shown important differences. It may also be that this small percentage of staff nurses perceived that their nurse manager used close supervision or an autocratic style of leadership. According to Likert (1961) managers who generally use close supervision or an autocratic style of leadership produce subservient attitudes in their subordinates.

High directive and high supportive behavior (S2). S2 was perceived to be the primary leadership style of nurse managers by a slightly higher percentage of nurse managers than RN staff (37% and 31% respectively). Substantially more nurse managers than RN staff perceived S2 as the nurse managers secondary leadership (45% vs 24% respectively).

It is concluded, based on Hersey and Blanchard's (1998) description of the S2 leadership style, that both nurse managers and RN staff believed that (1) nurse managers explained decisions, (2) RN staff suggestions were solicited, and (3) nurse managers provided support to RN staff. It is further concluded that information regarding the reason(s) for these findings may be based on the nurse managers' knowledge regarding the RN staff' level of education, experience, and time in the nursing unit, as being in the second level of

development since the developmental style of S2 involves some competency and low commitment.

High supportive and low directive (S3). A similar percentage of nurse managers and RN staff (35% and 35% respectively) perceived the nurse mangers primary leadership style as S3. Forty-five percent of nurse managers and 32% of RN staff also perceived S3 as the secondary leadership of nurse managers. It was concluded that both nurse managers and RN staff perceived that nurse managers shared decision making, provided support and encouragement which is the basis for high supportive and low directive behavior for the S3 leadership style. It is concluded that nurse managers and RN staff perceived that RN staff were at the third developmental level which indicates increased maturity, readiness and preparedness for any given task (Fluker, 1995) .

High competence and high commitment (S4). Only one nurse manager perceived her primary leadership style as S4, which is noted as the highest level of development for followers (RN staff members). It is concluded that this nurse manager perceived her RN staff to be able to work without supervision. It is further concluded that the remaining 10 nurse managers perceived that their RN staff members had not as yet met the maturity required for the highest level of development and therefore needed at least some supervision..

A small percentage (5%) of RN perceived their nurse managers used S4 leadership as their primary leadership and 25% of this group perceived that their nurse managers used S4 as their secondary leadership style. It is concluded that these RN staff members perceived

their nurse managers believed that they could work without supervision in their unit and that they had reached the highest level of development in terms of their maturity.

Use of several types of leadership styles. One nurse manager perceived that she used a combination of S2 and S3 as primary leadership styles which are identified as high directive/high supportive and high supportive, low directive behavior with development levels of some competence/low commitment, and high competence/variable commitment respectively. It is concluded that the nurse manager perceived that her RN staff were at the second and third level of development, and that none of her staff were at the lowest level or highest level of development.

One nurse manager perceived that she used a combination of S3 and S4 which are identified as high directive/high supportive behavior and low supportive and low directive behavior with developmental levels identified as high competence/variable commitment and high competence/high commitment. It is concluded that this nurse manager perceived her RN staff at the third and at the highest level of development indicating that some of her RN staff could work with some supervision and the remaining RN staff could work without supervision. This indicated that the RN staff either require less structure or can work independently without supervision. This finding indicates that, in general the RN staff are considered to be mature (at a higher developmental level in terms of experience , time in nursing unit, and possibly educational level).

It was also noted that several RN staff members perceived that their nurse managers used several different types of leadership styles. Three (4%) perceived that their nurse managers used S1 and S2 leadership styles reflective of high directive/low support and

high directive/high supportive behavior which are identified with low competence, high commitment and some competence/low commitment. It is concluded that these RN staff members perceived their nurse managers believed that RN staff were in the first and second developmental level which are possibly indicative of educational level, lack of experience as an RN, lack of experience with type of nursing required, and/or length of time in the nursing unit.

Research Question 6

Are perceptions of the leadership style effectiveness and flexibility of nurse managers by RN staff predictive of satisfaction with (1) pay, (2) professional status, (3) task requirements, (4) interaction, (5) autonomy, and (6) organizational polices?

Leadership flexibility style of nurse managers as noted by RN staff was not significantly and linearly correlated with any of the IWS subscales. Leadership effectiveness style was significantly and linearly correlated only with nurse-nurse interaction and total interaction. The findings that there was a lack of a linear association between RNs' perceptions of leadership flexibility style of nurse managers and the IWS subscales indicates that satisfaction with (1) pay, (2) professional status, (3) task requirements, (4) interaction, (5) autonomy and (6) organizational polices is not predictive of RN staff' perception of leadership flexibility of their nurse managers. The same findings pertain to leadership effectiveness style of nurse managers with the exception of nurse-nurse interaction and total interaction. The results of the simple linear regression for (1) nurse-nurse interaction and (2) total interaction (nurse-nurse and physician interaction combined) were significant ($p < .05$).

It is concluded that RN staffs' perceptions of their nurse managers leadership effectiveness is predictive of satisfaction with nurse-nurse interaction and with total interaction based on a linear relationship. This finding is supported in the literature. McNeese-Smith found that there was higher staff nurse satisfaction when the nurse manager facilitated the nurses in doing their job, organized the work and followed-up on problems which is indicative of nurse-nurse interaction.

It is further concluded that RN staffs' perceptions of their nurse managers leadership effectiveness is not predictive of (1) satisfaction with pay, (2) professional status, (3) task requirements, (4) autonomy, or (5) organizational polices based on a linear relationship. This finding was not supported by Rhoton (1985) who found that charge nurse's leadership behavior was positively associated with staff nurses' overall job satisfaction. According to Hersey, Blanchard and Johnson (1996), effective leaders encourage others to behave in certain ways to facilitate achievement of desired goals or objectives. According to Simms (1991), effective leaders inspire and encourage innovation, assist staff in the self-actualization process.

Duxbury et al. (1984) found that head nurse structure had no significant effect on satisfaction, but did have an effect with consideration which may be related to interaction between nurses. Duxbury et al.(1982), (1984) also noted that nurse managers who provided a leadership style that was supportive of staff nurses (nurse-nurse interaction) could moderate effects of the environment and promote job satisfaction.

Gustin (1988) found that RN staff members who worked in hospitals which utilized a traditional management structure rather than a shared governance management structure

had a significantly lower degree of job satisfaction then when the type of leadership used was shared governance. According to Likert (1961) managers who generally use close supervision or an autocratic style of leadership produce subservient attitudes in their subordinates

Conclusions regarding the findings from the Eta correlation analysis

A substantial amount of variance in all dependent variables explained by leadership effectiveness and leadership flexibility of nurse managers was noted for nurse managers while a much lower amount of variance in all dependent variables was explained by leadership effectiveness and leadership flexibility noted by RN staff. Therefore it is concluded that nurse managers perceived that the association between their (1) leadership effectiveness and job satisfaction, and (2) leadership flexibility and job satisfaction as being substantially greater than that perceived by RN staff. (Job satisfaction includes all components of the IWS). It is noted, however, that the findings are based on a combination of a linear and non-linear relationship.

Conclusions Regarding the Secondary Analysis of the IWS Questionnaire

A secondary analysis of the IWS questionnaire was conducted to determine the nurse managers and RN staff perceptions of the rankings of importance of the six components of Part A of the IWS and the perceived rankings of the six components of part B of the IWS.

Organizational policies was ranked as most important by nurse managers while organizational policies, task requirements and interaction were ranked as most important by RN staff. Task requirements were ranked as second in importance by nurse managers while professional status was ranked as second in importance by RN staff. Professional

status, interaction and pay were ranked third in importance by nurse managers while autonomy was ranked third in importance by RN staff. Autonomy was ranked as least important by nurse managers while pay was ranked as least important by RN staff.

It was concluded that, in general, with the exception of organizational policies, nurse managers and RN staff differed in their perception of the importance of all aspects relating to job satisfaction. According to Lucas (1991) job satisfaction was related to years employed in the hospital. It would have been interesting to determine if actual years of education, years of experience, and years in current unit would have resulted in different conclusions.

Relationship to the Conceptual Framework (Situational Leadership Model (SLM) Nurse Managers

The findings in this study were related to the conceptual framework in that the three basic components of the SLM [Amount of guidance and direction a leader gives, the amount of socio-economic support a leader provides (nurse-nurse interaction), and the developmental readiness level (maturity level) that followers exhibit] showed that nurse managers used styles S2 (high directive and high support behavior), S3 (high supportive and low directive behavior) as primary and secondary leadership styles, and S4 (low supportive and low directive behavior) only as a primary leadership style. The S1 (high directive and low supportive behavior) was not used as either a primary or secondary leadership styles.

However, both S1 and S2 leadership styles were used as primary and as secondary leadership styles by a small percentage of nurse managers, and both S2 and S3 leadership

styles were used by one nurse manager, while both S3 and S4 styles were used by one manager as a primary leadership style.

RN staff

The findings in this study for RN staff also supported the SLM in that the three basic components of the SLM model S1, S2, S3 and S4 leadership styles applied to their perceptions of their nurse managers primary and secondary leadership styles. A few RN staff also perceived that their nurse managers used a combination of leadership styles as their primary leadership style..

Implications and Recommendations for Nursing Administration

Nurse managers need to implement leadership styles that promote the most efficient use of human resources. As professional employees, nursing staff must be provided a practice environment that supports their development in such a manner that encourages innovation and facilitation of a self-actualization process. Development of nursing staff is critical. One method that would be useful in meeting this recommendation is to implement the use of the four development levels noted in the SLM. A second method would be for nursing administration to share talents, experiences, and political savvy with promising nurse managers in a mentoring process.

Recommendations for Nursing Research

(1) Replication of the study is recommend with the following additions: (a) measure the influence of educational levels on the RN staff, years of nursing experience, type of nursing unit, and time in current unit on leadership effectiveness and leadership flexibility styles of nurse mangers (b) to determine if the leadership style of nurse managers as

perceived by RN staff members is influenced by the educational level of the RN, years of experience as an RN, and years of experience in type of nursing unit. Additional a cross classification study could be conducted which (a) examines the leadership styles of nurse managers related to the length of time as a nurse manager, educational level, and time in current unit with (b) RN staff perceptions of leadership styles of nurse managers in terms of the RNs educational level, time as an RN staff member, and time in current unit.

(2) A replication of the study, with the aforementioned additions, using a before and after research design. Following the first data collection period, the SLM Development model would be implemented for one year in the selected hospital setting and followed by a second data collection period. The purpose of this design would be to determine if the use of the SLM development model significantly changed the (1) nurse managers' perceptions of their leadership styles and (2) RN staffs' perceptions of their nurse managers' leadership styles.

Recommendations for Nursing Education

Education and training influence the development of leadership styles. Education has linked to increased levels of job satisfaction. Leadership style has been linked to increased levels of job satisfaction. (1) Education of nursing students on both the undergraduate and graduate levels should include contents of leadership styles to fully prepare them for the future in the dynamic environment of health care. (2) Workshops for nursing management should be conducted for the purpose of allowing nurse managers to practice/role play leadership behaviors proven to be appropriate in a variety of interactions with RN staff.

Such workshops would provide a safe unthreatening environment or enhancing skills essential for growth in the nursing profession.

Summary

Findings from this study are very encouraging for continued use of the SLM to determine how nurse managers and RN Staff perceive nurse managers' leadership styles. Use of the developmental stages of the SLM model associated with the leadership styles did indicate different maturity levels of RN staff as perceived by both nurse managers and RN staff.

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APPENDIX A

APPROVAL FROM THE CHIEF OPERATIONS OFFICER

UNIVERSITY OF SOUTH ALABAMA
HOSPITALS

MEDICAL CENTER
ADMINISTRATION

TELEPHONE: (334) 471-7110
2451 FILLINGIM STREET
MOBILE, ALABAMA 36617-2293

January 21, 2000

Mr. Richard McElhaney
University of South Alabama
Knollwood Park Hospital
Quality Management

Dear Mr. McElhaney:

This letter is to inform you that the University of South Alabama Medical Center can serve as a site for your doctoral research study. You must have University of South Alabama IRB approval before any surveys can be distributed to employees and proof of IRB approval must be presented to me.

Good luck in your research endeavors.

Sincerely,

Beth

Beth Ramsey
Chief Operations Officer

BR/lv

APPENDIX B

APPROVAL FROM THE INSTITUTIONAL REVIEW BOARD OF THE STUDY SITE

UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF MEDICINE
INSTITUTIONAL REVIEW BOARD

TELEPHONE: (251) 460-6308
CSAB 138 • MOBILE, ALABAMA 36688-0002
FAX: (251) 461-1595

INSTITUTIONAL REVIEW BOARD
FWA 00001602

REVIEW DATE: October 22, 2002 **PROTOCOL NUMBER:** 02-180

TITLE OF PROTOCOL: Perceptions of nurse managers leadership style by nurse managers and RN staff: Job satisfaction as perceived by RN.

PRINCIPAL INVESTIGATOR: Richard McElhaney, RN, MSN

This panel, operating under the authority of the DHHS Office for Human Research and Protection, assurance number FWA 00001602, has reviewed the following items: 1) protection of the rights and welfare of the human subjects involved; 2) the methods used to secure, and the appropriateness of, informed consent; 3) the risks and potential benefits to the subject. On the basis of this review, we recommend:

(X)	**Approval**			
(x)	**Initial approval 1 year**	( )	Amendment/Revision	( ) Pending
( )	1 yr Re-approval/renewal	( )	Deferral	( ) Denied
( )	See remarks	( )	See attachment	

for this protocol and consent in terms of the University of South Alabama's statement of policy and procedure concerning the use of human subjects in investigation.

The regulations require that the investigator not initiate any changes in the research without prior IRB approval, except where necessary to eliminate immediate hazards to the human subjects, and that all problems involving risks and adverse events be reported to the IRB immediately. Advertisements for recruitment of subjects must receive prior IRB approval. This and subsequent consent forms are approved by the IRB stamp on the last page. You must use copies with the current IRB approval stamp unless written consent has been waived. All subjects must receive a copy of the consent form.

Remarks:

Charles Rich, MD /pbh
Chair, IRB

22 Oct 02
Date

APPENDIX C

APPROVAL FROM THE INSTITUTIONAL REVIEW BOARD OF LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER

EXPEDITED APPROVAL
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
(Assurance Number M1130)

FROM: LSUHSC Institutional Review Board

TO: Joseph Moerschbaecher, Ph.D.,
Vice Chancellor for Academic Affairs

RE: Grant Application By: **Patricia Beare, RN, Ph.D.**
Department of Graduate Nursing

Entitled: IRB#5399: Perception of Nurse Managers' Leadership Style by Nurse Managers and RN Staff: Job Satisfaction as Perceived by RN Staff.

This is to document review and approval of the above research proposal. In the judgment of this Board, the procedures delineated in said application conform to the pertinent DDHS and FDA rules and regulations regarding use of human subjects. This procedure is authorized by 45 CFR 46.110 and 21 CFR 56.110 as published in the Federal Register November 9, 1998. Records regarding action of the Board, referable to said project, are on file in the Office of the Chairman. This study is expedited under 46.110 category #7 of 45 CFR Part 46.

THE INVESTIGATOR agrees to report to the Committee any emergent problems, serious adverse reactions, or procedural changes that may affect the status of the investigation, and that no such change will be made without Board Approval, except where necessary to eliminate apparent immediate hazards. The investigator also agrees to periodic review of this project by the Board at intervals appropriate to the degree of risk to assure that the new project is being conducted in compliance with the Board's understanding and recommendation, and this interval will not exceed one year.

***PLEASE NOTE:**

1. Any advertisement to recruit subjects for this study must be approved by the IRB prior to posting, publication and/or distribution.
2. Other institutional approvals may be required before the study can be initiated.
3. Written notification (at the time this study is completed/ canceled) must be sent to the Office of the Chairman.

Approval Period: 10/8/02 - 10/7/03

Principal Investigator DATE: 10/9/02

Kenneth E. Kratz, Ph.D., Chairman DATE: 10/8/02

APPENDIX D

CONSENT FORM

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER IN NEW ORLEANS
CONSENT FORM

1. **STUDY TITLE:**
   Perceptions of Nurse Managers's Leadership Style by Nurse Managers and RN Staff: Job Satisfaction as Perceived by RN Staff.

2. **PERFORMANCE SITE:**
   University of South Alabama Medical Center, Mobile, Alabama.

3. **NAME AND TELEPHONE NUMBERS OF INVESTIGATORS:**
   A. Pat Beare, RN, PhD, Principal-Investigator, Louisiana State University Health Sciences Center in New Orleans , School of Nursing, Department Number (504) 568-4142, 24 hour number (504)866-2283.
   B. Richard McElhaney, RN, MSN, CNA, Co-Investigator, University of South Alabama Knollwood Park Hospital, Quality Management Department, Department Number (251) 660-5617, 24 hour number (251) 342-0888.

4. **PURPOSE OF THE STUDY:**
   This is a research study. The purpose of this study is twofold: (1) to describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of nursing staff. The six components of job satisfaction include pay, professional status, task requirement, interaction, autonomy, and organizational policies.

5. **DESCRIPTION OF THE STUDY:**
   Potential subjects will be full-time nurse managers and RN staff members from a non-profit acute care hospital. Subjects included will be registered nurses (both genders) licensed by the state to practice professional nursing, full-time (i.e., at least 32 hours per week) nursing personnel employed with the hospital at least six uninterrupted months preceding the study. RN staff members will have worked for the nurse manager for at least six months. Subjects excluded from the study will be nursing personnel employed less than six months with the hospital, RN staff members who have worked with the nurse manager for less than six months, and registered nurses not licensed by the state.

   Packets will be distributed to the nurse managers. The Nurse Managers will distribute the packets to their RN Staff. Packets will contain a cover letter explaining the study, the

5. **DESCRIPTION OF THE STUDY**: (continued

consent form, the social characteristics form, the LBAII and IWS instruments and two large envelopes labeled " Consent Forms Only" and "Completed Questionnaires Only". The .
approximate time for completing the questionnaires 30-60 minutes. Once completed, the questionnaires will be placed in the appropriate envelope and sealed by the participant

The sealed envelopes containing the consent forms will be placed into a sealed slotted box marked (Consent Forms Only) and the sealed envelopes containing the completed questionnaires will be place into a sealed box labeled (Completed Questionnaires Only- For Richard McElhaney, RN, MSN). Boxes will be placed in a central location. If the response rate is low a notice may be posted on each unit reminding potential participants to place the questionnaires and consent forms in the appropriate boxes if they have not already done so.

6. **BENEFITS TO SUBJECT:**
Subjects may not benefit from participation in this research study.

7. **RISK TO SUBJECT:**
There are no known risks to subjects participating in this research study. Since subject's absenteeism record will remain nameless, there is no risk of reprisal from employer.

8. **ALTERNATIVES TO PARTICIPATION IN THE STUDY:**
Involvement in this study is strictly voluntary.

9. **SUBJECT REMOVAL:**
Subjects will be removed from the study if they do not return the completed questionnaires or the returned questionnaires are incomplete.

10. **SUBJECT'S RIGHT TO REFUSE TO PARTICIPATE OR WITHDRAW**:
Participation is voluntary. Refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

11. **SUBJECT'S RIGHT TO PRIVACY:**
The results of this study may be published using only group information in nursing journals or presented in research conferences. The results may be presented to the staff of the hospital included in the study. The privacy of he subjects will be protected, and not be individually identified in any way.

12. **RELEASE OF INFORMATION:**
All data collected related to this study will be available to the sponsoring educational institution. A copy of the subject's results will be available upon request. A copy of the group result with no individual names will be available to the participating institution and may also be made available to LSUHSC IRB.

13. **FINANCIAL INFORMATION**
Participants in this study will not receive financial rewards or compensation for participation in the study. There will be no costs associated with participation in this study.

14. **SIGNATURES**
The study has been discussed with me and all my questions have been answered. I understand that additional questions regarding the study should be directed to investigators listed on page 1 of this consent form. I understand that if I have questions about subjects rights, or other concerns, I can contact the Chancellor of LSU Health Science Center, at (504) 568-4801. I agree with the terms above and acknowledge I have been given a copy of the consent form and agree to participate in this study. I understand that I have not waived any of my legal rights by signing this form.

_____ _____
Signature of Subject Date

_____ _____
Signature of Co-Investigator Date

APPENDIX E

SOCIAL CHARACTERISTICS FORM

SELECTED SOCIAL CHARACTERISTICS SHEET

The following data will be used only for statical purposes. The purpose is develop a profile of the participants in the study.

Instructions: Please complete the selected social characteristics information below by placing a check in the appropriate box. Place this questionnaire along with the Lead Self Questionnaire and the Index of Work Satisfaction in the self-addressed, stamped envelope. Individuals will not be identified; group data only will be reported.

1. What is your highest level of education?
   _____AND.
   _____Diploma
   _____BSN/BS
   _____MSN/MS/MN
   _____DNS/Ph.D.
   _____Other

2 Sex?
   _____Male
   _____Female

3. Actual Age?
   _____ years

4. Do you hold a Nurse Manager position?
   _____Yes
   _____No
   For how many years?
   _____1 year
   _____2 years
   _____3 years
   _____4 years
   _____5 years
   _____Over 5 years

5. How many years have you been a Nurse Manager on the unit(s)you are in charge?
   _____1 year
   _____2 years
   _____3 years
   _____4 years
   _____5 years
   _____Over 5 years

SELECTED SOCIAL CHARACTERISTICS SHEET

6. How many years have you been an RN?
_____Less than 1 year
_____1-5 years
_____5-10 years
_____10-15 years
_____15-20 years
_____Over 20 years

7. How long have you been employed at this hospital?
_____Less than 1 year
_____1-5 years
_____5-10 years
_____10-15 years
_____15-20 years
_____Over 20 years

8. How many years have you been working on the unit you now work?
_____Less than 1 year
_____1 year
_____2 years
_____3 years
_____4 years
_____5 years
_____Over 5 years

APPENDIX F

LEADERSHIP BEHAVIOR ANALYSIS II-SELF INSTRUMENT

THE LEADER BEHAVIOR ANALYSIS II (LBAII)
PERCEPTIONS OF LEADERSHIP STYLE BY NURSE MANAGERS

Directions: **The purpose of the LBAII is to provide you with information about your perceptions of your own leadership style. This instrument consists of 20 typical job situations that involve a leader and one or more staff members. Following each situation are four possible actions that a lead may take. Assume that you are the nurse manager involved in each of the 20 situations. In each of the situations, you must choose one of the four leader decisions. *Circle* the letter of the decision that you think would most closely describe your behavior in the situation presented on the *Leadership Answer Form* provided for this purpose.**

1. You have asked a new RN staff member to write a report to purchase new equipment for the unit. She needs to learn more about this equipment to make a sound decision about options and costs. She feels this assignment will stretch her already full schedule. You would:

A) Tell her you want the report. Explain what you want in the report. Outline the steps she should take to become knowledgeable about the new equipment. Set weekly meetings with her to track progress.

B) Ask her to produce the report. Discuss its importance. Ask her for a deadline for completion. Give her resources she thinks she needs. Periodically check with her to track progress.

C) Tell her you want the report and discuss its importance. Explain what you want in the report. Outline steps she should take to learn more about the equipment. Listen to her concerns and use her ideas when possible. Plan weekly meetings to track her progress.

D) Ask her to produce the report. Discuss its importance. Explore the barriers she feels must be removed and the strategies for removing them. Ask her to set a deadline for completion and periodically check with her to track progress.

Go to next page

2. Your task force has been working hard to complete its unit-wide report. A new RN staff member has joined this group. He must present cost figures at the end of next week but he knows nothing about the report requirements and format. He is excited about learning more about his role in the group. You would:

A) Tell him exactly what is needed. Specify the format and requirements. Introduce him to other task-force members. Check with him frequently during the week to monitor progress and to specify any corrections.

B) Ask him if there is anything you can do to help. Introduce him to other task-force members. Explore with him what he thinks he needs to get up speed with the report. Check with him frequently during the week to see how he is doing.

C. Specify the report format and information needed and solicit his ideas. Introduce him to each task-force member. Check with him frequently during the week to see how the report is progressing and to help with modifications.

D) Welcome him and introduce him to members of the task force who could help him. Check with him during the week to see how he is doing.

3. You have recently noticed a performance problem with one of your RN staff members. He seems to show a "don't care" attitude. Only your constant prodding has brought about task completion. You suspect he may not have enough expertise to complete the high-priority task you have given him. You would:

A) Specify the steps he needs to take and the outcomes you want. Clarify timeliness and paperwork requirements. Frequently check to see if the task is progressing as it should.

B) Specify the steps he needs to take and the outcomes you want. Ask for him ideas and incorporate them as appropriate. Ask him to share her feelings about this task assignment. Frequently check to see the task is progressing as it should.

C) Involve him in problem solving for this task. Offer your help and encourage him to use his ideas to complete the project. Ask him to share his feelings about the assignment. Frequently check to see that the task is progressing as it should.

D) Let him know how important this task is. Ask him to outline his plan for completion and to send you a copy. Frequently check to see if the task is progressing as it should.

Go to next page

4. **Your RN staff group's composition has changed because of hospital nursing service restructuring. Performance levels have dropped. Deadlines are being missed and your supervisor is concerned. RN staff members want to improve their performance but need more knowledge and skills. You would:**

A) Ask them to develop their own plan for improving performance. Be available to help them, if asked. Ask them what training they think they need to improve performance and give them the resources they need. Continue to track performance.

B) Discuss your plan to solve this problem. Ask for their input and include their ideas in your plan, if possible. Explain the rationale for your plan. Track performance to see how it is carried out.

C) Outline the specific steps you want them to follow to solve this problem. Be specific about the time needed and the skills you want them to learn. Continue to track performance.

5. **Because of budget cuts, it is necessary to consolidate. You have asked a highly experienced RN staff member to take charge of the consolidation. This person has worked in all areas of your unit. In the past, she has usually been eager to help. While you feel she is able to perform the assignment, she seems indifferent to the task. You would:**

A) Reassure her. Outline the steps she should take to handle this project. Ask for her ideas and incorporate them when possible, but make sure she follows your general approach. Frequently check to see how things are going.

B) Reassure her. Ask her to handle the project as she sees fit. Let her know that you are available for help. Be patient but frequently check to see what is being done.

C) Reassure her. Ask her to determine the best way to approach the project. Help her to develop options and encourage her to use her own ideas. Frequently check to see how she is doing.

D) Reassure her. Outline an overall plan and specify the steps you want her to follow. Frequently check to see how the steps are being implemented.

Go to next page

6. **For the second time in a month you are having a problem with one of your RN staff members. His weekly progress reports have been incomplete and late. In the past year he has submitted accurately completed reports on time. This is the first time you have spoken to him about this problem. You would:**

A) Tell him to improve the completeness and timeliness of his paperwork. Go over the areas that are incomplete. Make sure he knows what is expected and how to fill out each report section. Continue to track his performance.

B) Ask him to turn in his reports on time and accurately, without pushing him. Continue to track his performance.

C. Discuss time and completion standards with him. Listen to his concerns but make sure he knows what is expected. Go over each report section and answer any questions he may have. Use his ideas, if possible. Continue to track his performance.

D. Ask him why the paperwork is incomplete. Listen to his concerns and do what you can to help him understand the importance of timeliness and completeness. Continue to track his performance.

7. **You have asked one of your senior RN staff members to take on a new project. In the past, his performance has been outstanding. The project you have given him is important to the future of your RN staff group. He is excited about the new assignment but doesn't know where to begin because he lacks project information. Your relationship with him is good. You would:**

A) Explain why you think he has the skills to do the job. Ask him what problems he anticipates and help him explore alternative solutions. Frequently stay in touch to support him.

B) Specify how he should handle the project. Define the activities necessary to complete the job. Regularly check to see how things are going.

C) Ask him for a plan for completing the project in two weeks and to give you a copy for your approval. Give him enough time to get started, without pushing him. Frequently offer your support.

D) Outline how the project should be handled and solicit his ideas and suggestions. Incorporate his ideas when possible but make sure your general outline is followed. Regularly check to see how things are going.

Go to next page

8. One of your RN staff members is feeling insecure about a job you have assigned to him. He is highly competent and you know that he has the skills to successfully complete the task. The deadline for completion is near. You would:

A) Let him know of your concerns about the impending deadline. Help him explore alternative action steps and encourage him to use his own ideas. Frequently check with him to lend your support.

B) Discuss with him your concerns about the impending deadline. Outline an action plan for him to follow and get his reactions to the plan. Modify the plan if possible but make sure he follows your general outline. Frequently check with him to see how things are going.

C) Specify the reasons for on-time completion of the assignment. Outline the steps you would like him to start following. Ask that the steps be followed. Frequently check to see how he is progressing.

D) Ask him if there are any problems but let him resolve the issue himself. Remind him of the impending deadline, without pushing him. Ask for an update in three days.

9. Your RN staff has asked you to consider a change in their work schedule. Their changes make good sense to you. Your RN staff is well aware of the need for change. Members are very competent and work well together. You would:

A) Help them explore alternative scheduling possibilities. Be available to facilitate their group discussion. Support the plan they develop. Check to see how they implement their plan.

B) Design the work schedule yourself. Explain the rationale behind your design. Listen to their reactions, ask for their ideas and use their recommendations when possible. Check to see how they carry out your schedule.

C) Allow the staff to set a work schedule on their own. Let them implement their plan after you approve it. Check with them at a later date to assess their progress.

D) Design the work schedule yourself. Explain how the schedule will work and answer any questions they may have. Check to see that your schedule is followed.

Go to next page

10 **Due to an hospital organizational change, you have been assigned six new RN staff members whose performance has been declining over the past three months. They do not seem to have the task knowledge and skills to do their new jobs, and their attitudes have worsened because of the change. In a group meeting, you would:**

A) Make them aware of their three-month performance trend. Ask them to decide what to do about it and set a deadline for implementing their solution. Monitor their progress.

B) Make them aware of their three-month performance trend. Specify the action steps you want them to follow. Give constructive feedback on how to improve performance. Continue to monitor performance.

C) Make them aware of their three-month performance trend. Outline the steps you want them to follow, explain why and seek their feedback. Use their ideas when possible but make sure they follow your general approach. Continue to monitor their progress.

D) Make them aware of their three-month performance trend. Ask them why their performance is declining. Listen to their concerns and ideas. Help them create their own plan for improving performance. Track their performance.

11 **A RN staff member on your unit has had a fine performance record over the last 22 months. She is excited by the challenges of the upcoming year. Budgets and unit goals have not changed much from last year. In a meeting with her to discuss goals and an action plan for next year, you would:**

A) Ask her to submit an outline of her goals and an action plan for next year for your approval. Tell her you will call her if you have any questions.

B) Prepare a list of goals and an action plan that you think she can accomplish next year. Send it to her and meet with her to see if she has any questions.

C) Prepare a list of goals and an action plan that you think she can achieve next year. Meet with her to discuss her reactions and suggestions. Modify the plan as you listen to her ideas, but make sure you make the final decision.

D) Ask her to send you an outline of her goals and an action plan for next year. Review the goals and plan with her. Listen to her ideas and help her explore alternatives. Let her make the final decisions on her goals and plan.

Go to next page

12 **Your unit has had an excellent performance record over the past two years. However, they have recently experienced three major setbacks due to factors beyond their control. Their performance and morale have drastically dropped and your supervisor is concerned. In a group meeting, you would:**

A) Discuss the recent setbacks. Give them the specific steps you want them to follow to improve their performance. Continue to track performance.

B) Ask them how they feel about the recent setbacks. Listen to their concerns and encourage and help them to explore their ideas for improving performance. Continue to track performance.

C) Discuss the recent setbacks. Clarify the steps you want them to follow to improve performance. Listen to their ideas and incorporate them, if possible. Emphasize results. Encourage them to keep trying. Continue to track performance.

D) Discuss the recent setbacks, without pressuring them. Ask them to set a deadline to improve performance and to support each other along the way. Continue to track performance.

13 **You were recently assigned a new RN staff member who will perform an important job in your unit. Even though she is inexperienced, she is enthusiastic and feels she has the confidence to do the job. You would:**

A) Allow her time to determine what the job requires and how to do it. Let her know why the job is important. Ask her to contact you if she needs help. Track her progress.

B) Specify the results you want and when you want them. Clearly define the steps she should take to achieve results. Show her how to do the job. Track her progress.

C) Discuss the results you want and when you want them. Clearly define the steps she can take to achieve results. Explain why these steps are necessary and get her ideas. Use her ideas if possible but make sure your general plan is followed. Track her performance.

D) Ask her how she plans to tackle this job. Help her explore the problems she anticipates by generating possible alternative solutions. Encourage her to carry out her plan. Be available to listen to her concerns. Track her performance.

Go to next page

14 Your supervisor has asked you to increase your unit's output by seven percent. You know this can be done but it will require your active involvement. To free your time, you must reassign the task of developing a new cost-control system to one of your RN staff members. The person you want has had considerable experience with cost-control systems, but she is slightly unsure of doing this task on her own. You would:

A) Assign her the task and listen to her concerns. Explain why you think she has the skills to handle this assignment. Help her explore alternative approaches if she thinks it would be helpful. Encourage and support her by providing needed resources. Track her progress.

B) Assign her the task and listen to her concerns. Discuss the steps she should follow to complete the task. Ask for her ideas and suggestions. After incorporating her ides, if possible, make sure she follows your general approach. Track her progress.

C) Assign her the task. Listen to her concerns but let her resolve the issue. Give her time to adjust and avoid asking for results right away. Track her progress.

D) Assign her the task. Listen to her concerns, and minimize her feelings of insecurity by telling her specifically how to handle this task. Outline the steps to be taken. Closely monitor her progress.

15 Your supervisor has asked you to assign someone to serve on a hospital-wide task force. This task force will make recommendations for restructuring the hospital's compensation plan. You have chosen a highly productive RN staff member, who knows how her coworkers feel about the existing compensation plan. She has successfully led another unit task force. She wants the assignment. You would:

A) Give her the assignment but tell her how she should represent her coworkers' point of view. Specify that she give you a progress report within two days of each task-force meeting.

B) Ask her to accept the assignment. Help her develop the point of view she will take on the task force. Periodically check with her.

C) Give her the assignment. Discuss what she should do to ensure her coworkers' perspective is considered by the task force. Ask for her ideas and make sure she follow your general approach. Ask her to report to you after every task-force meeting.

D) Give her the assignment. Ask her to keep you informed as things progress. Periodically check with her.

Go to next page

16 **Due to illness in your family, you have been forced to miss two meetings of a committee under your direction. Upon attending the next meeting, you find that the committee is operating well and making progress toward completing its goals. All group members come prepared, participate and seem to be enthusiastic about their progress. You are unsure of what your role should be. You would:**

A) Thank the committee members for their work so far. Let the group continue to work as it has during the last two meetings.

B) Thank the committee members for their work so far. Set the agenda for the next meeting. Begin to direct the group's activities.

C) Thank the committee members for their work so far. Do what you can to make the members feel important and involved. Try to solicit alternative ideas and suggestions.

D) Thank the committee members for their work so far. Set the agenda for the next meeting but make sure to solicit their ideas and suggestions.

17 **Your RN staff is very competent and works well on their own. Their enthusiasm is high because of a recent success. Their performance as a group is outstanding. Now, you must set unit goals for next year. In a group meeting, you would:**

A) Praise them for last year's results. Involve the group in problem solving and goal setting for next year. Encourage them to be creative and help them explore the alternatives. Track the implementation of their plan.

B) Praise them for last year's results. Challenge them by setting the goals for next year. Outline the action steps necessary to accomplish these goals. Track the implementation of your plan.

C) Praise them for last year's results. Ask them to set the goals for next year and define their action plan to accomplish these goals. Be available to contribute when asked. Track the implementation of their plan.

D) Praise them for last year's results. Set the goals for next year and outline the action steps necessary to accomplish these goals. Solicit their ideas and suggestions and incorporate them if possible. Track the implementation of your plan.

Go to next page

18. You and your supervisor know that your unit needs a new set of work procedures to improve long-term performance. Unit RN staff members are eager to make some changes but, because of their specialized functions, they lack the knowledge and skills for understanding the *big picture*. You would:

A) Outline the new procedures. Organize and direct the implementation. Involve the group in a discussion of alternatives. Use their suggestions when possible, but make them follow your general approach. Track their use of the new procedures.

B) Outline and demonstrate the new procedures. Closely direct the group in their initial use of the procedures. Track their use.

C) Involve the group in a discussion of what the new procedures should be. Encourage their initiative and creativity in developing the new procedures. Help them explore possible alternatives. Support their use of the procedures. Closely track results.

D) Ask the group to formulate and implement a set of new procedures. Answer any informational concerns but give them the responsibility for the task. Closely track the use of the new procedures.

19. You were recently appointed head of your unit. Since taking over, you have noticed a drop in performance. There have been changes in technology, and your staff has not mastered the new skills and techniques. Worst of all, they do not seem to be motivated to learn these skills. In a group meeting, you would:

A) Discuss the staff's drop in performance. Listen to their concerns. Ask for their solutions for improving performance. Express your faith in their strategies. Emphasize their past efforts but track performance as they carry out their strategies.

B) Outline the necessary corrective actions you want them to take. Discuss this outline and incorporate their ideas but see that they implement your corrective action plan. Track their performance.

C) Tell them about the drop in performance. Ask them to analyze the problem and draft a set of action steps for your approval. Set a deadline for the plan. Track its implementation.

D) Outline and direct the necessary corrective actions you want them to take. Define roles, responsibilities and standards. Frequently check to see if their performance is improving.

Go to next page

20. **You have noticed that one of your inexperienced RN staff members is not properly completing certain tasks. She has submitted inaccurate and incomplete reports. She is not enthusiastic about this task and often thinks paperwork is a waste of time. You would:**

A) Let her know that she is submitting inaccurate and incomplete reports. Discuss the steps she should take and clarify why these steps are important. Ask for her suggestions, but make sure she follows your general outline.

B) Let her know that she is submitting inaccurate and incomplete reports. Ask her to set and meet her own paperwork deadlines. Give her more time to do the job properly. Monitor her performance.

C) Let her know that she is submitting inaccurate and incomplete reports. Ask her what she plans to do about it. Help her develop a plan for solving her problems. Monitor her performance.

D) Let her know that she is submitting inaccurate and incomplete reports. Specify the steps she should take with appropriate deadlines. Show her how to complete the reports. Monitor her performance.

Thank you for your participation

This instrument has been modified for the population in this study with permission from Blanchard, Hambleton, Zigarmi, & Forsyth (Appendix H).

NURSE MANAGERS

LEADERSHIP BEHAVIOR ANALYSIS II (LBAII)

CIRCLE ONLY ONE CHOICE (A, B, C, OR, D) ON THE LEADERSHIP STYLE ANSWER FORM FOR EACH SITUATION ON THE LBAII INSTRUMENT.

LEADERSHIP STYLE ANSWER FORM

The column headings under Style Flexibility correspond to the four leadership styles
S1 - High Directive, Low Supportive Behavior
S2 - High Directive, High Supportive Behavior
S3 - High Supportive, Low Directive Behavior
S4 - Low Supportive, Low Directive Behavior

Situation	S1	S2	S3	S4
1	A	C	D	B
2	A	C	B	D
3	A	B	C	D
4	C	B	D	A
5	D	A	C	B
6	A	C	D	B
7	B	D	A	C
8	C	B	A	D
9	D	B	A	C
10	B	C	D	A
11	B	C	D	A
12	A	C	B	D
13	B	C	D	A
14	D	B	A	C
15	A	C	B	D
16	B	D	C	A
17	B	D	A	C
18	B	A	C	D
19	D	B	A	C
20	D	A	C	B
TOTAL				

APPENDIX G

LEADERSHIP BEHAVIOR ANALYSIS II-OTHER INSTRUMENT

THE LEADER BEHAVIOR ANALYSIS II (LBAII)
PERCEPTIONS OF LEADERSHIP STYLE OF THE NURSE MANAGER

***Directions*: The purpose of the LBAII is to determine your perceptions of your nurse manager's leadership style. This instrument consists of 20 typical job situations that involve a nurse manager and one or more staff members. Following each situation are four possible actions that a lead may take. Assume that you're the nurse manager is involved in each of the 20 situations. In each of the situations, you must choose one of the four leader decisions. *Circle* the letter of the decision that you think would best describe the behavior of your nurse manager in each situation on the *Leadership Answer Form* provided for this purpose.**

1. A new RN Staff member has been asked to write a report to suggest purchase of new equipment for the unit. She needs to learn more about this equipment to make a sound decision about options and costs. She feels this assignment will stretch her already full schedule. Your nurse manager would:

A) Tell her when the report is needed and what should be in the report. Outline the steps the new RN staff member should take to become knowledgeable about the new equipment. Set weekly meetings with her to track progress.

B) Ask her to produce the report and discuss its importance. Ask her for a deadline for completion. Give her resources she thinks she needs. Periodically check with her to track progress.

C) Tell her when the report is needed, and discuss its importance. Explain what the report should include. Outline steps the new RN staff member should take to learn more about the equipment. Listen to her concerns and use her ideas when possible. Plan weekly meetings to track her progress.

D) Ask her to produce the report, and discuss its importance. Explore the barriers the new RN staff member feels must be removed and the strategies for removing them. Ask her to set a deadline for completion and periodically check with her to track progress.

Go to next page

2. Your nurse manager's task force has been working hard to complete its unit-wide report. A new RN staff member has joined this group. He must present cost figures at the end of next week but he knows nothing about the report requirements and format. He is excited about learning more about his role in the group. Your nurse manager would:

A) Tell him exactly what is needed, and specify the format and requirements. Introduce hi to other task-force members. Check with him frequently during the week to monitor progress and to specify any corrections.

B) Ask him if there is anything he or she can do to help. Introduce him to other task-force members. Explore with him what he thinks he needs to get "up speed" with the report. Check with him frequently during the week to see how he is doing.

C. Specify the report format and information needed and solicit his ideas. Introduce him to each task-force member. Check with him frequently during the week to see how the report is progressing and to help with modifications.

D) Welcome him and introduce him to members of the task force who could help him. Check with him during the week to see how he is doing.

3. The nurse manager has recently noticed a performance problem with one of the RN staff members. He seems to show a "don't care" attitude. Only your nurse manager's constant prodding has brought about task completion. Your nurse manager suspects this RN staff member may not have enough expertise to complete the high-priority task you have given him. Your nurse manager would:

A) Specify the steps this RN staff member needs to take and the desired outcomes. Clarify timeliness and paperwork requirements. Frequently check to see if the task is progressing as it should.

B) Specify the steps this RN staff member needs to take and the desired outcomes. Ask for his ideas and incorporate them as appropriate. Ask him to share her feelings about this task assignment. Frequently check to see the task is progressing as it should.

C) Involve this RN staff member in problem solving for this task. Offer help and encourage him to use his ideas to complete the project. Ask him to share his feelings about the assignment. Frequently check to see that the task is progressing as it should.

D) Let him know how important this task is. Ask him to outline his plan for completion and to send you a copy. Frequently check to see if the task is progressing as it should.

Go to next page

4 The composition of the nurse manager's RN staff group has changed because of hospital nursing service restructuring. Performance levels have dropped. Deadlines are being missed and your nurse manager's supervisor is concerned. RN staff members want to improve their performance but need more knowledge and skills. Your nurse manager would:

A) Ask the RN Staff group to develop their own plan for improving performance. Be available to help them, if asked. Ask them what training they think they need to improve performance and give them the resources they need. Continue to track performance.

B) Discuss a plan to solve this problem. Ask the RN staff members for their input and include their ideas in the plan, if possible. Explain the rationale for your plan. Track performance to see how it is carried out.

C) Outline the specific steps the RN staff group should follow to solve this problem. Be specific about the time requirements and the skills they need to learn. Continue to track performance.

5. Because of budget cuts, it is necessary to consolidate. A highly experienced RN staff member has been asked to take charge of the consolidation. This person has worked in all areas of your nurse manager's unit. In the past, she has usually been eager to help. While the nurse manager feels she is able to perform the assignment, the RN staff member seems indifferent to the task. Your nurse manager would:

A) Reassure her. Outline the steps she should take to handle this project. Ask for her ideas and incorporate them when possible, but make sure she follows the nurse manager's general approach. Frequently check to see how things are going.

B) Reassure her. Ask her to handle the project as she sees fit. Be patient but be available to help. Frequently check to see what is being done.

C) Reassure her. Ask her to determine the best way to approach the project. Help her to develop options and encourage her to use her own ideas. Frequently check to see how she is doing.

D) Reassure her. Outline an overall plan and specify the steps she should follow. Frequently check to see how the steps are being implemented.

Go to next page

6. **For the second time in a month, an RN staff member's weekly progress reports have been incomplete and late. In the past year he has submitted accurately completed reports on time. This is the first time your nurse manager has spoken to him about this problem. Your nurse manager would:**
A) Tell him to improve the completeness and timeliness of his paperwork. Go over the areas that are incomplete. Make sure he knows what is expected and how to fill out each report section. Continue to track his performance.

B) Ask him to turn in his paperwork on time and accurately, without pushing him. Continue to track his performance.

C) Discuss time and completion standards with him. Listen to his concerns but make sure he knows what is expected. Go over each report section and answer any questions he may have. Use his ideas, if possible. Continue to track his performance.

D. Ask him why the paperwork is incomplete. Listen to his concerns and do what you can to help him understand the importance of timeliness and completeness. Continue to track his performance.

7. **A senior RN staff member has been asked to take on a new project. In the past, his performance has been outstanding. The project he has been given is important to the future of your nurse manager's RN staff. He is excited about the new assignment but doesn't know where to begin because he lacks project information. The nurse manager's relationship with him is good. Your nurse manager would:**
A) Explain why this RN staff member has the skills to do the job. Ask him what problems he anticipates and help him explore alternative solutions. Frequently stay in touch to support him.

B) Specify how this RN staff member should handle the project. Define the activities necessary to complete the job. Regularly check to see how things are going.

C) Ask this RN staff member for a plan for completing the project in two weeks. Ask him to send a copy for approval. Give him enough time to get started, without pushing him. Frequently offer your support.

D) Outline how the project should be handled and solicit the RN staff member's ideas and suggestions. Use his ideas when possible but make sure the nurse manager's general outline is followed. Regularly check to see how things are going.

Go to next page

8. A RN staff member is feeling insecure about a job you have assigned to him. He is highly competent and your nurse manager knows that this RN staff member has the skills to successfully complete the task. The deadline for completion is near. Your nurse manager would:

A) Let this RN staff member know of his or her concerns about the impending deadline. Help him explore alternative action steps and encourage him to use his own ideas. Frequently check with him to lend support.

B) Discuss his or her concerns about the impending deadline. Outline an action plan for the RN staff member to follow and get his reactions to the plan. Modify the plan if possible but make sure this RN staff member follows the general outline. Frequently check with him to see how things are going.

C) Specify the reasons for on-time completion of the assignment. Outline the steps the RN staff member should follow. Ask that the steps be followed. Frequently check to see how he is progressing.

D) Ask the RN staff member if there are any problems but let him resolve the issue himself. Remind him of the impending deadline, without pushing him. Ask for an update in three days.

9. The RN staff has asked your nurse manager to consider a change in their work schedule. Their changes make good sense, and the nurse manager is well aware of the need for change. Members are very competent and work well together. Your nurse manager would:

A) Help them explore alternative scheduling possibilities. Be available to facilitate their group discussion. Support the plan they develop. Check to see how they implement their plan.

B) Design the work schedule and explain the rationale behind the design. Listen to their reactions, ask for their ideas and use their recommendations when possible. Check to see how they carry out the schedule.

C) Allow the RN staff to set a work schedule on their own. Let them implement their plan after the nurse manager has approved it. Check with them at a later date to assess their progress.

D) Design the work schedule and explain how it will work. Answer any questions they may have. Check to see that the schedule is followed.

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10 **Due to an hospital organizational change, your nurse manager has been assigned six new RN staff members whose performance has been declining over the past three months. They do not seem to have the task knowledge and skills to do their new jobs, and their attitudes have worsened because of the change. In a group meeting, your manager would:**

A) Make them aware of their three-month performance trend. Ask them to decide what to do about it and set a deadline for implementing their solution. Monitor their progress.

B) Make them aware of their three-month performance trend. Specify the action steps they should follow. Give constructive feedback on how to improve performance. Continue to monitor performance.

C) Make them aware of their three-month performance trend. Outline the steps they should follow, explain why the steps are important, and seek their feedback. Use their ideas when possible but make sure they follow the general approach. Continue to monitor their progress.

D) Make them aware of their three-month performance trend. Ask them why their performance is declining. Listen to their concerns and ideas. Help them create their own plan for improving performance. Track their performance.

11 **A RN staff member of your unit has had a fine performance record over the last 22 months. This RN staff member is excited by the challenges of the upcoming year. Budgets and unit goals have not changed much from last year. In a meeting with her to discuss goals and an action plan for next year, your nurse manager would:**

A) Ask this RN staff member to submit an outline of her goals and an action plan for next year for the nurse manager's approval. Tell the RN staff member to expect a call if there are any questions.

B) Prepare a list of goals and an action plan for the RN staff member to accomplish next year. Send it to her and meet with her to see if she has any questions.

C) Prepare a list of goals and an action plan for the RN staff member to achieve next year. Meet with her to discuss her reactions and suggestions. Modify the plan as you listen to her ideas, but make the final decision.

D) Ask the RN staff member to submit an outline of her goals and an action plan for next year. Review the goals and plan with her. Listen to her ideas and help her explore alternatives. Let her make the final decisions on her goals and plan.

Go to next page

12 **Your nurse manager's unit has had an excellent performance record over the past two years. However, they have recently experienced three major setbacks due to factors beyond their control. Their performance and morale have drastically dropped and your nurse manager's immediate supervisor is concerned. In a group meeting, your nurse manager would:**

A) Discuss the recent setbacks. Give them the specific steps they should follow to improve their performance. Continue to track performance.

B) Ask them how they feel about the recent setbacks. Listen to their concerns and encourage and help them to explore their ideas for improving performance. Continue to track performance.

C) Discuss the recent setbacks. Clarify the steps they should follow to improve performance. Listen to their ideas and incorporate them, if possible. Emphasize results. Encourage them to keep trying. Continue to track performance.

D) Discuss the recent setbacks, without pressuring them. Ask them to set a deadline to improve performance and to support each other along the way. Continue to track performance.

13 **Your nurse manager was recently assigned a new RN staff member who will perform an important job in your unit. Even though this RN staff member is inexperienced, she is enthusiastic and feels she has the confidence to do the job. Your nurse manager would:**

A) Allow her time to determine what the job requires and how to do it. Let her know why the job is important. Ask her to be in touch if she needs help. Track her progress.

B) Specify the desired results and timeliness. Clearly define the steps this RN staff member should take to achieve results. Show her how to do the job. Track her progress.

C) Discuss the desired results and timeliness. Clearly define the steps she can take to achieve the results. Explain why these steps are necessary and get her ideas. Use her ideas if possible but make the manager's general plan is followed. Track her performance.

D) Ask her how she plans to tackle this job. Help her explore the problems she anticipates by generating possible alternative solutions. Encourage her to carry out her plan. Be available to listen to her concerns. Track her performance.

Go to next page

14 **Your nurse manager's immediate supervisor has requested a seven percent increase in the unit's output. Your nurse manager knows it can be done but it will require his or her active involvement. To free the nurse manager's time, the task of developing a new cost-control system must be reassigned. The RN staff member chosen has had considerable experience with cost-control systems, but she is slightly unsure of doing this task on her own. Your nurse manager would:**

A) Assign her the task and listen to her concerns. Express confidence in her skills to handle this assignment. Help her explore alternative approaches if she thinks it would be helpful. Encourage and support her by providing needed resources. Track her progress.

B) Assign her the task and listen to her concerns. Discuss the steps she should follow to complete the task. Ask for her ideas and suggestions. After incorporating her ideas, if possible, make sure she follows the nurse manager's general approach. Track her progress.

C) Assign her the task. Listen to her concerns but let her resolve the issue. Give her time to adjust and avoid asking for results right away. Track her progress.

D) Assign her the task. Listen to her concerns, and minimize her feelings of insecurity by telling her specifically how to handle this task. Outline the steps to be taken. Closely monitor her progress.

15 **Your nurse manager's nursing administrator has asked to have someone assigned to serve on a hospital-wide task force. This task force will make recommendations for restructuring the hospital's compensation plan. Your nurse manager has chosen a highly productive RN staff member, who knows how her coworkers feel about the existing compensation plan. She has successfully led another unit task force. She wants the assignment. Your nurse manager would:**

A) Give this RN staff member the assignment but tell her how she should represent her coworkers' point of view. Specify that she give the nurse manager a progress report within two days of each task-force meeting.

B) Ask this RN staff member to accept the assignment. Help her develop the point of view she will take on the task force. Periodically check with her.

C) Give this RN staff member the assignment. Discuss what she should do to ensure her coworkers' perspective is considered by the task force. Ask for her ideas and make sure she follow the nurse manager's general approach. Ask her for a report after every task-force meeting.

D) Give her the assignment. Ask her to keep you informed as things progress. Periodically check with her.

(Go to next page)

16 **Due to a family illness, your nurse manager has been forced to miss two meetings of a committee he or she directs. Upon attending the next meeting, your nurse manager finds that the committee is operating well and making progress toward completing its goals. All group members come prepared, participate and seem to be enthusiastic about their progress. Your nurse manager is unsure of what his or her role should be. Your nurse manager would:**

A) Thank the committee members for their work so far. Let the group continue to work as it has during the last two meetings.

B) Thank the committee members for their work so far. Set the agenda for the next meeting. Begin to direct the group's activities.

C) Thank the committee members for their work so far. Make the members feel important and involved. Try to solicit alternative ideas and suggestions.

D) Thank the committee members for their work so far. Set the agenda for the next meeting but make sure to solicit their ideas and suggestions.

17 **Your nurse manager's RN staff is very competent and works well on their own. Their enthusiasm is high because of a recent success. Their performance as a group is outstanding. Now, your nurse manager must set unit goals for next year. In a group meeting, your nurse manager would:**

A) Praise them for last year's results. Involve the group in problem solving and goal setting for next year. Encourage them to be creative and help them explore the alternatives. Track the implementation of their plan.

B) Praise them for last year's results. Challenge them by setting the goals for next year. Outline the action steps necessary to accomplish these goals. Track the implementation of your plan.

C) Praise them for last year's results. Ask them to set the goals for next year and define their action plan to accomplish these goals. Be available to contribute when asked. Track the implementation of their plan.

D) Praise them for last year's results. Set the goals for next year and outline the action steps necessary to accomplish these goals. Solicit the RN staff members' ideas and suggestions and incorporate them if possible. Track the implementation of your plan.

Go to next page

18. **Your nurse manager and his or her immediate supervisor know that his or her unit needs a new set of work procedures to improve long-term performance. Unit RN staff members are eager to make some changes but, because of their specialized functions, they lack the knowledge and skills for understanding the *big picture*. Your nurse manager would:**

A) Outline the new procedures. Organize and direct the implementation. Involve the group in a discussion of alternatives. Use their suggestions when possible, but see that they follow the general outline. Track their use of the new procedures.

B) Outline and demonstrate the new procedures. Closely direct the group in their initial use of the procedures. Track their use.

C) Involve the group in a discussion of what the new procedures should be. Encourage their initiative and creativity in developing the new procedures. Help them explore possible alternatives. Support their use of the procedures. Closely track results.

D) Ask the group to formulate and implement a set of new procedures. Answer any informational concerns but give them the responsibility for the task. Closely track the use of the new procedures.

19. **Your nurse manager was recently appointed head of your unit. Since taking over, there has been a drop in performance. There have been changes in technology, and your nurse manager's RN staff members have not mastered the new skills and techniques. Worst of all, they do not seem to be motivated to learn these skills. In a group meeting, your nurse manager would:**

A) Discuss the staff's drop in performance. Listen to their concerns. Ask for their solutions for improving performance. Express your faith in their strategies. Emphasize their past efforts but track performance as they carry out their strategies.

B) Outline the necessary corrective actions you want them to take. Explore alternatives and incorporate their ideas. Modify the plan if appropriate, but see that they implement it. Track their performance.

C) Tell them about the drop in performance. Ask them to analyze the problem and draft a set of action steps for approval. Set a deadline for the plan. Track its implementation.

D) Outline and direct the necessary corrective actions they should take. Define roles, responsibilities and standards. Frequently check to see if their performance is improving.

Go to next page

20. Your nurse manager has noticed that an inexperienced RN staff members is not properly completing certain tasks. She has submitted inaccurate and incomplete reports. She is not enthusiastic about this task and often thinks paperwork is a waste of time. Your nursing manager would:

A) Let this RN staff member know that she is submitting inaccurate and incomplete reports. Discuss the steps she should take and clarify why these steps are important. Ask for her suggestions, but make sure she follows the nurse manager's general outline.

B) Let this RN staff member know that she is submitting inaccurate and incomplete reports. Ask her to set and meet her own paperwork deadlines. Give her more time to do the job properly. Monitor her performance.

C) Let this RN staff member know that she is submitting inaccurate and incomplete reports. Ask her what she plans to do about it. Help her develop a plan for solving her problems. Monitor her performance.

D) Let this RN staff member know that she is submitting inaccurate and incomplete reports. Specify the steps she should take with appropriate deadlines. Show her how to complete the reports. Monitor her performance.

Thank you for your participation

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RN STAFF MEMBERS

LEADERSHIP BEHAVIOR ANALYSIS II (LBAII)

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LEADERSHIP STYLE ANSWER FORM

The column headings under Style Flexibility correspond to the four leadership styles
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S2 - High Directive, High Supportive Behavior
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S4 - Low Supportive, Low Directive Behavior

Situation	S1	S2	S3	S4
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2	A	C	B	D
3	A	B	C	D
4	C	B	D	A
5	D	A	C	B
6	A	C	D	B
7	B	D	A	C
8	C	B	A	D
9	D	B	A	C
10	B	C	D	A
11	B	C	D	A
12	A	C	B	D
13	B	C	D	A
14	D	B	A	C
15	A	C	B	D
16	B	D	C	A
17	B	D	A	C
18	B	A	C	D
19	D	B	A	C
20	D	A	C	B
TOTAL				

APPENDIX H

AUTHORIZATION TO USE THE LEAD-SELF, OTHER

BLANCHARD
TRAINING & DEVELOPMENT, INC.
btd

April 21, 1998

Mr. Richard McElhaney
1006 Uster Street
Mobile, Alabama 36608

Dear Richard:

Over the years the LBAII® Self or Other has been used in over forty dissertations on Master studies. We are pleased that the model and instruments have become more visible. As the requests for LBAIIs increase, we have found it necessary to humbly request that researchers follow some general guidelines.

BTD will provide the LBAII instruments to you at no cost providing you are willing to meet the following conditions:

- That any dissertations, papers, etc. written from this theoretical framework and using these instruments give citations and references as to where the instruments can be obtained.

- That you do not sell or make economic gain from selling the instruments for popular consumption and that any copies of the instruments used be clearly marked "For research only."

- That Blanchard Training and Development receive a full bound copy of any dissertation or monograph written concerning this research.

- That Blanchard Training and Development be allowed to pass on your research (in summary form) to others who might be doing similar research as a way of supporting those who are working hard to further the field of education.

- That the following scores be produced and reported in your publication using your sample base.

1. Average Flexibility Score and Standard Deviation
2. Average Effectiveness Score and Standard Deviation
3. Average Style Score Means and Standard Deviations to S1 through S4
4. Per cent of Primary Styles 1 through S4
5. Per cent of Secondary Styles 1 through S4
6. Per cent of Developing Styles 1 through S4
7. Maximums and Minimums

This request has emerged because researchers do not fully utilize the six scores that can be derived from the LBAII®. With these scores, BTD will be able to compare across populations. These numbers may aid in a future meta analysis.

Optional scores that would help further comparisons are

8. Average Flexibility Scores and Standard Deviations by Gender
9. Average Effectiveness Scores and Standard Deviations by Gender
10. Average Style Score Means and Standard Deviations by Gender

Enclosed are the LBAII Self and Scoring instruments which you requested, the Reliability/Validity Study which describes the LBAII Self and Other and relevant research and an article which summarizes some of the changes in the model since 1981 and some pertinent research findings. If you decide to use the LBAII, please call me so we can discuss your research design.

Sincerely,

Drea Zigarmi, Ed.D.
Research Coordinator

DZ:ks

Enclosures

- Reliability and Validity Study
- "Situational Leadership after 25 Years: a Retrospective"

THE Ken Blanchard COMPANIES
SAN DIEGO • LONDON • TORONTO

International Group • Learning Materials
Performance Systems • Solutions Group • Speakers Bureau

March 28, 2001

Mr. Richard McElhaney
1051 East Chalet Drive
Mobile, Alabama 36608

Dear Mr. McElhaney:

As per your request in your letter dated January 4, 2001, I give you permission to modify the LBAII self in accordance with your proposed changes:

Manager = Nurse Manager
Employees, Staff, Staff Member, Group, Group member = Registered Nurse Staff Members.
Department = Unit
New People = New RN Staff
Company = Hospital or Nursing Administration
Manager's Boss = Vice President of Nursing Administration
Division = Unit

If you have any questions, please do not hesitate to call me.

Sincerely,

Drea Zigarmi

Drea Zigarmi, Ed.D.
Research Coordinator

APPENDIX I

THE INDEX OF WORK SATISFACTION INSTRUMENT

The Index of Work Satisfaction Questionnaire ©

Part A (Paired Comparisons)

Listed and briefly defined below are six terms or factors that are involved in how people feel about their work situation. Each factor has something to do with "work satisfaction". We are interested in determining which of these is **most important** to you in relation to the others.

Please carefully read the definitions for each factor as given below:

➔ ***Pay*** -- dollar remuneration and fringe benefits received for work done

➔ ***Autonomy*** -- amount of job related independence, initiative, and freedom, either permitted or required in daily work activities.

➔ ***Task Requirements*** -- tasks or activities that must be done as a regular part of the job

➔ ***Organizational Policies*** -- management policies and procedures put forward by the hospital and nursing administration of this hospital

➔ ***Interaction*** -- opportunities presented for both formal and informal social and professional contact during working hours

➔ ***Professional Status*** -- overall importance or significance felt about your job, both in your view and in the view of others

Instructions: These factors are presented in pairs on the next page. A total of 15 pairs are presented: this is every set of combinations. No pair is repeated or reversed. For each pair of terms, decide which one is *more important* for your job satisfaction or morale, and check the appropriate box. For example, if you feel that Pay (as defined above) is more important than Autonomy (as defined above), check the box for Pay.

It will be difficult for you to make choices in some cases. However, please do try to select the factor which is more important to you. Please make an effort to answer every item; do not go back to change any of your answers.

Part A (Paired Comparisons, Continued)

Please choose the one member of the pair which is *most important* to you.

1.	☐	Professional Status	or	☐ Organizational Policies
2.	☐	Pay Requirements	or	☐ Task Requirements
3.	☐	Organizational Policies	or	☐ Interaction
4.	☐	Task Requirements	or	☐ Organizational Policies
5.	☐	Professional Status	or	☐ Task Requirements
6.	☐	Pay	or	☐ Autonomy
7.	☐	Professional Status	or	☐ Interaction
8.	☐	Professional Status	or	☐ Autonomy
9.	☐	Interaction	or	☐ Task Requirements
10.	☐	Interaction	or	☐ Pay
11.	☐	Autonomy	or	☐ Task Requirements
12.	☐	Organizational Policies	or	☐ Autonomy
13.	☐	Pay	or	☐ Professional Status
14.	☐	Interaction	or	☐ Autonomy
15.	☐	Organizational Policies	or	☐ Pay

Part B (Attitude Questionnaire)

The following items represent statements about how satisfied you are with your current nursing job. Please respond to each item. It may be very difficult to fit your responses into the seven categories; in that case, select the category that *comes closest* to your response to the statement. It is very important that you give your *honest* opinion. Please do not go back and change any of your answers.

Instructions: Please circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degrees of *agreement*. The *right* set of numbers indicates degrees of *disagreement*. For example, if you strongly agree with the first item, circle 1; if you agree with this item, circle 2; if you moderately agree with the first statement, circle 3. The middle response (4) is reserved for feeling neutral or undecided. Please use it as little as possible. If you moderately disagree with this first item, you should circle 5; to disagree, circle 6; and to strongly disagree, circle 7.

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

		Agree						Disagree
1.	My present salary is satisfactory.	1	2	3	4	5	6	7
2.	Nursing is not widely recognized as being an important profession.	1	2	3	4	5	6	7
3.	The nursing personnel on my service pitch in and help one another out when things get in a rush.	1	2	3	4	5	6	7
4.	There is too much clerical and "paperwork" required of nursing personnel in this hospital.	1	2	3	4	5	6	7
5.	The nursing staff has sufficient control over scheduling their own shifts in my hospital.	1	2	3	4	5	6	7
6.	Physicians in general cooperate with nursing staff on my unit.	1	2	3	4	5	6	7
7.	I feel that I am supervised more closely than is necessary.	1	2	3	4	5	6	7
8.	It is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay.	1	2	3	4	5	6	7
9.	Most people appreciate the importance of nursing care to hospital patients.	1	2	3	4	5	6	7
10.	It is hard for new nurses to feel 'at home' in my unit.	1	2	3	4	5	6	7
11.	There is no doubt whatever in my mind that what I do on my job is really important.	1	2	3	4	5	6	7
12.	There is a great gap between the administration of this hospital and the daily problems of the nursing service.	1	2	3	4	5	6	7
13.	I feel I have sufficient input into the program of care for each of my patients.	1	2	3	4	5	6	7
14.	Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable.	1	2	3	4	5	6	7
15.	I think I could do a better job if I did not have so much to do all the time.	1	2	3	4	5	6	7
16.	There is a good deal of teamwork and cooperation between various levels of nursing personnel on my service.	1	2	3	4	5	6	7

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

	Agree						Disagree
17. I have too much responsibility and not enough authority.	1	2	3	4	5	6	7
18. There are not enough opportunities for advancement of nursing personnel at this hospital.	1	2	3	4	5	6	7
19. There is a lot of teamwork between nurses and doctors on my own unit.	1	2	3	4	5	6	7
20. On my service, my supervisors make all the decisions. I have little direct control over my own work.	1	2	3	4	5	6	7
21. The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory.	1	2	3	4	5	6	7
22. I am satisfied with the types of activities that I do on my job.	1	2	3	4	5	6	7
23. The nursing personnel on my service are not as friendly and outgoing as I would like.	1	2	3	4	5	6	7
24. I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	1	2	3	4	5	6	7
25. There is ample opportunity for nursing staff to participate in the administrative decision-making process.	1	2	3	4	5	6	7
26. A great deal of independence is permitted, if not required, of me.	1	2	3	4	5	6	7
27. What I do on my job does not add up to anything really significant.	1	2	3	4	5	6	7
28. There is a lot of "rank consciousness" on my unit: nurses seldom mingle with those with less experience or different types of educational preparation.	1	2	3	4	5	6	7
29. I have sufficient time for direct patient care.	1	2	3	4	5	6	7
30. I am sometimes frustrated because all of my activities seem programmed for me.	1	2	3	4	5	6	7
31. I am sometimes required to do things on my job that are against my better professional nursing judgment.	1	2	3	4	5	6	7

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

	Agree						Disagree
32. From what I hear about nursing service personnel at other hospitals, we at this hospital are being fairly paid.	1	2	3	4	5	6	7
33. Administrative decisions at this hospital interfere too much with patient care.	1	2	3	4	5	6	7
34. It makes me proud to talk to other people about what I do on my job.	1	2	3	4	5	6	7
35. I wish the physicians here would show more respect for the skill and knowledge of the nursing staff.	1	2	3	4	5	6	7
36. I could deliver much better care if I had more time with each patient.	1	2	3	4	5	6	7
37. Physicians at this hospital generally understand and appreciate what the nursing staff does.	1	2	3	4	5	6	7
38. If I had the decision to make all over again, I would still go into nursing.	1	2	3	4	5	6	7
39. The physicians at this hospital look down too much on the nursing staff.	1	2	3	4	5	6	7
40. I have all the voice in planning policies and procedures for this hospital and my unit that I want	1	2	3	4	5	6	7
41. My particular job really doesn't require much skill or "know-how".	1	2	3	4	5	6	7
42. The nursing administrators generally consult with the staff on daily problems and procedures.	1	2	3	4	5	6	7
43. I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.	1	2	3	4	5	6	7
44. An upgrading of pay schedules for nursing personnel is needed at this hospital.	1	2	3	4	5	6	7

APPENDIX J

PERMISSION TO USE THE INDEX OF WORK SATISFACTION

UNIVERSITY OF MASSACHUSETTS
AMHERST

Arnold House
Box 30430
Amherst, MA 01003-0430
(413) 545-1312
FAX: (413) 545-6536

School of Public Health
and Health Sciences

Department of
Community Health Studies

March 23, 2000

Richard McElhaney
1051 East Chalet Dr.
Mobile, Alabama 36608

Dear Mr. McElhaney::

I appreciate receiving your request for permission to use the Index of Work Satisfaction (IWS) in your dissertation research. I am not sure if I specifically asked you about which version of my book you are using, but I assume that you were able to get a copy of the second edition, published in 1997. The 1986 version is now out of print and I am encouraging all researchers to use the newer version. The book provides information about the way in which the IWS was developed, as well as the statistical description of the structure of the scale. Included in this volume are results from over 80 studies which have used the IWS, as well as several investigators writing about their experience with this tool. The IWS questionnaire itself has been slightly modified in the new edition of this book. The book may be ordered by you or your school's library from Health Administration Press (US$44.) by mail, telephone or fax:

The Foundation of the American College of Healthcare Executives
1951 Cornell Center
Melrose Park, IL 60160-1001
Phone: (708) 450-9952
Fax: (708) 450-1618

The IWS questionnaire is a copyrighted measurement tool, with the copyright held by myself and Market Street Research, Inc., a full-service marketing research and evaluation firm located in Northampton, Massachusetts. If you wish to use the IWS questionnaire, a fee of $12.50 payable to Market Street Research covers permission to use the

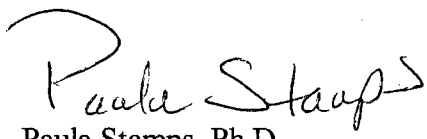
questionnaire, a print-ready hard copy formatted for use in your study, and an IBM-compatible floppy diskette which you can use in the event you wish to add questions of interest to your particular area of research. Other services available from Market Street Research include:

- A step-by step instruction manual so you can score the IWS yourself
- Data entry services and scoring assistance
- Reports comparing local results to national averages for the IWS
- Technical assistance in modifying or expanding the questionnaire

I have enclosed a complete description of these services as well as a price list. If you do decide to collect data, you will need the scoring manual unless you would like for Market Street Research to do the scoring for you. If you have any questions about any of these services, please feel free to call either myself or Market Street Research.

I would very much appreciate hearing about your results, as I am keeping a file of the types of research for which people are using the IWS. I would also appreciate any comments you might have on the scoring procedures manual. Good luck with your research.

Sincerely,



Paula Stamps, Ph.D.
University of Massachusetts
Phone: (413) 545-6880
Fax: (413) 545-6536
Email: pstamps@sover.net

Market Street Research, Inc.

395 Pleasant Street
Northampton, MA 01060
(413) 584-0465

Invoice

DATE	INVOICE NO.
6/19/2000	1804

BILL TO
Richard McElhaney 1051 East Chalet Mobile, AL 36608

TERMS	DUE DATE
On receipt	6/19/2000

DESCRIPTION	AMOUNT
IWS Questionnaire on disk and paper	12.50
IWS Scoring Manual	26.00
FedEx delivery	25.00

Pd. in full
6/19/00
#5211 DM

This invoice is permission to use the Index of Work Satisfaction Questionnaire.

Total $63.50

APPENDIX K

NURSE MANAGERS COVER LETTER

June 14, 2002

Dear Nurse Manager:

I am enrolled a student at the Louisiana State University Health Sciences Center School of Nursing Doctor of Nursing Science graduate program who would like you to participate in my research study to complete the requirements for my dissertation. The purpose of this study is twofold: (1) to describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of nursing staff. The six components of job satisfaction include pay, professional status, task requirement, interaction, autonomy, and organizational policies.

This study has been approved by the Institutional Review Boards at the Louisiana State University Health Sciences Center and the University of South Alabama. I have also received permission to use USA Medical Center by the Chief Operations Officer. You were selected because of your position as a nurse manager.

Your participation in this study is completely voluntary. If you volunteer to participate, your identity will remain antonymous and you will be free to withdraw from the study at anytime. Employment status will not be affected whether or not you agree to take part in this study

The enclosed questionnaires and consent form will take you approximately 45 minutes to complete. If you agree to participate in the program please sign the consent form and place it in the envelope marked "Consent Forms Only". I would like you to fill out the demographics questionnaire, LBAII-Self questionnaire, and the IWS questionnaire and place them in the envelop marked " Completed Questionnaires Only". The sealed envelops will be place in the appropriate sealed slotted boxes placed on each unit. I do hope you chose to participate. Participating in nursing research will allow you to contribute to the knowledge base of the nursing profession.

Sincerely,

Richard McElhaney, RN, MSN
Graduate Student
LSU Health Science Center
School of Nursing
New Orleans, La 70112

APPENDIX L

RN STAFF COVER LETTER

June 14, 2002

Dear RN:

I am a doctoral student at Louisiana State University Health Sciences Center School of Nursing graduate program who would like for you to participate in my research study to complete the requirements for my dissertation The purpose of this study is twofold: (1) to describe, compare, and explore the nurse managers' perceptions of their leadership style versus RN staff members' perceptions of their nurse managers' leadership styles, and (2) to ascertain if leadership style effectiveness and leadership flexibility of nurse managers are predictive of job satisfaction of nursing staff. The six components of job satisfaction include pay, professional status, task requirement, interaction, autonomy, and organizational policies.

This study has been approved by the Institutional Review Boards at the Louisiana State Health Science Center and the University of South Alabama. I have also received permission to use USA Medical Center by the Chief Operations Officer. You were selected because of your position as an RN.

Your participation in this study is completely voluntary. If you volunteer to participate, your identity will remain antonymous and you will be free to withdraw from the study at anytime. Employment status will not be affected whether or not you agree to take part in this study

The enclosed questionnaires and consent form will take you approximately 45 minutes to complete. If you agree to participate in the program please sign the consent form and place it in the envelope marked "Consent Forms Only". I would like you to fill out the demographics questionnaire, LBAII-Other questionnaire, and the IWS questionnaire and place them in the envelop marked " Completed Questionnaires Only". Place the sealed envelops place in the appropriate sealed slotted boxes placed on each unit. I do hope you chose to participate. Participating in nursing research will allow you to contribute to the knowledge base of the nursing profession.

Sincerely,

Richard McElhaney, RN, MSN
Graduate Student
LSU Health Science Center
School of Nursing
New Orleans, La 70112

APPENDIX M

Table of Normal Deviates Z

APPENDIX A: TABLE OF NORMAL DEVIATES Z*

Table A-1

Table of Normal Deviates Z Corresponding to Proportions p of a Dichotomized Unit Normal Distribution

p	0	1	2	3	4	5	6	7	8	9
.99	2.326	2.366	2.409	2.457	2.512	2.576	2.652	2.748	2.878	3.090
.98	2.054	2.075	2.097	2.120	2.144	2.170	2.197	2.226	2.257	2.290
.97	1.881	1.896	1.911	1.927	1.943	1.960	1.977	1.995	2.014	2.034
.96	1.751	1.762	1.774	1.787	1.799	1.812	1.825	1.838	1.852	1.866
.95	1.645	1.655	1.665	1.675	1.685	1.695	1.706	1.717	1.728	1.739
.94	1.555	1.563	1.572	1.580	1.589	1.598	1.607	1.616	1.626	1.635
.93	1.476	1.483	1.491	1.499	1.506	1.514	1.522	1.530	1.538	1.546
.92	1.405	1.412	1.419	1.426	1.433	1.440	1.447	1.454	1.461	1.468
.91	1.341	1.347	1.353	1.359	1.366	1.372	1.379	1.385	1.392	1.398
.90	1.282	1.287	1.293	1.299	1.305	1.311	1.317	1.323	1.329	1.335
.89	1.227	1.232	1.237	1.243	1.248	1.254	1.259	1.265	1.270	1.276
.88	1.175	1.180	1.185	1.190	1.195	1.200	1.206	1.211	1.216	1.221
.87	1.126	1.131	1.136	1.141	1.146	1.150	1.155	1.160	1.165	1.170
.86	1.080	1.085	1.089	1.094	1.098	1.103	1.108	1.112	1.117	1.122
.85	1.036	1.041	1.045	1.049	1.054	1.058	1.063	1.067	1.071	1.076
.84	.994	.999	1.003	1.007	1.011	1.015	1.019	1.024	1.028	1.032
.83	.954	.958	.962	.966	.970	.974	.978	.982	.986	.990
.82	.915	.919	.923	.927	.931	.935	.938	.942	.946	.950
.81	.878	.882	.885	.889	.893	.896	.900	.904	.908	.912
.80	.842	.845	.849	.852	.856	.860	.863	.867	.871	.874
.79	.806	.810	.813	.817	.820	.824	.827	.831	.834	.838
.78	.772	.776	.779	.782	.786	.789	.793	.796	.800	.803
.77	.739	.742	.745	.749	.752	.755	.759	.762	.765	.769
.76	.706	.710	.713	.716	.719	.722	.726	.729	.732	.736
.75	.674	.678	.681	.684	.687	.690	.693	.697	.700	.703
.74	.643	.646	.650	.653	.656	.659	.662	.665	.668	.671
.73	.613	.616	.619	.622	.625	.628	.631	.634	.637	.640
.72	.583	.586	.589	.592	.595	.598	.601	.604	.607	.610
.71	.553	.556	.559	.562	.565	.568	.571	.574	.577	.580
.70	.524	.527	.530	.533	.536	.539	.542	.545	.548	.550
.69	.496	.499	.502	.504	.507	.510	.513	.516	.519	.522
.68	.468	.470	.473	.476	.479	.482	.485	.487	.490	.493
.67	.440	.443	.445	.448	.451	.454	.457	.459	.462	.465
.66	.412	.415	.418	.421	.423	.426	.429	.432	.434	.437
.65	.385	.388	.391	.393	.396	.399	.402	.404	.407	.410
.64	.358	.361	.364	.366	.369	.372	.375	.377	.380	.383
.63	.332	.335	.337	.340	.342	.345	.348	.350	.353	.356
.62	.305	.308	.311	.313	.316	.319	.321	.324	.327	.329
.61	.279	.282	.285	.287	.290	.292	.295	.298	.300	.303
.60	.253	.256	.259	.261	.264	.266	.269	.272	.274	.277
.59	.228	.230	.233	.235	.238	.240	.243	.246	.248	.251
.58	.202	.204	.207	.210	.212	.215	.217	.220	.222	.225
.57	.176	.179	.181	.184	.187	.189	.192	.194	.197	.199
.56	.151	.154	.156	.159	.161	.164	.166	.169	.171	.174
.55	.126	.128	.131	.133	.136	.138	.141	.143	.146	.148
.54	.100	.103	.105	.108	.111	.113	.116	.118	.121	.123
.53	.075	.078	.080	.083	.085	.088	.090	.093	.095	.098
.52	.050	.053	.055	.058	.060	.063	.065	.068	.070	.073
.51	.025	.028	.030	.033	.035	.038	.040	.043	.045	.048
.50	.000	.003	.005	.008	.010	.013	.015	.018	.020	.023

* *This table is taken from Edwards, Allen L. Techniques of Attitude Scale Construction. New York: Appleton-Century-Crofts, 1957.*

Table of Normal Deviates Z Corresponding to Proportions p of a Dichotomized Unit Normal Distribution

p	0	1	2	3	4	5	6	7	8	9
.49	-.025	-.023	-.020	-.018	-.015	-.013	-.010	-.008	-.005	-.003
.48	-.050	-.048	-.045	-.043	-.040	-.038	-.035	-.033	-.030	-.028
.47	-.075	-.073	-.070	-.068	-.065	-.063	-.060	-.058	-.055	-.053
.46	-.100	-.098	-.095	-.093	-.090	-.088	-.085	-.083	-.080	-.078
.45	-.126	-.123	-.121	-.118	-.116	-.113	-.111	-.108	-.105	-.103
.44	-.151	-.148	-.146	-.143	-.141	-.138	-.136	-.133	-.131	-.128
.43	-.176	-.174	-.171	-.169	-.166	-.164	-.161	-.159	-.156	-.154
.42	-.202	-.199	-.197	-.194	-.192	-.189	-.187	-.184	-.181	-.179
.41	-.228	-.225	-.222	-.220	-.217	-.215	-.212	-.210	-.207	-.204
.40	-.253	-.251	-.248	-.246	-.243	-.240	-.238	-.235	-.233	-.230
.39	-.279	-.277	-.274	-.272	-.269	-.266	-.264	-.261	-.259	-.256
.38	-.305	-.303	-.300	-.298	-.295	-.292	-.290	-.287	-.285	-.282
.37	-.332	-.329	-.327	-.324	-.321	-.319	-.316	-.313	-.311	-.308
.36	-.358	-.356	-.353	-.350	-.348	-.345	-.342	-.340	-.337	-.335
.35	-.385	-.383	-.380	-.377	-.375	-.372	-.369	-.366	-.364	-.361
.34	-.412	-.410	-.407	-.404	-.402	-.399	-.396	-.393	-.391	-.388
.33	-.440	-.437	-.434	-.432	-.429	-.426	-.423	-.421	-.418	-.415
.32	-.468	-.465	-.462	-.459	-.457	-.454	-.451	-.448	-.445	-.443
.31	-.496	-.493	-.490	-.487	-.485	-.482	-.479	-.476	-.473	-.470
.30	-.524	-.522	-.519	-.516	-.513	-.510	-.507	-.504	-.502	-.499
.29	-.553	-.550	-.548	-.545	-.542	-.539	-.536	-.533	-.530	-.527
.28	-.583	-.580	-.577	-.574	-.571	-.568	-.565	-.562	-.559	-.556
.27	-.613	-.610	-.607	-.604	-.601	-.598	-.595	-.592	-.589	-.586
.26	-.643	-.640	-.637	-.634	-.631	-.628	-.625	-.622	-.619	-.616
.25	-.674	-.671	-.668	-.665	-.662	-.659	-.656	-.653	-.650	-.646
.24	-.706	-.703	-.700	-.697	-.693	-.690	-.687	-.684	-.681	-.678
.23	-.739	-.736	-.732	-.729	-.726	-.722	-.719	-.716	-.713	-.710
.22	-.772	-.769	-.765	-.762	-.759	-.755	-.752	-.749	-.745	-.742
.21	-.806	-.803	-.800	-.796	-.793	-.789	-.786	-.782	-.779	-.776
.20	-.842	-.838	-.834	-.831	-.827	-.824	-.820	-.817	-.813	-.810
.19	-.878	-.874	-.871	-.867	-.863	-.860	-.856	-.852	-.849	-.845
.18	-.915	-.912	-.908	-.904	-.900	-.896	-.893	-.889	-.885	-.882
.17	-.954	-.950	-.946	-.942	-.938	-.935	-.931	-.927	-.923	-.919
.16	-.994	-.990	-.986	-.982	-.978	-.974	-.970	-.966	-.962	-.958
.15	-1.036	-1.032	-1.028	-1.024	-1.019	-1.015	-1.011	-1.007	-1.003	-.999
.14	-1.080	-1.076	-1.071	-1.067	-1.063	-1.058	-1.054	-1.049	-1.045	-1.041
.13	-1.126	-1.122	-1.117	-1.112	-1.108	-1.103	-1.098	-1.094	-1.089	-1.085
.12	-1.175	-1.170	-1.165	-1.160	-1.155	-1.150	-1.146	-1.141	-1.136	-1.131
.11	-1.227	-1.221	-1.216	-1.211	-1.206	-1.200	-1.195	-1.190	-1.185	-1.180
.10	-1.282	-1.276	-1.270	-1.265	-1.259	-1.254	-1.248	-1.243	-1.237	-1.232
.09	-1.341	-1.335	-1.329	-1.323	-1.317	-1.311	-1.305	-1.299	-1.293	-1.287
.08	-1.405	-1.398	-1.392	-1.385	-1.379	-1.372	-1.366	-1.359	-1.353	-1.347
.07	-1.476	-1.468	-1.461	-1.454	-1.447	-1.440	-1.433	-1.426	-1.419	-1.412
.06	-1.555	-1.546	-1.538	-1.530	-1.522	-1.514	-1.506	-1.499	-1.491	-1.483
.05	-1.645	-1.635	-1.626	-1.616	-1.607	-1.598	-1.589	-1.580	-1.572	-1.563
.04	-1.751	-1.739	-1.728	-1.717	-1.706	-1.695	-1.685	-1.675	-1.665	-1.655
.03	-1.881	-1.866	-1.852	-1.838	-1.825	-1.812	-1.799	-1.787	-1.774	-1.762
.02	-2.054	-2.034	-2.014	-1.995	-1.977	-1.960	-1.943	-1.927	-1.911	-1.896
.01	-2.326	-2.290	-2.257	-2.226	-2.197	-2.170	-2.144	-2.120	-2.097	-2.075
.00		-3.090	-2.878	-2.748	-2.652	-2.576	-2.512	-2.457	-2.409	-2.366

* *This table is taken from Edwards, Allen L. Techniques of Attitude Scale Construction. New York: Appleton-Century-Crofts, 1957.*

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PROFESSIONAL EXPERIENCE

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Quality Management Special Projects Coordinator

University of South Alabama Knollwood Park Hospital, Mobile, Alabama, 1991-1994
Performance Improvement/Special Projects Coordinator for Nursing

University of South Alabama Knollwood Park Hospital, Mobile, Alabama, 1989-1991
Unit Manager 40 bed Medical/Surgical Unit

Doctors Hospital, Mobile, Alabama, 1988-1989
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Nursing Management, 27(3), 49-50.

Expert Witness/Legal Consultant, 1998
Clinical Nurse Specialist, 12(3), 1-4.