THE EFFECT OF LEADERSHIP STYLE OF NURSING HOME ADMINISTRATORS ON QUALITY OF CARE: AN EXPLORATORY STUDY IN MINNESOTA

by

Dawn J. Chiabotti

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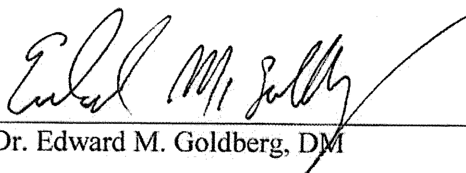

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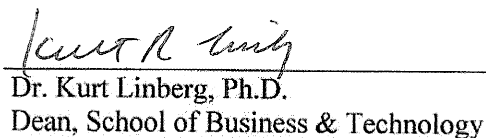

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Abstract

With recent changes in long-term care, there comes added responsibility to successfully lead others to success. Changes in reimbursement and payment based on quality are pending in the near future. It will be more important than ever to present increased quality of care and fewer deficiencies to capture the rewards. The author investigates the leadership styles of long-term care Administrators in the State of Minnesota and demonstrates that quality of care can be affected by the leadership style, style adaptability and leadership range. This study provides some evidence that facilities with better leaders tend to have fewer total deficiencies. However, this translation makes the assumption that the DON Leadership Score accurately captures the quality of leadership.

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Dedication

The author would like to dedicate this dissertation to my family who without them, none of this would be possible, to my husband and children for their patience and understanding and to my dad, who taught me to pursue my dreams and to finish what I started.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction to the Problem

The ability to identify one's own leadership style and knowing when it is effective is important to the success of the leader. Furthermore, being able to identify whether the leadership style has a positive or negative effect on an organization is essential.

Leadership has been defined as a group process, a personality perspective, an act, and a behavior (Northouse, 2004). It has, as well, been characterized as a relationship between leaders and followers (Bennis & Spreitzer, 2001). Burns (1979) noted that leadership is an aspect of power that is "relational, collective, and purposeful" (p. 18). While leaders need to communicate a clear and simple vision, strong values, and organizational beliefs (Wheatley, 1994), they must also be able to evaluate circumstances and make decisions based on the situation (Wills, 1994).

Leadership within an organization presents unending challenges: leadership style can be the result of either positive or negative reactions within the organization. In turn, the results of the leader's actions can result in success or failure for the entire organization "It's accepted business doctrine that corporate success begins with effective leadership" (Schettler, 2003 p.1). Kouze and Posner (1995) indicate that successful leaders are visionary and coaching, able to communicate their expectations in a clear and concise manner, to convey a vision of the future, and to adapt to the changing needs of the organization.

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An area that is changing frequently and demanding more from its leaders is the field of healthcare, including the area of long-term care. "Responsibilities of nursing home administrators have evolved over the past 30 years as a wide array of regulatory and market demands transformed the day-to-day management of nursing homes" (Angelelli, Gifford, Shah and Mor, 2001). In turn, the role of the administrator has changed significantly with new requirements for quality of care, resident assessment, care planning, and the use of medication and physical restraints.

Healthcare has shifted with the need to reduce costs, but quality in healthcare is still listed as a third priority after the primary foci became the marketing of healthcare and access to it (Finkel & Lubin, 1997). There is a new challenge to reengineer the business of healthcare to determine if the product that is being sold can be evaluated on the basis of quality rather than on price. In this instance, *quality* implies that the appropriate services are being provided and can be measured by means of patient satisfaction feedback. Other methods of identifying quality of care involve the Department of Health survey, which is based on the assumption that the fewer number of deficiencies a facility experiences, the higher the quality of care that is achieved.

There are several strategies currently used to measure quality. The objective, of course, should be to assess the most effective care for patients. It can be reached by measuring an impressive list of entities: e.g., consumer, provider, and employer satisfaction; efficiency; clinical outcomes; cost and access to care. Ideally this information will lead to improved health and well being for the client. However, Kinard & Kinard (2004) note that nursing shortages, declining enrollment and limited instructors

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will inevitably add to the complications faced by the aging population and those who care for them.

One area of concern is leadership in long-term care facilities (Angelelli, Gifford, Shah and Mor, 2001). Hasemann (2004) notes that the long-term care facilities that offer quality care have a “dynamic and effective leader” (p. 2). Unfortunately, turnover rates for nursing home administrators are as high as 40 percent in some states. There is a need for stability in both nursing home administration and the available quality of care as regulatory agencies make increased use of outcome measures to demonstrate that quality to consumers, government agencies, and other purchasers of long-term care services.

Background of the Study

Improving the quality of care of residents of long-term care facilities has become a public topic. State and federal guidelines are becoming stricter, monetary fines are being imposed, and aging populations are demanding improved care for themselves and for their family members. At the same time, there is a growing interest in determining if the leadership style of a nursing home administrator has an influence on the quality of patient care. The success of an organization may directly relate to outcomes of the survey process, perceived quality of care, or may be indirectly related to retention of staff and employee satisfaction rates. A study performed by Hasemann (2004) noted that there is a need for further research into administrative leadership styles and the quality of care that is exhibited by any long-term care facility. In that study, the delegating and telling

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leadership styles based on the LEAD inventory of Situational Leadership there appeared to be a positive influence based on survey outcomes.

"Excellence in long-term care delivery requires administrators who are capable of being leaders, in their organizations and in the community (Pratte, 1995). "Nursing homes and their staffs are undergoing unprecedented turbulence and, more than ever, they need administrators who can provide direction, vision, and motivation to ensure their survival during this time of change" (p. 1). An area of concern in the post-OBRA environment is the relationship between staff turnover and quality of care. A structure that emphasizes the nursing home quality outcomes suggests that stability in management and staff of nursing home could be an important factor in ensuring high quality nursing home care. "Management research has consistently shown strong and consistent leadership to be an important factor in determining the success or failure of firms" (Pratte, 1995, p. 53).

Statement of the problem

The problem lies in the identification of the effectiveness of leadership styles and the manner in which – and extent to which – they influence the outcomes or quality of care being provided within a long-term care facility. The role of nursing home administrator changes frequently. Given the current changes in regulation and requirements to improve the quality of care, it is vital that the leader be flexible and able to meet the needs of clients, employees and family members. It is important, too, that a

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leader to be able to identify his/her own leadership style and be able to identify instances when the style results in negative or positive outcomes.

Quality and customer satisfaction will continue to be critical issues (Kleinsorge and Koening, 1991). Customers have discovered an ability to demand quality in products and in services provided, and this demand has expanded in all areas of business. Healthcare is not an exception. In long-term care the demand for quality comes from both the customer and the regulators. Ebersole (1994) noted, “The successful operation of any nursing home depends heavily on the skills, qualifications and education of the person responsible for directing its operations” (p. 1).

Purpose of the Study

The purpose of this research is to determine the extent of the relationship between the leadership characteristics of nursing home administrators in Minnesota and quality of care. The researcher will distribute and draw conclusions based on data results from Paul Hersey and Kenneth Blanchard’s (1997) Situational Leadership Model of the LEAD-Self, LEAD- Others tools. It is important to discover if relationships exist between nursing home administrators leadership styles and quality of care issues. Improved quality of care in long-term care facilities would not only benefit the customer, but would also reduce costs spent by facilities in penalties for noncompliance of state and federal regulations.

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Rationale

The rationale for doing this research is to determine if there is a relationship between the leadership styles of a nursing home administrator and the quality of care that is provided in the long-term care facilities of Minnesota. If there is a relationship, this can have an impact on the quality of care that is provided in our future: there should then be further research and education into how and why these leadership styles can have a positive rather than a negative influence on the care that is provided. The number of elderly is increasing daily as the Baby Boomer population ages and our aging citizens live longer. There is an increased need for quality services in health care and if one is able to identify leadership styles that have positive outcomes, then this information may be used in future hiring practices, education, and possibly in standards set by the state as a minimum requirement for licensure.

Research Questions/ Hypotheses

1. Is there a relationship between the leadership style of nursing home administrators and the quality of care in nursing facilities? For example, if the administrator exhibits a leadership style of high performance and low task, does that facility have fewer deficiencies than one that has an administrator who exhibits a low relationship and low task style of leadership? (*Quality* being defined as fewer deficiencies issued to the facility by the Minnesota Department of Health during an annual or recertification survey.)

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2. Can leadership styles of nursing home administrators influence quality of care in nursing facilities? Can a more flexible leadership style have a more positive effect on the outcomes of quality within the nursing facility?
3. Nursing home administrators who encompass flexibility in style and effectiveness on the LEAD-Self and LEAD-Other tools will have a higher level of quality in their facilities than those who report a very narrow leadership style range and effectiveness rating (Center for Leadership Studies, 2002).

Significance of the Study

The quality of patient care suffers because health care administrators lack self-awareness of their own leadership style. The ability to match the proper leadership style to the situation can influence the quality of care that is delivered to the resident. This study is important in that it identifies the leadership style of long-term care administrators in Minnesota and indicates which leadership style is most effective in a long-term care setting in relation to the quality of care provided to the resident. Leadership style is one factor that can have an effect on the quality of care provided, costs of turnover, employee satisfaction and employee retention; there can be savings noted related to the costs of dissatisfied residents and employees.

This study will use the LEAD-self tool for identifying leadership characteristics in nursing home administrators in Minnesota and determining what leadership styles are predominately exhibited by long-term care administrators (Center for Leadership Studies,

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2002). Using this information, the study will then compare the leadership style to the Minnesota Department of Health Survey results for each location and assess the outcome for relationships indicating that a more positive leadership style exhibits fewer deficiencies or higher quality of care. (This is, of course, based on the assumption that fewer deficiencies indicate better quality.)

Definition of Terms

Deficiency – Failure to meet a federal rule is called a deficiency. The Department of Health gives the home a period of time to develop a plan to correct deficiencies and approves the home's time frame for making corrections. The more serious deficiencies must be corrected quickly. Federal rules set up penalties that will be imposed on a facility for failure to correct the deficiencies within the approved time frame. The type of penalty that would be imposed depends on both the severity and scope of the deficiencies. The severity of deficiencies is determined by evaluating whether the deficiencies caused actual harm or had the potential for causing more than minimal harm to residents. The scope of the deficiencies is based on the number of residents impacted by the deficiencies. Examples of remedies include placement of a state monitor, directed in-service training, denial of payment for new admissions or civil money penalties. Failure to correct violations or deficiencies can lead a home to financial penalties (fines), other legal actions by the state, and can ultimately lead to closure (AHCA, 2005).

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Director of Nursing – Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility (AHCA, 2005).

Facility- A skilled nursing facility or a nursing facility which meets the requirements of sections 1819 or 1919 (a), (b), (c), and (d) of the Act. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution (AHCA, 2005).

LEAD-Other- A leadership inventory tool that documents the leadership style of a person as determined by a colleague (Hersey, Blanchard, & Johnson, 2001).

LEAD-Self- A leadership inventory tool that determines the leadership style of the person who completes it (Hersey, Blanchard, & Johnson, 2001).

Long-Term Care – A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care (AHCA, 2005).

Medicaid – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if the applicant qualifies for both Medicare and Medicaid (AHCA, 2005).

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Medicare-The federal health insurance program for the following applicants: people 65 years of age or older; certain younger people with disabilities; and people with End-Stage Renal Disease (AHCA, 2005).

Nursing Home Administrator- Statute 144A.04 Each nursing home must employ an administrator who must be licensed or permitted as a nursing home administrator by the Board of Examiners for Nursing Home Administrators. The nursing home may share the services of a licensed administrator. The administrator must maintain a sufficient on-site presence in the facility to effectively manage the facility in compliance with applicable rules and regulations. The administrator must establish procedures and delegate authority for on-site operations in the administrator's absence, but is ultimately responsible for the management of the facility. Each nursing home must have posted at all times the name of the administrator and the name of the person in charge on the premises in the absence of the licensed administrator (AHCA, 2005).

Plan of Correction – the form according to which a facility is responsible to document the procedure and time frame for correction violations of certification regulations cited by the state survey agency (AHCA, 2005).

Quality – the extent to which the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results (AHCA, 2005).

Restraints – any manual method or physical or mechanic device, material or equipment attached to or adjacent to the resident's body that the individual can not

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remove easily which restricts freedom from movement or normal access to ones body (AHCA, 2005).

Survey – The method used by states and the federal government to decide whether a home has permission to operate. A survey is performed to see whether a home "measures up" to state and federal standards. Every nursing and boarding care home in Minnesota must have a state license to operate. Any home that gets payment through the Medicare or Medical Assistance program must obey federal certification rules as well. These rules are basic standards for the patient's care and comfort. Surveys help assure that patients receive the kind of care they want and that money paid to homes was appropriately spent (AHCA, 2005).

Quality Measure – come from resident assessment data that nursing homes routinely collect on every resident at specified intervals during the resident's stay. These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to quality measures; these offer consumers another source of information that indicates how well nursing homes are caring for their residents' physical and clinical needs (AHCA, 2005).

Skilled Nursing Care – A level of care that includes services that can be performed safely and correctly by only a licensed nurse (AHCA, 2005).

Skilled Nursing Facility – These facilities offer a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing)

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cannot, in itself, qualify a prospective patient for Medicare coverage in a skilled nursing facility. However, if an individual does qualify for coverage based on his/her need for skilled nursing or rehabilitation, Medicare will cover all of that patient's care needs in the facility, including assistance with activities of daily living (AHCA, 2005).

Assumptions and Limitations

1. It is assumed that the level of care and quality provided within each facility will be consistent with the level demonstrated on the day or days that the survey team was evaluating the facility.
2. The sample size will be limited to the process and data collection.
3. Quality of care provided by the facility will be consistently good, as directed by the Minnesota Department of Health, no matter what the size of the facility or the number of beds within the facility. (Some persons assume that a smaller facility automatically means better quality of care.)
4. The geographic region is Minnesota. The area will be limited to this state and the long-term facility in which this researcher works will be excluded from the study. There are a possible 409 facilities within the state of Minnesota.

Leadership styles can make the difference in an organization and being an administrator in a long-term care facility can be challenging (Hasemann, 2004). Further research is needed to determine if the leadership style in long-term care facilities in Minnesota can make a difference in the quality of care. There is a question if the

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leadership style seen in New York long-term care facilities is consistent throughout the nation or local to that area of the country.

The LEAD- Self and LEAD – Other leadership tools (Hersey, Blanchard, & Johnson, 2001) will be distributed to long-term care administrators and to the directors of nursing services in the state of Minnesota. Data will be collected from each facility regarding the last Minnesota Department of Health survey and the results related to the numbers of deficiencies, the scope and severity of the deficiencies, and the deficiencies that relate to quality of care.

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CHAPTER 2. LITERATURE REVIEW

Rationale for the Research

Improving the quality of care to residents of long-term care facilities has become a very public topic. State and federal guidelines are becoming more strict, monetary fines are being imposed and aging populations are demanding improved care for themselves and for their family members. With this information, comes the desire to determine if the leadership style of a nursing home administrator has an influence on the quality of patient care. The success of an organization may directly relate to outcomes of the survey process, perceived quality of care, or may be indirectly related to retention of staff and employee satisfaction rates. A study performed by Hasemann (2004) noted that there is a need for further research in the area of administrator leadership styles and quality that is exhibited by the long-term care facility. In that study, the delegating and telling leadership styles based on the LEAD inventory of Situational Leadership there appeared to be a positive influence based on survey outcomes.

"Excellence in long-term care delivery requires administrators who are capable of being leaders, in their organizations and in the community (Pratte, 1995). "Nursing homes and their staffs are undergoing unprecedented turbulence and, more than ever, they need administrators who can provide direction, vision, and motivation to ensure their survival during this time of change" (p. 1). An area of concern in the post-OBRA environment is the relationship between staff turnover and quality of care.   A structure that emphasizes nursing home quality outcomes suggests that stability in management

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and staff of nursing home could be an important factor in ensuring high quality nursing home care. "Management research has consistently shown strong and consistent leadership to be an important factor in determining the success or failure of firms" (p. 53).

Leadership Research

Leadership has been studied for many years, and there are currently several thousand publications on leadership (Yukl, 1989). Vance (2002) noted,

> The phenomenon of leadership continues to predominate the literature of the professions, organizations and corporate life. Stogdill's major review of literature on personal factors associated with leadership was published in 1948, with an update in 1974, and further updates by Bass in 1981 and 1990. Bass & Stogdill's *Handbook of Leadership: Theory, Research and Managerial Applications* (1990) included over 7,000 leadership research citations. These reviews, spanning more than 50 years, show an evolving conceptualization of leaders, the leadership process and the effects of leadership. (p. 165)

Yukl (1989) notes that advances in leadership research are being made. This trend is marked by an increase in the scope of inquiry and variety of methodology being used by researchers, which, in turn, provides a continued opportunity for research and growth. There is also an opportunity to examine leadership from other perspectives such as the cognitive view of leadership, the ways in which leadership can affect emotions of the leader or followers, or the extent to which a leader's vision can affect the outcomes as well as the success of the leader. Humphreys (2002) sums up the changing situation succinctly: "Effective leadership is somewhat dependent upon the current context and environment. It's readily apparent that emerging technology has forever changed the

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management landscape and that many of the current leadership models are simply not adequate at this time in history" (p. 151).

Northouse (2004) adds, "A review of the scholarly studies on leadership shows that there is a wide variety of different theoretical approaches to explain the complexities of the leadership process" (p. 1). When reviewing styles of leadership, one can easily see that one author may refer to a style previously outlined by another, but call it by a different name. Leadership has also been described as diplomatic, charismatic, opportunistic, or artistic (Wills, 1994).

Schriesheim & Bird (1979) state, "The Ohio State studies comprise one of the most important and comprehensive research programs in the fields of management and organizational behavior" (p. 135). The Ohio State studies utilized an interdisciplinary approach to research that remained focused on leadership phenomena (p. 137) and helped to create a standard for the thorough examination of a phenomenon in two ways. Schriesheim and Bird note, "First, the Ohio State researchers performed multi-sample studies to provide evidence of generalizability of results" (p. 137), and "The second way in which the Ohio State studies contributed to advancing quality in leadership research was due to the publication strategy followed by members of its staff" (p. 137). In other words, the Ohio State studies produced a large amount of data to advance the research of leadership, and this information was published in comprehensive and technical reports. As a result, the Ohio State studies are an example of emphasis on quality and quantity of research completed. Schriesheim & Bird (1979) conclude by stating:

> Thus the model of conduct for research offered by the Ohio State studies provides current and future generations of researchers with an ideal that

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> may be difficult to realize: emphasis on quantity and quality, even at the cost of some personal prestige. (p. 137)

Other contributions made by the Ohio State studies relate to the methodology used by the researchers and the development of at least one research instrument (Schriesheim & Bird, 1979). Schriesheim and Bird note that these researchers began with careful attention to the way in which key variables were measured and provided a model for the process that has become known as "construct validation" (p. 141). In a study, Schriesheim, Castro, Zhou, & Yammarino, (2001), conclude:

> Leadership research has recently begun to emphasize the importance of examining the level of analysis at which phenomena are hypothesized to occur. Unfortunately, however, it is still not commonplace for theory to clearly specify, and for investigations to directly test, expected and rival level-of-analysis effects (p. 515), and: although some laboratory studies have been conducted, research testing the normative model has typically used retrospective accounts of decisions and their effectiveness, comparing the effects of leadership styles that were either consistent or inconsistent with the model's prescriptions. (p. 519)

Later research (Judge, Piccolo, & Llies, 2004) continued to question the validity of information presented by the Ohio State Leadership Studies. "Questions were raised about the generality of the validities and the nature of the measures themselves; many felt that these questions were never answered satisfactorily" (p. 2). Judge et al concludes, "These studies may be labeled as 'weak and inconsistent' but the information remains valuable as 'fundamental indicators of effective leadership' " (p. 9).

Lord (2000) took a different approach to the study of leadership as he reviewed leadership research over the past ten years, including the potential paths in leadership that relate to cognitive characteristics of charisma, organizational performance, and

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transformation. Lord notes that within this information there is “a need for further study of leadership related to individual cognitions and social /contextual factors and the relation of intervening and outcome processes” (p. 17). He also cites the fact that there has been an increase in leadership research related to “the development and use of collective cognitions, particularly in constructing a leader’s vision” (p. 18). Lord reviewed previous research, identified underlying themes, and validated the information and results of previous studies – but also identified a need for further research. Lord concludes, “Information processing studies are contributing to a deeper understanding of key processes, and they make us optimistic regarding future leadership research” (p. 18).

Waldman, Lituchy, Gopalakrishnan, Laframboise, Galperin, and Kaltsounakis, (1998) conducted a qualitative study to investigate the effects of leadership on quality improvement. Through the use of interviews, this research identified themes (e.g., categorical schemes), collected data in an open and unstructured manner, and developed theory based on this information. They proposed a model of alternative paths of both managerial leadership and commitment to a quality improvement process. Through the use of an inductive methodology, they felt they were able to link leadership, commitment, culture and outcomes while being able to respond to the “how” and “why” questions. Waldman et al state that, “A case study is an appropriate research method when the research question is exploratory in nature, is contemporary, and significant events or variables cannot be manipulated experimentally” (p. 5). Waldman et al also noted that the collection of interview data, observation, and examination of documents were especially useful with checking the validity of information. With this study, Waldman

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et al utilized a process similar to that used by other researchers (e.g., Fleisher and Nickel) to increase accuracy and reliability of the information collected. This included ”neutral probing of answers, promises of anonymity, and the preparation of informants prior to interviews” (p. 7). Waldman et al felt that by doing this they increased the accuracy and reliability of their own information.

There are tools already developed to study leadership in organizations (Schriesheim et al, 2001). One such study is the Leadership Opinion Questionnaire, or a revised model, the Leader Behavior Description Questionnaire (LBDQ). Bass & Stogdill (1990) comment that this is a questionnaire “consisting of 40 statements” (p. 512) that “measures two factors of consideration and initiation” (p. 512). Schriesheim et al (2001) note that this tool was designed to describe the behavior of a supervisor or manager. It does not ask if the behavior is desirable or undesirable and is not a test of the ability of a supervisor or manager.

There are advantages to using leadership models that have been validated and tested for reliability. In essence, the LBDQ has been tested for evidence regarding stability, and thus instability has been eliminated as a major concern in the use of this test. The revised LBDQ shows adequate evidence of validity. Nevertheless, additional research is needed to assure the validity and reliability of these tools. Moreover, the information obtained by these tools is dated, and there is a need for current research. It is well worth the effort: when results are reliable and updated, leadership tools, studies, and information can be used in a variety of ways to enhance the environment of organizations (Schriesheim et al, 2001).

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Northouse (2004) acknowledged the leadership styles that have been researched and evaluated by Dunham & Klafehn (1990), Nakata & Saylot (1994), Moss & Rowles (1997), and others, but how does that information make a difference in one's ability to know the potential of a leader? There have been tools developed and implemented to assist in the determination of personal characteristics of a leader. Such a tool would be the Minnesota Multiphasic Personality Inventory, the Myers-Briggs Type Indicator, or the Leadership Trait Questionnaire (p. 29). For example: The Leadership Trait Questionnaire is designed to evaluate the weaknesses and strengths of a leader as well as to gauge at what points the leader's perceptions agree with those of others and where there are discrepancies.

Schriesheim, Castro, and Cogliser, (1999) comment that leadership research has undergone a "metamorphosis since its infancy" (p. 1). A relationship-based research approach that was initially named "Vertical Dyad Linkage" (VDL) has evolved into what is most commonly referred to as Leader-Member Exchange (LMX) (p. 1). Although this research is a composition of past research, there have been only ten studies that have employed appropriate methodology for analysis of the LMX theory. There is a need for improved authorization for LMX and its basic process for improved measurement practices, as well as for enhanced and more appropriate data-analytic techniques (Schriesheim et al, 1999).

Schriesheim & Powers (1993) assert that there are not well-established quantitative methods for examining content adequacy. Consequently, there is need for a new approach for the quantitative assessment of content adequacy. Schriesheim et al

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noted that there were problems in the research that has been published in relation to the reporting of reliability issues. Even though reliability has been demonstrated for a particular tool, it should be demonstrated for every sample to which it is administered. Because a researcher assumes that a particular study is reliable based on past research, any discrepancy puts the entire study at risk for errors.

Hunt (2000) writes "leadership studies are unlikely to be of any additive value until they take into account organizational variables" (p. 1). He clarifies his statement by adding, "organizational variables need to be constant to explore for leadership effects" (p. 1). Hunt notes that leadership is a mature field and can be traced back to ancient Egypt and China and suggests that leadership needs to be examined with a historical-contextual approach to avoid or at least minimize the déjà vu effect. Leadership research does not have a focus on the future and an understanding of the past; the result is gaps in the research that could be further minimized. Researchers get involved so deeply in their own research that they will sometimes miss an important part of a broader perspective.

Bass and Stogdill (1990) have collected data and leadership research for a number of years. They point out that there can be problems with how valid the information from a leadership study may be. Most leadership performance is based on information that is a judgment made by others and may not be reliable for data collection. In other words, this information is subjective in its evaluation of the leader's performance and may not be reliable for data collection. The reliability and validity of forecasting the success of a leader can be increased through the use of standardization of judgmental requirements, the pooling of judgments, and the training of the judges. Bass and Stogdill also suggest

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that valid scores from psychometric tests, application blanks, and biographical-information blanks can be used with or without the use of other mathematical statistics such as a multiple regression to make predications of the success of a leader.

Common Themes and Concepts of Leadership Styles

Leadership styles have been identified in many ways. Terms used to describe leaders include the following: *charismatic, traditional, diplomatic, military, constitutional, artistic, saintly, formal, informal, and visionary* (Wills, 1994). Goleman, Boyatzis & McKee (2002) describe leadership as also having an "emotional connection" (p. 5). This means that the decisions leaders make are affected by emotions. Bass, (1990) states that there is a "plethora of taxonomies of leadership" (p. 33), but adds that there are common themes noted in all styles of leadership. Bass suggests that the leader may help to set and clarify the mission and goals of the individual member, the group or organization; the leader is able to energize and direct others toward the goals and missions of the organization; the leader provides structure, tactics, methods and instruments for achieving those goals and missions; and, lastly, helps to resolve conflicting views. Northouse (2004) writes that leadership is a process, involves influence of others, occurs within a group context, and involves goal attainment (p. 3).

While leadership styles may vary in characteristics, Bennis (2003) believes that all leaders tend to share some ingredients; i.e., a guiding vision and driving passion. Guiding vision is "a clear idea of what the leader wants to do– personally and professionally – and the strength to persist in the face of setbacks, even failures" (p. 31).

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Second is a passion – "the underlying passion for the promises of life combined with a very particular passion for a vocation, a profession, a course of action" (p. 32). Leaders love what they are doing. Third, leaders exhibit integrity. They know their own faults and assets, and are able to deal with them directly. Integrity is the basis of trust and is essential to any leadership style. And fourth are the ingredients of curiosity and daring. Leaders are curious and are willing to take risks, experiment and try new things. They embrace errors and mistakes, and learn from the experience.

It would be misleading to say that one type of leadership style is better than the next. Each style has advantages and disadvantages, and not all constructs of style work in every situation (Northouse, 2004). A leader who is flexible and able to manage challenging environments should assess each situation and adopt an appropriate leadership style.

Leaders need to be able to identify their own leadership style and put it to use in a productive manner that reflects the goals and visions of the organization and the employees (Northouse, 2004). The styles are unique and each offers advantages and disadvantages. The leader in an appropriate setting can use each style effectively, and each leadership style can have a substantial effect on the outcomes of an organization. It is up to the individual leader to identify his/her own strengths, abilities and weaknesses and to be able to make a decision as to what leadership style is best suited to the needs of the individual and the organization.

Traditional leadership styles are no longer effective in a fast paced global society in which the demands and challenges for leaders are more evident than in the past (Burns,

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1979). Burns adds, “One of the most universal cravings of our time is a hunger for compelling and creative leadership” (p. 1). Leadership styles and the emotions and moods that are generated by the leader can have tremendous effects on the staff and the organization itself. Leadership styles that spread negativity can ultimately be the cause of a decrease in revenues. They can spread fear, anger, and dissatisfaction among employees. Leadership styles that are visionary can motivate others by guiding, inspiring, listening, and persuading others to perform at or above expected standard. Effective leadership styles are seen in leaders who are able to share a vision, enable others to act, model performance, and encourage others to act in a way that promotes leadership in the organization. Schettler (2003) states, “It’s accepted business doctrine that corporate success begins with effective leadership” (p. 1).

Leadership Versus Followership

Conchie (2004) writes, “Leadership is about a relationship between people – leaders and followers – that is built on firm ground; enduring values that build trust” (p. 1). Conchie implied that leadership and followership are a joint effort needed by both the leader and the follower. Bennis & Spreitzer (2001) define leadership as “a relationship. Sometimes the relationship is one-to-many. Sometimes it’s one-to-one. But regardless of whether the number is one or one thousand, leadership is a relationship between those who aspire to lead and those who choose to follow” (p. 84). Northouse (2004) states, “Because leaders and followers are both a part of the leadership process, it is important to address issues that confront followers as well as those that confront leaders. Leaders and followers need to be understood in relation to each other” (p. 11). Bennis & Spreitzer

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(2001) agree. "Young and old alike agree that success in leadership, success in business, and success in life has been, is now, and will be a function of how well we work and play together" (p. 84).

Kelley (1991) describes followers as "the people who know what to do without being told, the people who act with intelligence, independence, courage, and a strong sense of ethics" (p. 12). Kelley (1991) adds, "Followers determine not only if someone will be accepted as a leader, but also if that leader will be effective. Effective followers are critical for a leader's or an organization's success" (p. 13).

Bennis and Thomas (2002) write, "There are three essentials to leadership: a leader, followers, and a common goal (p. 137), and leadership is a partnership. This information reiterates the role of leadership and followership as a cooperation of being able to work together." (Bennis & Thomas, 2002).

Leadership and followership relationships indicate that there are characteristics that are common to each role (Northouse, 2004). For example, a characteristic that is seen in a servant leadership style is noted by Howatson-Jones (2004): "Servant leadership focuses on the followers and the needs of the follower with an ability to collaborate with them to achieve organizational goals" (p. 2). Bass & Stogdill (1990) noted that follower's expectations of what can be accomplished could be increased "if the leader obtains or shows them how to obtain the resources that will enable them to reach their higher goals" (p. 213). A leader can do this by being able to envision the future and by communicating this clearly to the follower. Bennis & Thomas (2002) noted, "Effective leaders don't just impose their vision on others, they recruit others to a shared vision"

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(p.137), and "One way that leaders create shared meaning; Leaders must trust and empower followers" (p. 138).

Bennis & Spreitzer (2001) supported the notion of trust and stated: "At the heart of the relationship is trust. Without trust you cannot lead. Exemplary leaders are devoted to building relationships based on mutual respect and caring" (p. 85). Bennis & Spreitzer also noted, "Long before 'empowerment' was written into the popular vocabulary, leaders understood that only when their constituents feel strong, capable and efficacious, and when they feel connected with one another, could they ever hope to get extraordinary things done" (p. 85).

Maccoby, Gittell, & Ledeen (2004), commented on followership. "People follow leaders for different reasons, some conscious and some unconscious. Emotions like love and fear, trust and mistrust, can play a significant role in whether a leader gains followers" (p. 2). Maccoby et al went on to say, "Love is fickle, and followers are likely to turn on their leader at the first sign that things are going badly. Fear is much more reliable because it is 'maintained by dread of punishment, which never fails'" (p. 4). Leaders that exhibit Machiavellian behaviors such as strong, ruthless, and cynical leadership styles are self-interested and self-serving (Bass & Stogdill, 1990). These leaders exploit their external resources to make others do what they want done (Burns, 1979). Burns states, "More than mere selfishness; at the core of Machiavellianism lay the most pernicious and inhuman concept of all: the treatment of other persons, other leaders, as things" (p. 446).

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Antonioni (2003) takes a different perspective:

> Leaders need to develop the potential of leading with responsibility among their followers. Followers, who are able and willing to lead upward, enhance their leaders' growth to be responsible. A great leader seeks service to others above self and is willing to be accountable for his or her choices. (p. 9)

This perspective represents a more cooperative nature and is not based on fear or mistrust as is sometimes noted in the literature (Maccoby et al, 2004). In the discussion of leadership, Vecchio (1997) notes that some styles of followership incorporate two dimensions:

- "Compliance-defiance is a behavioral dimension, and reflects the extent to which a follower conforms to the directives of a superior, versus undermines or counters the supervisor's desires" (p. 118).
- "Loyalty-hostility is an attitudinal dimension which represents the degree to which a subordinate is support of, versus antagonistic toward, a supervisor and his or her goals" (p. 118).

By crossing the two dimensions, a set of quadrants is created, each of which has a unique meaning. Quadrant II refers to an individual who is maliciously obedient and any of these quadrants in the extreme is an indication of mental illness or extreme distress (Vecchio, 1997).

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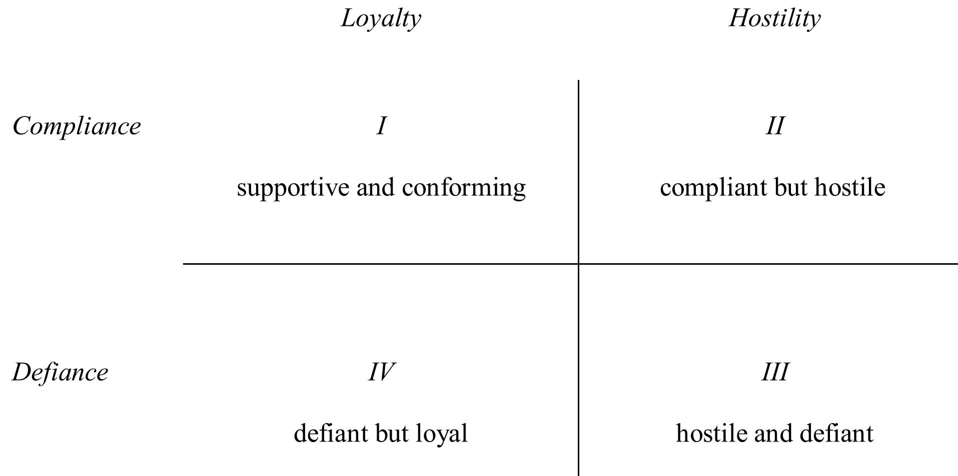

Figure 1. Followership styles. *Note*: Adapted from *Leadership: Understanding the Dynamics of Power and Influence in Organizations* by R. P. Vecchio (editor), 2002, p. 118.

Ramsey (2003) writes, "Leadership, in a time not so long ago, was about managers who were expected to control their environments" (p. 1). This definition of leadership is less about service and more about power. Managers hoarded information because sharing information was equated with sharing power with employees, an unacceptable behavior. Ramsey comments:

> Workers today want and expect respect, autonomy and a piece of the action. They want to be listened to, to be kept in the loop, to be informed about what's going on in the organization and what's coming down the road, to have opportunities for growth and to share in decision-making, as well as in the profits (p. 2).

And Daniel (2003) adds, "A leader's style can literally train his or her followers not to think. While this isn't the intention of any rationale business leader, it is an unintended consequence for many" (p. 1).

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The concept of leadership has changed over the past years. Chaleff (2003) comments, "Leadership requires looking outward and forward" (p. 30), and Vecchio (1997) adds, "The activities of leadership and followership are inextricably related" (p. 114). An argument can be made that when we commonly speak of effective leadership, we are really speaking of effective followership.

> As evidence of this, consider that we typically measure a manager's effectiveness by examining the performance of his or her unit. The performance of a unit, however, is often more a function of the talents and desires of the followers than the leader. (p. 115)

Vecchio (1997) noted, "Managers have a responsibility for developing and maintaining the followership of their subordinates" (p. 119), and to "involve subordinates in the decision making process. It increases the individual's sense of 'ownership' for a goal" (p. 121), and "As a manager, loyalty by the employee is fostered by understanding the value system of the employee" (p. 121). "If a manager understands the values of an employee, he or she can highlight these themes in the administration of duties" (p. 122). Vecchio continues, "Paying attention to the needs of the follower can enhance the relationships between leader and follower" (p. 122). Weiss (2004) maintains:

> The person with a plan that benefits the group will quickly have followers. Leaders come up with ideas for almost every situation. Followers commit themselves to leaders if they have confidence in their plans and/or their abilities. Usually this is based on experience with their previous ideas. Leaders make sure they know what their followers want and think. (p. 2)

Kelley (1991) points out that each leader must learn when and how to be a follower or a leader, and that positions remain static within an organization, but the performance goals and demands are constantly changing. As a result, there is a constant challenge of knowing when to lead and when to follow. There are also times when a leader needs to

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take an active role in following: first is when a leader is able to identify that the follower has more experience, skill, or judgment that enables the follower to be the best choice for leading; second, when team performance, goals, and agreed working approach requires the leader to take a followership role; and third when the organization performance requires that the leader take a follower role such as being able to follow a shared vision that requires this of a leader.

Kelley (1991) identified common themes, concepts and similarities among leadership and followership relationships. The follower is also noted to have a significant place in history. Followers gained prestige rather than losing it by their places in society. Kelley continues, "Followership and leadership are a dialectic. Just as the word *right* makes no sense without *left*, they depend upon each other for existence and meaning. They can never be independent" (p. 45). Ramsey (2003) expands this concept:

> You need to get with the program in order to succeed as a supervisor today. You may not have to wash the feet of your followers; but you will need to support them, nurture them, protect them and lead them more by influence than by edict (p. 2) and it all starts with attitude. As a manager or supervisor, you are only as good as the people who work for you and they are only as good as you allow and equip them to be. You have to give employees permission to succeed and help them achieve it. Good supervisors believe this. And it shows in their attitude. (p. 2)

Kelley (1991) suggests that followers make life decisions much as leaders do. "As a follower, you have choices to remain unhappy, leave before getting fired, or move to another style" (p. 105). Kelley noted, "Exemplary leaders are simply able to carry out their jobs and to work with others in a way that adds considerable value to the enterprise" (p. 129), and "The first hurdle facing followers is to demonstrate their value. Leaders and co-workers alike want to know what you can bring that will help the organization

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achieve its goals. Followers are expected to prove themselves" (p. 130). "These followers see clearly how their jobs relate to the larger enterprise, they do research to understand the goals and visions of the organization and how they affect the role of the follower" (p. 135). "Followers will also track the progress they make and the difference they can make to an organization and make a point of doing a superb job on the daily tasks before adding duties or tasks" (p. 144). "Once they are comfortable with the tasks at hand they are ready to tackle other duties, develop additional expertise, and champion new ideas" (p. 145). "Less effective followers would expect the training and expertise to come to them" (p. 146).

Kelley (1991) adds "The best followers know how to get along with their co-workers and leaders in ways that benefit the organization" (p. 149). These are not the followers that are in the organization for "selfish" reasons, but understand that the actions they take are to the benefit of the whole (p. 149). Seterhoff (2003) comments that leaders "will willingly subordinate themselves to a follower status and give way to the individual who is most knowledgeable or better fit to lead an effort (p. 9).

Kelley (1991) notes that the environment of the workplace is changing, a fact that results in leaders' having more and more numbers of employees to supervise. This leads to less direct supervision or input from the leader. As a result, the followers will need to depend more on themselves and the teams in which they participate. Bennis (2004) comments that the success or failure of a leader/follower relationship could predate one's arrival. Bennis adds that followers also make decisions based on their past, and a leader should not take the follower's assessments too personally. It was noted that relationships

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that resulted in alienation were frequently the result of unmet expectations and broken trust (Kelley, 1991). Since most followers start as exemplary followers and specific events occur to cause changes, it is necessary to repair, correct, or make changes that remedy the situation. If trust is broken, it needs to be repaired; if expectations were unmet, changes need to happen to address this situation; and if goals are not met, they may need to be realigned. Kelley writes:

> Leaders who exploit followers for their own personal gain can expect hostility directed back at them. Or a leader may simple mismanage a worker so badly that alienation results. Alienation also occurs when leaders or organizations switch goals on their followers, replacing mutually shared ones with goals that followers don't believe in. (p. 104)

Kelley continues: "Contrary to belief, followers are not passive and take an active role in an organization. They have courage to be honest with themselves and together can make dreams become a reality" (p. 27). Followers work with others when appropriate rather than compete with others and will stand up for what is right rather than make a decision that gets them promoted. Kelley (1991) noted:

> If the United States is faltering now, it is because of a failure of followership more than a failure of leadership. The fate of the United States, and particularly U.S. industry, depends on a return to our roots – a belief in the power of the follower, that we are the ones who ultimately make the difference whether it be at home, at work, in our communities, or in our nation. (p. 31)

There are specific goals, visions, and missions related to leadership, but there are also tasks and goals that followers must achieve to be considered a follower (Kouzes and Posner, 1995). Examples of what a follower needs to do are to focus on the goal, do a great job on the critical-path activities related to the goal, take initiative to increase their value to the organization, and realize that they add value to their work by being who they

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are, with all their experiences, ideals, and dreams (Kelley, 1991). Kelley states emphatically, “Followers are committed to a cause, a product, an organization, an idea, a person” (p. 132). They are loyal, committed, intelligent, supportive, independent, courageous, honest, and able to articulate clearly, thus making their needs and expectations clear to others. Kouzes & Posner (1995) consider these the same characteristics of admired leaders. There is much in common between leaders and followers in relation to the characteristics each exhibits within his/her role. Chaleff (2003) describes this fluidity:

As soon as we enter the social arena we are involved with leadership and followership roles. The less rigidly that our culture or an activity prescribes these relationships, the more fluid they may be; in some situations we lead, in others we follow, and in still others we move back and forth between these roles or share them equally with our fellows (p. 218).

Every person will fall, on either a professional or personal level, into one of two categories: leader or follower. Many will experience both roles each and every day (Kelley, 1991). It is the ability to function in one role or the other that contributes to the making of a good leader or a good follower. Many people will learn to lead and not recognize that being able to follow is a vital part of leading. Many will learn to follow and not have the desire to lead. The difficulty comes with trying to place both roles into black and white categories of leaders and followers, for many individuals will fall somewhere in the middle and experience both roles regularly. It is the leader who is able to recognize the value of the follower who will lead both the organization and the

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individual to success. But it is also the follower who is competent, independent, and trustworthy who enhances the role of the leader and is successful as a follower.

The relationship between leader and follower can be fragile but is essential to the maintenance of a balance. For the leader, honest and open relationships with the followers will provide uncensored feedback. It is through this feedback that a leader will not become excessive. It is also through this relationship that the follower is able to speak openly, honestly, and with trust. This is a relationship that allows the follower and the leader to discuss in a mature fashion those behaviors that may be disruptive or nonproductive. This is sometimes difficult for both leader and follower, but should be pursued with respect to the relationship and in a way that preserves the adult's self-esteem and challenges the immature behavior.

As with leaders and leadership styles, followers make a choice about a followership style. However, leaders need to act as followers at times, and it is the mutual responsibility of both leader and follower to develop a relationship that is advantageous to both. The key is knowing when and how to make these transitions, and to make decisions that are consistent with one's ethical and moral values.

Building relationships takes time, work, trust, and an ability to adapt. Leaders need to continually inspire and motivate followers by making decisions that are consistent with the goals of the organization, but also benefit the employee. The leadership and followership relationships need courageous followers who can maintain genuine relationships with leaders and leaders who can maintain honesty and open communications with followers.

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Characteristics of Leadership Styles

Burns (1979) notes, “Leadership is one of the most observed and least understood phenomena on earth” (p. 2). Mumford, Dansereau, & Yammarino (2000) state that “Leadership has traditionally been seen as a distinctly interpersonal phenomenon demonstrated in the interactions between leaders and subordinates” (p. 1). Effective leadership behavior fundamentally depends upon the leader’s ability to solve the kinds of complex social problems that arise in organizations. Wheatley (1994) suggests that leaders need to communicate a clear and simple vision, strong values, and organizational beliefs. A leader must be able to evaluate circumstances and make decisions based on the situation (Wills, 1994). This may necessitate follower involvement in the decision-making process. Such participation increases the employee’s sense of involvement, dedication to the outcome and his/her sense of identity with a group or its leader and thus reinforces the leaders ability to lead (Kouze and Posner, 1997). The most successful leaders are visionary and coaching, able to communicate their expectations in a clear and concise manner to convey a vision of the future and adapt to the changing needs of the organization.

Tannenbaum & Warren (1973) describe a process of choosing a leadership pattern that is practical and desirable for the present situation. “The manager’s behavior in any given instance will be influenced greatly by the many forces operating within his own personality” (p. 173). Such forces may be the manager’s own confidence in subordinates, own leadership inclinations, or feelings or insecurities in a given situation. “The successful leader is one who is keenly aware of those forces which are most relevant to

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his behavior at any given time" (p. 180), and "[t]he successful leader is one who is able to behave appropriately in the light of the perceptions" (p. 180). The role a leader takes and the individual leadership style that a leader chooses can be important factor s in the success of a leader (Northouse, 2004).

Situational Leadership Model

"In early models of leadership study, Life Cycle Theory of Leadership (Hersey and Blanchard, 1981) it is proposed that as the level of maturity increases, effective leader behavior will involve less structuring, and less socio-emotional support. However, the decline in need for both of these leader behaviors is not straightforward. During the early stages an employee's tenure, a lower level of relationship orientation couple with high task orientation is consider to be ideal. As an employee gains maturity, the need for supervisory social-emotional support increased, while the need for structuring declines. Beyond a certain level of maturity, the need for both social-emotional support and structuring declines. "At the highest levels of employee maturity, supervisory tasks and social behaviors become superfluous to effective employee performance" (p. 2). Hersey and Blanchard suggested that the follower maturity can be broken into benchmark categories of high, moderate, and low and that appropriate leader style can be summarized in terms of a leader primarily telling, selling, participating, or delegating in relations with subordinates.

"Heresy and Blanchard's (1982) Situational Leadership Theory (SLT) embodies one of the more widely known and, at the same time, least researched views of

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managerial effectiveness" (Vecchio, 1987, p.1). It includes both directive (task) behaviors that clarify, are one-way conversations, say who is responsible and what is to be done; and supportive (relationship) behaviors that involve two-way communications and responses that show emotional and social support to others (Northouse, 2004).

Leadership styles are then classified into four distinct categories for directive and supportive behaviors (Northouse, 2004). First is a high directive-low supportive (directing) style. Here the leader focuses communication on goal achievement and spends as smaller amounts of time using supportive behaviors. A leader gives instructions about what and how the goals are to be achieved and supervises carefully. Second is a high directive-high supportive (coaching) style. The leader focuses the communication on both goal achievement and maintenance by giving encouragement and soliciting subordinate input. Third is a high supportive-low directive (supporting) style. The leader does not focus on goals, but uses supportive behaviors to bring out the employees' skills to accomplish a task. Last, there is a low supportive-low directive (delegating) style. In this approach, the leader offers less task input and this style allows subordinates to take responsibility for getting the job done.

A second part of situational leadership is concerned with the development level of subordinates (Northouse, 2004). "Development level refers to the degree to which subordinates have the competence and commitment necessary to accomplish a given task or activity" (p. 90). Employees are at a high development level if they are interested and confident in their work and know how to do the task. Employees are at a low development level if they have little skill for the task but feel they have the confidence

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and motivation to get the job completed. Development is classified into four categories. The D1 employees are low in competence and high in commitment. The D2 employees have some competence by are low on commitment. They have lost some of the initial motivation about the job. The D3 employees are moderate to high competence but may lack commitment. They are generally uncertain if they can complete a task by themselves. Last, the D4 employees are highest in development, and has a high degree of competence and commitment to getting the task completed. They have the skills and the motivation to do the job.

Vecchio (1987) argued that this theory overlapped many other theories: "This high degree of overlap suggests that SLT is not saying much that is new or original, it can also be contended that many of the above theories can also be shown to gentian a high degree of overlap. More positively, one can argue that SLT is focusing on critical features of behavior that have been previously identified" (p. 3). Fiedler's contingency theory is one such example. That contingency theory postulates that there is no one way for mangers to lead and that the situation will create a different leadership style for the manager. The model is designed to be multi-level and multi-score. It measures the leader's motivational orientation, characteristics of the situation and outcomes assessed at the group level.

LEAD-Self, LEAD-Others

A leadership style is the consistent patterns of behavior that is exhibited by one, perceived by others when attempting to influence the activities of others (Hersey and Blanchard, 1974). It is important to note that what one may think is their leadership style

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may be different from what others perceive to be the leadership style. It is for this reason that there should be an analysis of self and others to determine the differences. It is important to note that there is no single all-purpose leadership style. Any of the four styles may be effective or ineffective in any given situation. A dominant style plus supporting styles determines a style range. This is the ability to vary a leadership style. Style adaptability is the degree to which leader behavior is appropriate to the demands of a given situation.

The Effect of Various Leadership Styles

Leadership within an organization presents many challenges and leadership style can be the result of either positive or negative reactions within the organization. The results of the leaders actions can result in success or failure for the organization (Schettler, 2003). “It’s accepted business doctrine that corporate success begins with effective leadership” (p. 1). Kouze and Posner (1995) maintain that successful leaders are visionary and coaching, able to communicate their expectations in a clear and concise manner to convey a vision of the future, and also able to adapt to the changing needs of the organization.

An area that is changing frequently and demands more from their leaders is the field of healthcare. Included in that is the area of long-term care. “Responsibilities of nursing home administrators have evolved over the past 30 years as a wide array of regulatory and market demands transformed the day-to-day management of nursing homes (Angelelli, Gifford, Shah and Mor, 2001). One possible problem lies in the

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turnover rates of administrators and other staff. It is felt that turnover rates directly affect the quality of care provided by the facility. Some facilities have experienced turnover rates of over 40 percent, in some states, for administrators since the implementation of the 1987 Nursing Home Reform Act (NHRA) as part of the Omnibus Reconciliation Act (OBRA). This reform act changed the nursing home administrator's role significantly. Nursing home administrators are now responsible for the careful monitoring and processes for care of all residents as well as a higher acuity of skilled services that are provided. " One particular area of concern in the post-OBRA environment is the relationship between staff turnover and quality of care" (p. 53). Staffing continuity is associated with greater resident satisfaction and better physical functioning of the resident. " Management research has consistently shown strong and consistent leadership to be an important factor in determining the success or failure of firms" (p. 53).

All of these changes in healthcare make the need to retain staff more vital to the operations, and research indicates the leadership style exhibited within an organization can make this difference (Hoban & Hutlock, 2004). Bass (1990) note, " Ordinarily, the leader's performance will be better if they are more active than inactive. But activity does not guarantee effective satisfied and cohesive groups" (p. 901). Gruenfeld & Kassum (1973) mention in a sample of female healthcare workers that nursing supervisors who combine high levels of task and social-emotional orientation are more likely "to provide higher levels of satisfaction among their subordinates and better patient care as seen by other nurses" (p. 543).

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Sparks & Cooper (2001) suggested that managerial style impacts the well being of employees. "Type A behaviors by a manager are positively related to subordinates physical health symptoms" (p. 9), while managers who display an "inconsiderate" management style are related to the employees elevated stress levels and pressures. Sparks & Cooper (2001) record that employees perceive more stressors in a traditional organizations compared to those in a more democratic management style (p. 9). Changes not only in the management style but also in the culture of the organization can reduce absenteeism, turnover rates, and medical and disability costs for an organization (p. 11).

Manion (2004) holds that creating a culture of retention could make a difference and be beneficial. Being able to work in an environment where employees felt they made a contribution and that managers cared about them and were willing to listen and respond to the employees' needs reduced turnover, created an atmosphere of enjoyment, and created a win-win situation. Manion explains that coaching staff through setting high standards, supporting development, and modeling behaviors could easily and inexpensively do this. The managers needed to focus on results by solving problems and involving staff, but also needed to recognize that partnering with staff is also important. The manager needs to be visible, accessible, set clear boundaries, and communicate openly with staff. Melum (2002) noted there are positive results in an organization that identifies leadership styles and the affect on an organization. Melum explained there are four leadership styles or domains: the "charismatic leader with engaged followers," the "monastic leader with secure followers," the "bully leaders with frustrated followers,"

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and the bureaucratic leader with powerless followers." Moiden (2002) noted leadership styles in long-term care settings and the effects on healthcare workers noting,

> Dunham and Klafehn (1990) suggest transactional leaders acted as caretakers who had no vision for the future and overtly shared values, while excellent nurse leaders had transformational skills and qualities and were perceived to have them by staff. (p. 1)

Moiden explained that in a study, the leadership styles of authoritarian, democratic and laissez-faire were examined. This study indicated, "democratic leadership is most successful but may not always be an appropriate leadership style in every situation" (p. 2). Boumans & Landeweerd (1993) studied the relationship between leadership and nurse's well being by examining social and instrumental leadership styles. Boumans & Landeweerd found that challenges in the workplace did "lead to feelings of job significance, but at the same time they increased psychological and psychosomatic complaints" (p. 7). Moss & Rowles (1997) examined leadership types of management style. They concluded that each manager needed to evaluate his/her management style as what is intended and what is exhibited may not be the same causing difficulty in the working environment. This study showed that if leaders needed to change their management style, it needed to be done over a period of at least six months. Changes made in less time were "proven to be ineffective and increased the stress for the staff" (p. 34).

When evaluating the leadership style and effectiveness of working with staff it is important to understand that not one style is appropriate for all situations. Moiden (2002) notes, "The key to effective leadership is knowing how to use the right styles in each situation" (p. 5). Burns (1990) agrees in his statement that employee retention can be

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enhanced by conveying a message that is memorable and has meaning. It should be short and easily recalled by employees. There is also a matter of timing and consistency in the information that is conveyed to the employee (p. 112). Atchinson, (2004) supports this information: “Followers want a consistent message; they want to know how to move from the past to the present and know their specific role in building the bridge to the future” (p. 10). And Moiden (2003) adds, “Where leaders are concerned about the needs and objectives of their staff and are aware of the social and physical conditions that affect their working environments, productivity and efficiency will improve” (p. 1).

Nursing shortages, declining enrollment, and limited instructors will only add to the complications of the aging population and increased demand for quality in healthcare. There are issues of leadership styles that affect the turnover rates and employee satisfaction in long-term care and nursing fields. While any one leadership style may not be right for all occasions and environments, leadership styles that are more directive and do not allow participation by the employee are perceived as causing stressful work environments, while other styles that allow the employee to be involved in the decision-making process are less stressful and more desirable. Each leadership style has advantages and disadvantages, and not every style may work in every situation. A leader who is flexible and able to manage challenging environments should assess each specific situation and a leadership style that seems appropriate should be evaluated for effectiveness and subsequently applied by the leader.

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Demographics of an Aging Population

As leaders, Baby Boomers are "passionate and concerned about participation and spirit in the workplace" (Zemke, Raines & Filipczak, 2000, p. 79), but Baby Boomer managers have a hard time practicing the leadership style they profess to possess. Many are unaware they are lacking in skills such as understanding, listening, communicating, motivating and delegating. Boomers tend to be good at delivering service. They are good at building relationships and rapport, and they will do what is necessary to make the customer happy.

The sheer numbers of these Baby Boomers can be staggering when one realizes that they will soon be an aging population in need of health care. Baby Boomers are a vocal cohort and will not sit quietly, but will express their concerns and issues. The "Baby Boomer" generations, born between the years of 1943-1960, are noted to be the biggest, most powerful, most influential generation in United States history (Jennings, 2000). This translates to 78 million baby boomers, or one person who turns 50 years old every seven seconds (Raines, 1997). "By the year 2040, the Census expects 76 million Americans to be 65 and older, and 13.3 million to be older than 85. But that assumes that the average life expectancy will hold fairly steady" (Beck, 1993, p. 1). There could be as many as 138 million Americans older than 65 by 2040, and as many as 78 million people older than 85 by 2080. If longevity rates continue to increase, this could be 26 times more persons than there are presently. Either way, the implications for the health-care system are staggering.

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By 2012, there will be 77 million boomers retiring, and public financing problems will intensify at an even more alarming pace (Moeller & Christopherson, 2004). “Moreover, as rapidly as nursing home expenditures are expected to rise in the decades ahead, it is likely that the numbers of future retirees looking for non-institutional long-term care will dwarf those seeking admission to an institution” (p. 85). An aging baby boomer population and the health needs they experience are going to stress the health care system as it has never been stressed in the past (Raines, 1997).

Additionally, “6,000 Americans turn 65 every day. That number will double when the oldest baby boomers reach retirement age, 17 years from now” (p. 1). The implications can be staggering and could create problems that health care systems have not ever experienced. “Americans over 65 make up only about 13 percent of the nation’s population today, yet they account for more than one third of all health spending” (p. 1). They fill 40 percent of all hospital beds and consume twice as much prescription medications as all other age groups combined. The “oldest old” – those 85 and over – account for twice as much spending as those who are merely elder, and they are growing even faster as a percentage of the population (p. 1).

Health Care Costs

One of the primary factors impacting quality of care is the cost – with which the health care leader must be able to deal effectively. One’s leadership style may be related to the way in which one deals with costs as a part of the leadership-quality equation. Gleckman (2002) warns, “Already, the U.S. spends $1.4 trillion, or 14% of its gross domestic product, on medical care” (p. 1). Within a decade the U.S. “could be spending

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close to $3 trillion, or a staggering 17% of total national output, on health" (p. 1). If that growth continued unabated, medical care by mid-century would absorb one-third of the economy. The costs of health care will continue to rise, and health care "fixes" being considered by the White House and Congress will not be effective if they do not take into consideration the long-term demographic trends (Weinschrott, 1993). "Long-term considerations must dominate discussion of health-policy reforms" (p. 1). "Other than improving productivity, the only way to match rising demand with financial capacity is to restrict access to services or accept the increasing cost burden" (p. 1). "If by force of necessity in the future, the government limits funding to only the ones who need it the most, and the public is not ready for that, then it would too late for the public to do anything" (Panko, 2002, p. 76). Davis, Brannon, Zinn & Mor (2001) concur:

> Like the health care industry as a whole, the nursing home industry is in flux. Changes in service reimbursement, care regulations and environmental shift have created a particularly tumultuous environment for nursing facilities. To compensate, nursing facilities have downsized, substituted the use of less costly staff, or changed service mix. During the next decade, a growing elderly population will result in an increase in demand for nursing home and other long-term care services. Payment constraints will make it difficult for nursing facilities to thrive in this turbulent environment. Therefore, the potential for selective admission is high. Nursing facilities may choose to aggressively manage payor mix to ensure a sufficient and economically advantageous balance between private-pay, Medicaid, and Medicare residents. Many of these regulatory and reimbursement changes are a direct result of the billions of dollars spent on nursing home care each year by governmental payors Medicare and Medicaid in an effort to control or reduce expenditures while maintaining quality. Given these changes, facilities will need to adjust their strategies and structures, aligning each to environmental and regulatory demands, in order to ensure long-term survival. (p. 292)

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Omnibus Budget Reconciliation Act of 1987

In 1987, President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of both Medicare and Medicaid (Federal Nursing Home Reform Act, 1987). These changes came in response to a growing public concern over the poor quality in too many nursing homes. This reform act, or OBRA '87, creates a set of national minimum standards of care and rights for people living in certified nursing facilities. The minimum federal health and care requirements for nursing homes are to be delivered through a variety of established protocols within nursing homes and regulatory agencies. Some of the important aspects of this legislation include an emphasis on a resident's quality of life as well as his/her quality of care; expectations that the resident will be maintained at the highest possible level of functioning; the right of the patient to maintain a bank account while in the nursing facility; educational requirements for staff; uniform certification standards for Medicare and Medicaid homes; and new remedies to be applied to certified nursing homes that fail to meet minimum federal standards.

Quality in Long-Term Care

Health care has changed with the need to reduce costs, but quality in health care is still listed as a third priority after the primary focus became selling health care and access (Finkel & Lubin, 1997). There is a new challenge to reengineer the business of health care to see if the product that is being sold can be evaluated on a quality basis rather than on a price basis. In this instance *quality* implies that the appropriate services are being provided and can be measured through patient satisfaction feedback. Other ways of

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being able to identify quality of care relate to the Department of Health survey process. This implies that the fewer number of deficiencies a facility experiences, the higher quality of care that is achieved. There are several strategies by which to measure quality. The objective should be to assess the most effective care for patients. This can be done by measuring consumer, provider, and employer satisfaction, monitoring performance and promoting efficiency, measuring clinical outcomes, measuring and managing costs, and monitoring access to care. Ideally this information will lead to improved health and well being for the client.

> Nursing shortages, declining enrollment, limited instructors will only add to the complications of the aging population and increased demand for quality healthcare. Health care issues will continue to escalate as the general population continues to age and experts agree that the health care labor crisis is not limited to nursing. Nor is the problem attributable to stagnant supply or high turnover (Kinard & Kinard, 2004). "Instead, the shortage is driven by a sudden and sharp increase in the demand for health care services". (p. 166)

Quality Measures

Quality Measure information comes from resident assessment data that nursing homes routinely collect on all residents at specific intervals during their stay. The information collected pertains to the resident's physical, clinical conditions and abilities. Information collected is public information posted on a government website that compares the skilled nursing facility to the state and national averages for this information. The public is then encouraged to compare the skilled nursing facilities to one another and to choose the location that best meets their needs. Information posted on this website is taken from the assessments completed on the current resident population

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and is noted as a quality indicator. This information is then translated to quality measures. It provides such information as the number of residents who have had a decline in daily activities, the number of residents that have been identified to have moderate to severe pain, the number of residents at high risk for pressure sores, the number of residents with the use of restraints, and the number of residents who have urinary catheters or are high or low risk for loss of bowel or bladder control. This site also offers standards in staffing practices and information regarding the past year's Department of Health survey results and numbers of deficiencies a facility has experienced.

Kleinsorge & Koenig (1971) state, "Typically the state in which the nursing home is located gives an annual report of how well the home has met the state's requirements. The report is an outcome of an annual state inspection and financial audit for the purpose of licensing the facility. As a result of the licensing process, the regulators have as much or more power than a resident, family, friend or custodian" (p. 2). It is suggested that when the quality is high, costs go down, and demand, productivity and profits go up.

Survey Process

Nursing homes are inspected by the Department of Health every nine to fifteen months (AHCA, 2001). The survey process is designed to measure the level of quality care a nursing facility provides to the resident. The survey process starts before the survey team enters the facility. It begins with a preparation worksheet and a data collection based on the resident census. During this process, the survey team monitors

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the care of the resident, medication passes, the kitchen and food services, and conducts a general observation. They monitor to assure there are no violations in the following areas: resident rights, resident behavior and facility practices, quality of life, resident assessment, quality of care, and nursing services.

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CHAPTER 3. METHODOLOGY

Research and Design Methodology

The purpose of this research is to determine whether or not relationships exist between the leadership styles of nursing home administrators and the level of quality within their facilities. An exploratory study will be conducted utilizing demographic information and LEAD-Self questionnaires completed by the nursing home administrators in the sample; demographic information and LEAD-Other questionnaires (Center for Leadership Studies, 2002) completed by the director of nursing services working under the respective administrators; and a review of the recertification results from the preceding year's annual survey conducted by the Minnesota Department of Health.

Exploratory Research:

Exploratory research is valuable when a researcher does not have a clear idea of the problems they will encounter during the study (Cooper and Schindler, 2003). Different techniques (e.g., qualitative and quantitative) are applicable for exploratory study. A first step requires a research of the secondary literature related to the topic. It is necessary to understand prior results and to be able to identify methodologies that have been either successful or unsuccessful.

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Quantitative Research:

Quantitative analysis is best suited for single-subject analysis because it is more descriptive in nature, generally and/or quasi-experimental, and more correlational than the use of qualitative analysis (Cooper and Schindler, 2003). Such studies are steeped in traditional research design dealing with numbers, theory, and hypothesis testing. Quantitative research requires clear definition of data type, sample, and sample size. The researcher should consider the cost of the data collection, sample size, and the manner in which the information should be analyzed and documented. As the research progresses, one should consider the use of computer software such as SPSS, NVivo, Atlas, or other software designed for data analysis.

Data analysis is commonly divided into two broad types: exploratory (which explores the data) and confirmatory (Cooper and Schindler, 2003). A modern approach to quantitative analysis is exploratory data analysis (EDA), enabling the researcher to display the data in a diagram or picture. This process has been criticized for being an informal approach to analysis. It is necessary to note that one will also need to confirm data, and that the use of pictures is not sufficient to complete the analysis process.

Depending on the type of study, additional information might be based on differences in means, correlations, coefficients, and/or regression coefficients (Cooper and Schindler, 2003). Statistical analysis of quantitative data could include the use of measures of central tendency, measures of variability, standard deviation, confidence intervals, Chi square, cross tabulation, linear correlation, scatter diagrams, etc. There are also simple ways to describe the data such as summarizing the aspects of the data or the

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use of descriptive statistics. There is no clear and accepted single set of conventions for analysis corresponding to those observed with quantitative data (Robson, 2002). However, there are ways to deal with data in a systematic way. Investigative questions sometimes leave the option of choosing either approach. Surveying is more efficient and economical than observation: a few well-chosen questions can yield information that would take much more time and effort to gather by observation. A survey that utilizes the telephone, mail, or the Internet as the medium of communication can expand geographic coverage at a fraction of the cost and time required by observation. The most appropriate applications for surveying are those in which participants are uniquely qualified to provide the desired information (Cooper and Schindler, 2003).

Well-trained and experienced investigators are best qualified to use flexible designs for research. Investigators need to be good listeners who understand the issues involved and are open minded, unbiased, and sensitive to others (Cooper and Schindler, 2003).

The Sample

For the purpose of this study, licensed nursing home administrators who have been in their current positions for two or more years in Minnesota facilities were sampled. The initial population included the 409 nursing home names provided by the Minnesota Department of Health website: www.medicare.gov. The sample was selected by asking every name on the list (omitting the facility in which this researcher is

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employed) to participate. This means there should be rural and urban, privately and chain owned, for profit and not for profit locations included in the sample.

Procedure

Approval for this study was requested from Capella University Institutional Review Board and obtained. A current listing of 409 skilled nursing facilities was obtained from the www.medicare.gov website on October 15, 2005.

A letter of introduction was sent to the long-term care facilities Administrators and Directors of Nursing on October 27, 2005. Following in a packet, on November 1, 2005 were the letter of consent, demographic questionnaires, and assessment tools. On November 24, 2005, there were 36 incomplete packages returned with information completed by the Administrator only. A reminder letter was mailed that day to the facility Directors of Nursing that had not responded to the survey. A final date of November 30, 2005 for data collection was set.

Instruments

Data collection included demographic information questionnaires, and the LEAD-Self and LEAD-Other Leadership Style Inventories (Center for Leadership Studies, 2002). Collection of data required a review of the past year recertification results issued by the Minnesota Department of Health. This was obtained from the Minnesota Department of Health, from the www.medicare.gov website or from the facility. There are some 409 facilities in Minnesota and there was a possibility that the present

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administrator may not have been in his/her current location during the last survey process. Utilizing the demographic material made it possible to disregard administrators who have been at facility fewer than two years, and those locations were eliminated.

Each administrator and director of nursing services received a demographic questionnaire (Hasemann, 2003). This questionnaire was tested on five administrators and directors of nursing in 2003 for readability and reliability. Information on the demographic questionnaire included age, gender, highest educational level, years as an administrator or director of nursing, and years in present facility. The demographic information was collected and sorted for trends and patterns. This information was also used to eliminate those facilities in which the current administrators have been present for less than two years.

Leadership Style Inventories

The LEAD-Self and LEAD-Other assessment tools are inventories of situational leadership styles created by Paul Hersey and Ken Blanchard (Fernandez & Vecchio, 1997). Each administrator was asked to respond to the LEAD-Self assessment tool and each director of nursing services was asked to respond to the LEAD-Other. Situational Leadership Theory is based on the interplay among the extent of leader directive (task) behavior, leader socio emotional (relational) behavior, and follower readiness/maturity for performing a certain function.

The LEAD-Self and LEAD-Other (Center for Leadership Studies, 2002) assessments are twelve-item questionnaires that are used to assess style, style range and style adaptability of a leader. There are four leadership styles: high relationship/low task

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(participating); high task/high relationship (selling); high task/low relationship (telling); and low task/low relationship (delegating). The questionnaire is divided into four groups based on follower maturity. The level of maturity is on a scale of low to high. The four categories of question are split into three situations each with low, low to moderate, moderate to high and high maturity. The primary leadership style is determined by the style that has the most responses. A dominant style plus supporting styles determines a style range and is described in terms of task and relationship; i.e., the ability to vary a leadership style. Style adaptability is the degree to which leader behavior is appropriate to the demands of a given situation.

Information collected from the use of these tools was sorted and statistical analysis using independent tests was used to determine if relationships exist between leadership qualities and Minnesota Department of Health survey results. Specifically, the researcher was using the surveys to assess corrections that are issued related to hydration, nutrition, pressure ulcers and restraints. The researcher also took into consideration the scope and severity of the deficiency correction that was issued.

There are advantages to using leadership models that have been validated and tested for reliability. The LBDQ has been tested for evidence of stability, thus eliminating instability as a major concern in the use of this test. Moreover, it has been noted that the revised LBDQ showed adequate evidence of validity. However, additional research is still necessary to assure the validity and reliability of these tools: the information obtained by the tools is dated and there is a need for current research. The research called for will be worth the effort: leadership tools, studies, and information can

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be used in a variety of ways to enhance the environment of organizations (Schriesheim et al, 2002).

Schriesheim et al (1999) noted that leadership research has undergone a "metamorphosis since its infancy" (p. 1). A relationship-based research approach that was initially named "Vertical Dyad Linkage" (VDL) has evolved into what is most commonly referred to as Leader-Member Exchange (LMX) (p. 1). Although this research is a composition of past research, it is stated that in relation to LMX theory, there have been only ten studies that have employed appropriate methodology for analysis. It is also noted that there is a need for improved authorization regarding both LMX and its basic process for improved measurement practices, as well as for enhanced and more appropriate data-analytic techniques.

Schriesheim et al (1993) maintain that there are not well-established quantitative methods for examining content adequacy. Consequently, there is need for a new approach in the quantitative assessment of content adequacy, and there have been problems in the research that has been published in relation to the reporting of reliability issues. Even though reliability has been demonstrated for a particular tool, reliability should be demonstrated for every sample to which it is administered. A researcher assumes a particular study is reliable based on past research; any flawed sample or method of testing puts the entire study at risk for errors.

Hunt (2000) adds, "Leadership studies are unlikely to be of any additive value until they take into account organizational variables" (p. 1). He further clarifies that assertion by stating, "Organizational variables need to be constant to explore for

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leadership effects" (p. 1). Hunt notes that leadership is a mature field and can be traced back to ancient Egypt and China, but suggests that leadership needs to be examined with a historical-contextual approach to avoid or at least minimize the déjà vu effect and allow us to focus on the target to which leadership research needs to be directed. Hunt suggests that leadership research does not have either a focus on the future or an understanding of the past – and the unfortunate result is that there are gaps in the research that could be further minimized. He also warns that researchers may become so deeply involved in their own research that they fail to consider the broad perspective of their topic.

Bass & Stogdill (1990) collected data and leadership research for a number of years. It is noted within this literature that there can be problems with the validity of the information emanating from a leadership study. Bass and Stogdill conclude that most leadership performance is based on information that is subjective in relation to the performance of a leader. This information is a judgment made by others and may not be reliable for data collection. The reliability and validity of forecasting the success of a leader can be increased through the standardization of judgmental requirements, the pooling of judgments, and the training of the judges. It is also noted that valid scores from psychometric tests, application blanks, and biographical-information blanks can be used with or without the use of other mathematical statistics (e.g., a multiple regression) to make predications regarding the success of a leader.

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Statistical Methods

All analyses were performed using SPSS for Windows (SPSS 14.0, SPSS Inc., Chicago, IL). Both descriptive and inferential statistical methods were employed. All testing was based on determining statistical significance at a two-sided alpha level of 0.05. The study sample was described using frequency and percentage for categorical variables and mean and standard deviation for continuous variables. Mann-Whitney tests were used to compare the Administrator and Director of Nursing scores between facilities with deficiencies versus those without deficiencies. Spearman's correlation statistic was used to measure the association between the Administrator and Director of Nursing scores, and the total number of deficiencies.

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CHAPTER 4. PRESENTATION OF THE RESULTS

The following information reflects the quantitative results of this study. It includes the demographic data from each Administrator and Director of Nursing, information collected from the Minnesota Department of Health website related to the number of deficiencies, and the LEAD-Self, LEAD-other survey tool information. Both descriptive and inferential statistical methods were employed. Mann-Whitney tests were used to compare the Administrator and Director of Nursing scores between facilities with deficiencies versus those without deficiencies and Spearman's correlation statistic was used to measure the association between the Administrator and Director of Nursing scores, and the total number of deficiencies.

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Demographic Summary

There were 409 long-term care facilities throughout the state of Minnesota that were provided opportunities to participate in this study. There were 85 (20.87%) Long-Term Care Administrators that responded to this survey. The data shows there were 44 (52%) males and 41 (48%) females that responded to this survey. There were 60 (14.66%) Directors of Nursing that responded, 4 (4.7%) males and 56 (65.9%) females. Tables 1 and 2 reflect the gender information.

Table 1. Administrator Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	44	51.8	51.8	51.8
	Female	41	48.2	48.2	100.0
	Total	85	100.0	100.0	

Table 2. Director of Nursing Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	4	4.7	6.7	6.7
	Female	56	65.9	93.3	100.0
	Total	60	70.6	100.0	
Missing	System	25	29.4		
Total		85	100.0		

The ages of the Administrators that responded to this survey varied from 27-81 (mean 48.4) years of age while the Directors of Nursing ages varied from 30-60 (mean

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47.29) years of age. The length of employment for an Administrator in the facility was from 1-41 (mean 7.21) years. The length of time for a Director of Nursing in the present facility ranged from 1-30 (mean 5.3) years. The facility size varied from 25-343 beds. Table 3 indicates the demographic information for Administrators and Directors of Nursing that participated in this study.

Table 3. Demographics

	N						
	Valid	Missing	Mean	Median	Std. Deviation	Minimum	Maximum
Administrator Age	85	0	48.40	50.00	10.437	27	81
Facility Size	85	0	90.94	75.00	51.503	25	343
Administrator Number of Years at this Facility	80	5	7.21	4.50	7.445	1	41
Length of Employment as an Administrator	85	0	15.61	15.00	9.001	2	41
Administrator Length of time in Long-Term Care	85	0	20.27	20.00	9.475	3	45
Director of Nursing Age	58	27	47.29	48.00	7.500	30	60
Director of Nursing Number of Years at this Facility	50	35	5.30	3.00	5.578	1	30
Length of Employment as a Director of Nursing	53	32	7.66	5.00	6.975	1	30
Director of Nursing Length of time in Long-Term Care	59	26	20.24	20.00	9.134	2	38
Director of Nursing Length of time working with this Administrator	47	38	4.38	3.00	4.688	1	25
Total Number Deficiencies in Last Posted Survey	85	0	7.16	6.00	5.363	0	27

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The total number of deficiencies was reviewed and particular attention was paid to Quality of Care deficiencies that included hydration/ nutrition, pressure ulcers and restraints. As a reference, the number of deficiencies for the past year as reported by the www.medicare.gov (Last updated September 1, 2005) website ranged from 0-27 (mean 7.1). There were seven facilities that had deficiencies in the area of nutrition/hydration, with one location having a scope and severity of one (potential for minimal harm), five having a scope and severity of two (minimal harm or potential for actual harm), and one location having a scope and severity of three (actual harm). There were 16 facilities that had deficiencies in the area of pressure sores, with no locations having a scope and severity of one, 13 having a scope and severity of two and three locations had a scope and severity of three. Ten facilities had deficiencies in the area of restraints, with no locations having a scope and severity of one, eight having a scope and severity of two and one location had a scope and severity of three. Tables 4 to 9 illustrate these findings.

Table 4. Nutrition/Hydration Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	False	78	91.8	91.8	91.8
	True	7	8.2	8.2	100.0
	Total	85	100.0	100.0	

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Table 5. Average Scope and Severity for Nutrition/Hydration Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	77	90.6	91.7	91.7
	1	1	1.2	1.2	92.9
	2	5	5.9	6.0	98.8
	3	1	1.2	1.2	100.0
	Total	84	98.8	100.0	
Missing	System	1	1.2		
Total		85	100.0		

Table 6. Pressure Ulcer Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	False	69	81.2	81.2	81.2
	True	16	18.8	18.8	100.0
	Total	85	100.0	100.0	

Table 7. Average Scope and Severity for Pressure Ulcer Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	68	80.0	81.0	81.0
	2.00	13	15.3	15.5	96.4
	3.00	3	3.5	3.6	100.0
	Total	84	98.8	100.0	
Missing	System	1	1.2		
Total		85	100.0		

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Table 8. Restraint Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	False	75	88.2	88.2	88.2
	True	10	11.8	11.8	100.0
	Total	85	100.0	100.0	

Table 9. Average Scope and Severity for Restraint Deficiencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	75	88.2	89.3	89.3
	2.00	8	9.4	9.5	98.8
	3.00	1	1.2	1.2	100.0
	Total	84	98.8	100.0	
Missing	System	1	1.2		
Total		85	100.0		

In addition to the demographic and Minnesota Department of Health information, each participant was asked to complete a LEAD-Self or LEAD-Other survey tool (Center for Leadership Studies, 2002). The LEAD-Self and LEAD-Other assessment tools are inventories of situational leadership styles created by Paul Hersey and Ken Blanchard (Fernandez & Vecchio, 1997) and measure the leadership style, style range and style adaptability of the leader. Each administrator was asked to respond to the LEAD-Self assessment tool and each director of nursing services was asked to respond to the LEAD-Other. Situational Leadership Theory is based on the interplay among the extent of leader directive (task) behavior, leader socio emotional (relational) behavior, and follower readiness/maturity for performing a certain function.

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The LEAD-Self and LEAD-Other (Center for Leadership Studies, 2002) assessments are twelve-item questionnaires that are used to assess style, style range and style adaptability of a leader. There are four leadership styles: high relationship/low task (participating); high task/high relationship (selling); high task/low relationship (telling); and low task/low relationship (delegating). The questionnaire is divided into four groups based on follower maturity. The level of maturity is on a scale of low to high. The four categories of question are split into three situations each with low, low to moderate, moderate to high and high maturity. The primary leadership style is determined by the style that has the most responses. A dominant style plus supporting styles determines a style range and is described in terms of task and relationship; i.e., the ability to vary a leadership style. Style adaptability is the degree to which leader behavior is appropriate to the demands of a given situation. Using the LEAD survey tools, the Administrator and/or Director of Nursing gave responses to the 12 questions. Based on these responses, the highest possible score for any category S1, S2, S3, or S4 is a 12. Administrators and Directors of Nursing scored highest in the leadership style as Selling or a high task/high relationship style. Next, in a secondary style was the Participating or high relationship /low task style. Third was the Telling or high/task low relationship style. And last, was the Delegating or low relationship/ low task style. The adaptability scores varied from 19-32 based on the administrator response. The mean was a 24.07 and reflected a moderate degree of adaptability. Scores in this range (24-29) usually indicate a pronounced primary leadership style with less flexibility into the secondary styles (Center for Leadership Studies, Inc, 2005). While scores in the 0-23 range indicate a need for

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self- development to improve, both the ability to diagnose task readiness and to use appropriate leader behaviors and scores in the 30-36 range indicate a leader with a high degree of adaptability and a willingness of the follower to adjust accordingly. Table 10 illustrates these findings.

Table 10. LEAD Self and LEAD Other Statistics

	N Valid	N Missing	Mean	Median	Std. Deviation	Minimum	Maximum
ADM S1 Score Telling	83	2	1.29	1.00	1.030	0	4
ADM S2 Score Selling	83	2	5.24	5.00	1.904	1	9
ADM S3 Score Participating	83	2	4.42	4.00	1.733	1	10
ADM S4 Score Delegating	83	2	1.08	1.00	1.118	0	4
ADM Leadership Score Style Adaptability Score	83	2	26.59	27.00	2.893	19	32
DON S1 Score Telling	59	26	1.80	2.00	1.808	0	8
DON S2 Score Selling	59	26	5.20	5.00	2.369	1	11
DON S3 Score Participating	59	26	3.88	4.00	2.093	0	10
DON S4 Score Delegating	59	26	1.32	1.00	1.879	0	8
DON Leadership Score Style Adaptability Score	59	26	24.07	24.00	3.629	16	33
Total Deficiencies Total Deficiencies	85	0	7.16	6.00	5.363	0	27

Statistical Analysis

To determine if the leadership style of nursing home administrators can influence the quality, Mann-Whitney tests were completed to compare the average leadership

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scores between those with and without a nutrition/hydration, pressure ulcer or restraint deficiency. This nonparametric test is most commonly used as an alternative to the independent samples t test (Norusis, 2002). The Wilcoxon test was chosen because it uses the information about the size of the difference between the two members of a pair. It is more likely to detect true differences when they exist. In the information below, there is not a statistically significant difference in the administrators' scores between the two groups of facilities with or without a nutrition/hydration deficiency.

For example, when one looked at tables 11 and 12, it showed that there was not a statistically significant difference in the average "Administrator Scores 1, 2, 3, or 4" between the groups of those with or without nutrition/hydration deficiencies. In the "Administrator Score 1", the average (SD) score was 1.26 (1.038) versus 1.57 (.976) for those facilities without, and with a restraint deficiency respectively (P = 0.37). Further review of the data indicated that there was no statistically significant difference in the leadership style and nutrition/hydration deficiencies.

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Table 11. LEAD Self and LEAD Other- Nutrition/Hydration Statistics

	Nutrition/Hydration Deficiencies	N Valid	N Missing	Mean	Median	Std. Deviation	Minimum	Maximum
ADM S1 Score Telling	False	76	2	1.26	1.00	1.038	0	4
	True	7	0	1.57	2.00	.976	0	3
ADM S2 Score Selling	False	76	2	5.33	5.00	1.893	1	9
	True	7	0	4.29	4.00	1.890	2	7
ADM S3 Score Participating	False	76	2	4.36	4.00	1.757	1	10
	True	7	0	5.14	5.00	1.345	3	7
ADM S4 Score Delegating	False	76	2	1.08	1.00	1.152	0	4
	True	7	0	1.14	1.00	.690	0	2
ADM Leadership Score	False	76	2	26.64	27.00	2.929	19	32
	True	7	0	26.00	25.00	2.582	24	31
DON S1 Score Telling	False	52	26	1.79	2.00	1.786	0	8
	True	7	0	1.86	1.00	2.116	0	5
DON S2 Score Selling	False	52	26	5.33	5.50	2.431	1	11
	True	7	0	4.29	3.00	1.704	3	7
DON S3 Score Participating	False	52	26	3.79	3.00	2.090	0	10
	True	7	0	4.57	4.00	2.149	2	7
DON S4 Score Delegating	False	52	26	1.35	1.00	1.898	0	8
	True	7	0	1.14	.00	1.864	0	5
DON Leadership Score	False	52	26	24.19	25.00	3.705	16	33
	True	7	0	23.14	23.00	3.078	18	28

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Table 12. LEAD Self and LEAD Other-Nutrition/Hydration Test Statistics (b)

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)
ADM S1 Score Telling	213.500	3139.500	-.897	.370
ADM S2 Score Selling	186.500	214.500	-1.321	.186
ADM S3 Score Participating	177.500	3103.500	-1.479	.139
ADM S4 Score Delegating	230.000	3156.000	-.620	.535
ADM Leadership Score	209.000	237.000	-.941	.347
DON S1 Score Telling	179.500	207.500	-.061	.952
DON S2 Score Selling	135.000	163.000	-1.113	.265
DON S3 Score Participating	143.500	1521.500	-.918	.359
DON S4 Score Delegating	167.500	195.500	-.364	.716
ADM S1 Score Telling	145.500	173.500	-.860	.390

b Grouping Variable: Nutrition/Hydration Deficiencies

The information related to restraint deficiencies did indicate that Administrator Score 3, separately for those facilities with and without a restraint deficiency that there was a statistically significantly larger average "Administrator Score 3"(Participating) in the group that had a restraint deficiency compared to the group that did not have a restraint deficiency. The average (SD) score was 4.30 (1.75) versus 5.30 (1.42) for those facilities without, and with a restraint deficiency respectively (P = 0.038). Further investigation showed that there was not a statistically significant difference in the average "Administrator Score 1, 2, or 4" between the two groups of with or without a restraint deficiency. For example: the average (SD) score was 1.27 (0.96) versus 1.40 (1.51) for those facilities without, and with a restraint deficiency respectively (P = 0.95).

Tables 13-14 illustrate these findings.

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Table 13. LEAD Self and LEAD Other – Restraint Statistics

	Restraint Deficiencies	N Valid	N Missing	Mean	Median	Std. Deviation	Minimum	Maximum
ADM S1 Score Telling	False	73	2	1.27	1.00	.961	0	4
	True	10	0	1.40	1.00	1.506	0	4
ADM S2 Score Selling	False	73	2	5.32	5.00	1.899	1	9
	True	10	0	4.70	4.50	1.947	2	8
ADM S3 Score Participating	False	73	2	4.30	4.00	1.746	1	10
	True	10	0	5.30	5.50	1.418	3	7
ADM S4 Score Delegating	False	73	2	1.15	1.00	1.151	0	4
	True	10	0	.60	.50	.699	0	2
ADM Leadership Score	False	73	2	26.64	27.00	2.922	19	32
	True	10	0	26.20	26.50	2.781	21	30
DON S1 Score Telling	False	51	24	1.63	2.00	1.788	0	8
	True	8	2	2.88	2.50	1.642	1	5
DON S2 Score Selling	False	51	24	5.49	6.00	2.395	1	11
	True	8	2	3.38	3.00	1.061	2	5
DON S3 Score Participating	False	51	24	3.96	3.00	2.126	0	10
	True	8	2	3.38	4.00	1.923	0	6
DON S4 Score Delegating	False	51	24	1.18	.00	1.694	0	6
	True	8	2	2.25	1.50	2.765	0	8
DON Leadership Score	False	51	24	24.25	24.00	3.381	16	33
	True	8	2	22.88	25.00	5.055	16	29

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Table 14. LEAD Self and LEAD Other – Restraint Test Statistics (a)

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)
ADM S1 Score Telling	360.500	415.500	-.066	.948
ADM S2 Score Selling	297.000	352.000	-.965	.335
ADM S3 Score Participating	219.500	2920.500	-2.076	.038
ADM S4 Score Delegating	273.000	328.000	-1.353	.176
ADM Leadership Score	344.000	399.000	-.296	.767
DON S1 Score Telling	112.000	1438.000	-2.108	.035
DON S2 Score Selling	96.000	132.000	-2.417	.016
DON S3 Score Participating	187.500	223.500	-.372	.710
DON S4 Score Delegating	157.500	1483.500	-1.103	.270
DON Leadership Score	191.000	227.000	-.289	.772

a Grouping Variable: Restraint Deficiencies

Tables 15 and 16 showed there was not a statistically significant difference in the average “Administrator Score 1, 2, 3, or 4” between the two groups. For the “Administrator Score1” the average (SD) score was 1.25 (1.084) versus 1.47 (.743) for those facilities both without and with a pressure ulcer deficiency respectively (P = .308).

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Table 15. LEAD Self and LEAD Other – Pressure Ulcers Statistics

	Pressure Ulcer Deficiencies	N Valid	N Missing	Mean	Median	Std. Deviation	Minimum	Maximum
ADM S1 Score Telling	False	68	1	1.25	1.00	1.084	0	4
	True	15	1	1.47	1.00	.743	0	3
ADM S2 Score Selling	False	68	1	5.32	5.00	2.011	1	9
	True	15	1	4.87	5.00	1.302	2	7
ADM S3 Score Participating	False	68	1	4.43	4.00	1.765	1	10
	True	15	1	4.40	5.00	1.639	2	7
ADM S4 Score Delegating	False	68	1	1.04	1.00	1.112	0	4
	True	15	1	1.27	1.00	1.163	0	4
ADM Leadership Score	False	68	1	26.47	26.00	3.054	19	32
	True	15	1	27.13	27.00	1.995	24	31
DON S1 Score Telling	False	50	19	1.90	2.00	1.919	0	8
	True	9	7	1.22	1.00	.833	0	2
DON S2 Score Selling	False	50	19	5.38	6.00	2.364	1	11
	True	9	7	4.22	3.00	2.279	2	8
DON S3 Score Participating	False	50	19	3.78	3.00	2.063	0	10
	True	9	7	4.44	5.00	2.297	0	7
DON S4 Score Delegating	False	50	19	1.20	.00	1.750	0	6
	True	9	7	2.00	2.00	2.500	0	8
DON Leadership Score	False	50	19	24.00	24.00	3.653	16	33
	True	9	7	24.44	25.00	3.678	17	28

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Table 16. LEAD Self and LEAD Other – Pressure Ulcers Test Statistics (a)

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)
ADM S1 Score Telling	427.500	2773.500	-1.018	.308
ADM S2 Score Selling	432.500	552.500	-.930	.352
ADM S3 Score Participating	496.000	2842.000	-.169	.866
ADM S4 Score Delegating	446.500	2792.500	-.790	.430
ADM Leadership Score	431.500	2777.500	-.936	.349
DON S1 Score Telling	191.000	236.000	-.742	.458
DON S2 Score Selling	162.500	207.500	-1.332	.183
DON S3 Score Participating	164.000	1439.000	-1.308	.191
DON S4 Score Delegating	170.500	1445.500	-1.231	.218
ADM S1 Score Telling	189.500	1464.500	-.753	.452

a Grouping Variable: Pressure Ulcer Deficiencies

Spearman's correlation statistic was used to measure the association between the administrator and director of nursing scores, and the total number of deficiencies. The following are general rules of thumb for interpreting the strength of linear association measured by the Spearman correlation statistic:

+- 0.01 to +- 0.30 = Weak

+- 0.31 to +- 0.70 = Moderate

+- 0.71 to +- 0.99 = Strong

+- 1 = Perfect linear relationship

0 = No linear relationship

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Table 17. Correlations

			Total Deficiencies
Spearman's rho	ADM S1 Score Telling	Correlation Coefficient	-.042
		Sig. (2-tailed)	.705
		N	83
	ADM S2 Score Selling	Correlation Coefficient	-.010
		Sig. (2-tailed)	.929
		N	83
	ADM S3 Score Participating	Correlation Coefficient	.184
		Sig. (2-tailed)	.095
		N	83
	ADM S4 Score Delegating	Correlation Coefficient	-.082
		Sig. (2-tailed)	.460
		N	83
	ADM Leadership Score	Correlation Coefficient	-.053
		Sig. (2-tailed)	.632
		N	83
	DON S1 Score Telling	Correlation Coefficient	.078
		Sig. (2-tailed)	.555
		N	59
	DON S2 Score Selling	Correlation Coefficient	-.146
		Sig. (2-tailed)	.270
		N	59
	DON S3 Score Participating	Correlation Coefficient	.008
		Sig. (2-tailed)	.955
		N	59
	DON S4 Score Delegating	Correlation Coefficient	.085
		Sig. (2-tailed)	.522
		N	59
	DON Leadership Score	Correlation Coefficient	-.278
		Sig. (2-tailed)	.033
		N	59

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Table 17 shows that there was a statistically significant, weak negative correlation between the total deficiencies and the "DON Leadership Score", r = -0.28 (P = 0.033). The Director of Nursing Leadership Score reflected the score given to the administrators and was 24.07, representing a moderate degree of adaptability and pronounced primary leadership style with less flexibility into the secondary styles (Center for Leadership Studies, 2005).

Research Questions/ Hypotheses

Question 1. Is there a relationship between the leadership style of nursing home administrators and the quality of care in nursing facilities? For example, if the administrator exhibits a leadership style of high performance and low task, does that facility have fewer deficiencies than one that has an administrator who exhibits a low relationship and low task style of leadership? (*Quality* is defined here as fewer deficiencies issued to the facility by the Minnesota Department of Health during an annual or recertification survey.)

Data analysis indicated that there was a statistically significant difference in the leadership style as perceived by the director of nursing specifically related to restraint deficiencies. This significance was noted in the leadership scores of the Telling or S1 scores in the data. A telling leadership style is a high task/low relationship style. This is a leadership style in which the followers are being told what to do, where to do it, and how to do it. It is an appropriate style when an individual or group is low in ability and willingness and needs direction (Hersey, Blancard, & Johnson, 2001). There was

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evidence that suggested that if the administrator had a higher flexibility score, there were fewer deficiencies. This was noted in the Table 17, which shows there was a statistically significant, weak negative correlation between the total deficiencies and the "DON Leadership Score", r = -0.28 (P = 0.033). The DON Leadership Score reflects the responses of the way in which the takers of the survey felt the administrator would respond in a specific situation. This means that, on average, facilities with higher "DON Leadership" scores tend to have fewer total deficiencies.

Question 2. Can leadership styles of nursing home administrators influence quality of care in nursing facilities? Can a more flexible leadership style have a more positive effect on the outcomes of quality within the nursing facility?

Administrative leadership can influence the quality of care in nursing facilities as evidenced in question 1. However, data indicated that both the Administrator and Director of Nursing style adaptability scores were in the 24-29 ranges, which reflected a less flexible leadership style. Table 17 shows that the relationship between the "total deficiencies" and the "Administrator Score 1, 2, 2 or 4" are not statistically significant. For example there was not a statistically significant correlation between the total deficiencies and the Administrator Score 1, r = -0.042 (P = 0.71), but in the Director of Nursing scores, there was a statistically significant, weak negative correlation between the total deficiencies and the "DON Leadership Score", r = -0.28 (P = 0.033). This means that on average, facilities with higher "DON Leadership" scores tend to have fewer total deficiencies. Fewer deficiencies reflect better quality of care based on the Minnesota Department of Health Survey process.

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Question 3. Nursing home administrators who encompass flexibility in style and effectiveness on the LEAD-Self and LEAD-Other tools will have a higher level of quality in their facilities than those who report a very narrow leadership style range and effectiveness rating (Center for Leadership Studies, 2002).

Table 17 shows that there was a statistically significant, weak negative correlation between the total deficiencies and the “DON Leadership Score”, $r = -0.28$ ($P = 0.033$). These are the scores that the Directors of Nursing gave to the Administrator regarding leadership style range and adaptability. On average, facilities with higher “LEAD-Other” scores tend to have fewer total deficiencies, indicating improved quality of care or perceived quality of care by the Department of Health, the consumer, and the public.

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CHAPTER 5. DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This chapter reflects the findings and conclusions of an exploratory study of nursing home administrators in Minnesota. The study was completed to determine if there was a relationship between the leadership styles of nursing home administrators and the quality of care that was provided in their corresponding long-term care facilities of Minnesota. If there was a relationship, it could have an impact on the quality of care that is provided in our future.

Influences on Quality

Whether quality is an individual perception or specific measurements such as quality indicators, quality measures, a state or federal survey, or a scorecard that measure specific standards (www.medicare.gov), there is an ongoing need to look at what is being provided and ways in which to improve quality.

Leadership Style and Adaptability

Based on information from Hersey, Blanchard & Johnson (2001) a leader with the ability to have an adaptable leadership style and a higher readiness score has an increased chance of success as a leader. The data from this study indicated that Administrators exhibited a moderate degree of adaptability and less flexibility to other leadership styles. This meant that the person or groups were able to perform the tasks but were unwilling or insecure in the ability to perform the task, or it could be a group or person that required an increase in motivation. In this instance, a leader needs to be able

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to evaluate the roles and become encouraging and communicating rather than telling others what to do or where to do it. To be effective, a leader could evaluate their own style of sharing responsibilities and increase shared decision-making while focusing on results and discussing apprehensions with followers. A need to be confident and secure in the ability to lead others is necessary when dealing with situations such as a Department of Health survey. It may be assumed that facilities that experience higher leadership style adaptability scores will do better or experience fewer deficiencies during the survey process.

In a study by Hasemann (2003), there was significance in the fewer number of deficiencies in a recertification survey related to an authoritarian leadership style. The findings of this study are consistent with those of Hasemann (2003) in that the leadership style can affect the overall number of deficiencies the facility experiences.

The data from the current study noted that there were four areas of statistical significance. There were three significant variables for restraint deficiencies in the area of an Administrator's leadership style of "Participating," and the Director of Nursing perceptions of the Administrator's leadership style in "Telling" and in "Selling." It can be assumed that restraints affect the quality of care and the quality of life for the resident by causing the resident to experience such health complications as increased urinary incontinence, immobility of joints, and development of pressure areas. All of these areas identified can affect the perception of quality and can result in written deficiencies from the Department of Health.

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The fourth area of significance was related to the administrator and the total number of deficiencies in the facility. One may also assume that if there are fewer deficiencies, there is improved quality of care. This is based on the perception that the facility is providing quality care all of the time and not just when the survey team arrives.

The mean adaptability score for Administrators was 26.59. The mean adaptability scores given by the Directors of Nursing to the Administrator was 24.0. On average, facilities with higher "LEAD-Other" scores tend to have fewer total deficiencies resulting in perceived improved quality of care by the Department of Health, the consumer, and the public.

The Effect of Leadership Style Adaptability on Quality

Each participant was asked to complete a LEAD-Self or LEAD-Other survey tool (Center for Leadership Studies, 2002). The LEAD-Self and LEAD-Other assessment tools are inventories of situational leadership styles created by Paul Hersey and Ken Blanchard (Fernandez & Vecchio, 1997) and measure the leadership style, style range and style adaptability of the leader. Each Administrator was asked to respond to the LEAD-Self assessment tool and each Director of Nursing services was asked to respond to the LEAD-Other.

The LEAD-Self and LEAD-Other (Center for Leadership Studies, 2002) identified four leadership styles: high relationship/low task (participating); high task/high relationship (selling); high task/low relationship (telling); and low task/low relationship (delegating). The questionnaire is divided into four groups based on follower maturity.

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The level of maturity is measured on a scale of low to high. The four categories of questions were split into three situations each with low, low to moderate, moderate to high and high maturity. The primary leadership style was determined by the style that had the most responses. A dominant style plus supporting styles determined a style range and was described in terms of task and relationship; i.e., the ability to vary a leadership style. Style adaptability was the degree to which leader behavior was appropriate to the demands of a given situation. Using the LEAD survey tools, the Administrator and/or Director of Nursing gave responses to the 12 questions. Based on this, the highest possible score for any category S1, S2, S3, or S4 is a 12.

Administrators and Directors of Nursing scored highest in the leadership style as Selling or a high task/high relationship style. Next, was a secondary style: the Participating or high relationship/low task style. Third was the Telling or high/task low relationship style. And last was the Delegating or low relationship/low task style. The adaptability scores varied from 19-32 based on the administrator response. The mean was a 24.07 and reflected a moderate degree of adaptability. Scores in this range (24-29) usually indicated a pronounced primary leadership style with less flexibility into the secondary styles (Center for Leadership Studies, Inc, 2005). Scores in the 0-23 range indicated a need for self-development to improve both the ability to diagnose task readiness and to use appropriate leader behaviors; scores in the 30-36 ranges indicated a leader with a high degree of adaptability and a willingness of the follower to adjust accordingly.

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Evidence suggested that the facility with an Administrator who exhibited a higher degree of flexibility also experienced fewer deficiencies. This fact was supported by the statistically significant information related to the number of deficiencies and the perception of the leadership adaptability scores given by the Directors of Nursing during this study. As noted above, the perception and interpretation by the Minnesota Department of Health, the consumers, and the general public was that fewer deficiencies meant better quality of care.

The Effect of Regulation on Quality

Changes in the regulatory systems that measure quality are changing within the state of Minnesota. Since October 1, 2005, the regulatory process and quality in the long-term care facility has been determined by the state. Each facility is required to submit reports such as use of staffing pools, turnover rates, retention rates, the MDS Quality Indicators, and the Minnesota Department of Health Survey results (www.news.careproviders.org). The facility has the ability to obtain a possible 100 points. The facility reimbursement rates for Medicare and Medicaid patients are based on this score. The area of deficiencies is worth a possible 10 points and the number of deficiencies and the scope and severity of those deficiencies are considered. As a result, it is very important to be able to minimize the number of deficiencies that a facility experiences. As noted above, the evidence indicated that the leadership style and leadership adaptability could make a difference in this area.

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The use of restraints, acquiring pressure ulcers, nutritional or hydration deficits are all considered areas that identify lack of quality in healthcare (AHCA, 2005). There are many possible side effects that can be related to any of these areas of care. For example, the use of restraints can cause the resident to experience, but is not limited to, increased urinary incontinence, immobility of joints, and development of pressure areas. These can all result in further complications such as increased pain, lack of dignity, inability to experience outings or programs of interest, and added expense for the resident. Each of these areas is individually assessed during the survey process, can lead to written deficiencies, and can affect the perception of quality within the facility. For example, during this study, there were 10 (11.8%) participants who reported restraint deficiencies, 16 (18.8%) with pressure ulcer deficiencies, seven (8.2%) who were issued nutrition/hydration deficiencies, and the mean number of deficiencies was reported as 7.16. All of these areas can and do affect the perception of quality. The facility, staff, overall condition of the resident and the Department of Health all play a role in the outcomes of quality in long-term care.

Challenging Demographics for Healthcare

The sheer numbers of these Baby Boomers can be staggering when one realizes that they will soon be an aging population in need of health care. Baby Boomers are a vocal cohort and will not sit quietly, but have and will continue to express their concerns and issues. “By the year 2040, the Census expects 76 million Americans to be 65 and older, and 13.3 million to be older than 85. But that assumes that the average

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life expectancy will hold fairly steady" (Beck, 1993, p. 1). There could be as many as 138 million Americans older than 65 by 2040, and as many as 78 million people older than 85 by 2080. If longevity rates continue to increase, this could be 26 times more persons than there are presently. Either way, the implications for the health-care system are staggering.

White & Deitz (2001) noted the average age of registered nurses increased from 37 years old in 1983 to 42 years old in 1998. In this study, the range of reported ages of the Administrators was 27-81 years old, while the Directors of Nursing ages ranged from 30-60 years old. This data supported White and Deitz findings with the mean age of the Director of Nursing being 48.0 years old and the mean age of the Administrator being 48.4 years old. It would appear that the mean age of the healthcare worker continued to increase in Minnesota. It may be assumed that the aging healthcare worker will be an ongoing problem as the healthcare providers age along with the general population. In addition, large numbers of an aging population will strain the health care systems, while an aging population retires and will longer provide the services needed.

Limitations and Assumptions

During this study, it was assumed that the facilities provided quality care all the time and not just when the survey team arrived or was present in the facility. It was also assumed that the survey process was implemented in the same fair and consistent manner throughout the state of Minnesota. The state survey team is trained to apply the

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regulations in a standard way, but this may not be an accurate reflection of the process across the state. There may be differences in the application of the survey process from facility to facility. Some administrators and directors of nursing in Minnesota perceive that this process varied in the different areas of the state, and that this process is not applied in a consistent or fair manner. This is not the interpretation of the survey teams.

Implications

The research in this study showed evidence that leadership styles can make a difference in the number of deficiencies that a long-term care facility experienced and lends itself to the assumption that if one can decrease the total number of deficiencies than one should be able to decrease the scope and severity of the deficiencies that the facility does experience. It also indicated that if there were fewer deficiencies that there would be better or improved quality of care provided by the facility.

In this study, the evidence showed that the leadership style of a participatory leader did have a more positive outcome with fewer total deficiencies. Based on information related to Situation Leadership (Hersey, Blanchard & Johnson, 2001), one should understand that the leader and the follower do not always perceive the leadership style to be the same. The level of confidence with the staff, the leaders own value system, personal inclinations, and feelings of security in an uncertain situation can affect a leadership style. Knowing and understanding that one can affect the leadership style can make a difference in the total number of deficiencies and in the improvement of quality in healthcare and also in increased reimbursement based on the present systems

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seen in Minnesota. For example, a leader who is able to show a more mature level of flexibility in a given situation can make a difference from negative to more positive outcomes. Administrators in long-term care facilities who are able to adapt and adjust to the Minnesota Department of Health survey process can lead the facility to fewer deficiencies. This would result in improved quality of care and increased reimbursement rates for the facility. Improved quality of care is positive for the resident, family members and staff who care for the resident.

The ability to complete this research was dependent on the response rates of the Administrators and the Directors of Nursing in the state of Minnesota. It was vital to have contact information and to maintain an ethical and confidential approach during this study. Biases related to the survey process, the interactions with staff members and leadership needed to be considered in the data collection process. The use of individual envelopes and response forms was used to provide privacy to the respondent. Several of the participants opted to not complete the survey feeling they would skew the results, while some returned the surveys unanswered stating that there was not time in their day to complete the survey.

Respondents to this survey have continued to send back results. These results were beyond the date of submission for data and have been set aside and not opened. It was important for the integrity of this survey to set aside any information returned beyond the date for data collection. Any information reviewed but not used in these results could have had a potential for a different perspective in these results. As a result it was important to not respond to late respondents during the analysis of this data and

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information. Although, it is understood, that a larger number of participants in a timelier manner could have made a difference in the results of this survey.

Recommendations

This study showed that different leadership styles could make a difference in the quality of care that is provided in long-term care facilities. This was evidenced by the data for those facilities with and without a restraint deficiency that there was a statistically significantly larger average “Administrator Score 3” (Participating) in the group that had a restraint deficiency compared to the group that did not have a restraint deficiency. Further investigation showed that there was not a statistically significant difference in the average “Administrator Score 1, 2, or 4” between the two groups of with or without a restraint deficiency. There was a statistically significant, weak negative correlation between the total deficiencies and the “DON Leadership Score”. The Director of Nursing Leadership Score reflected the score given to the administrators as 24.07, representing a moderate degree of adaptability and pronounced primary leadership style with less flexibility into the secondary styles.

Individual leaders should evaluate and identify their own leadership styles. While any one style may not be right for every situation, an ability to be flexible and adaptable in a leadership role should be learned by leaders. As a leader, one should look for ways to further improve their own leadership styles through experience, further education, or training on an individual or organizational level. As a leader, one should understand how others perceive the leadership style of the leader as they may not be the same and

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can make a difference in outcomes. As evidenced by this study, leadership styles can make the difference in the types and total number of deficiencies that a facility experiences. It is in the interest of the facility to evaluate leadership styles on hire and to select leadership styles that are compatible for the culture of the facility and organization. It would be beneficial to offer training related to leadership styles to all staff members. Education opportunities allow staff members to better understand the leadership styles and to evaluate the styles that are positive or negative and allows for opportunity to make changes. An understanding of how and why leadership styles can affect the organization is vital to staff at all levels of an organization.

A leader should understand that not only a specific leadership style is needed, but also an ability to be flexible is a part of leadership. Leader adaptability scores in this study varied from 19-32 based on the Administrator response. The mean was a 24.07 and reflected a moderate degree of adaptability. Scores in this range (24-29) usually indicate a pronounced primary leadership style with less flexibility into the secondary styles (Center for Leadership Studies, Inc, 2005). While scores in the 0-23 range indicated a need for self- development to improve, both the ability to diagnose task readiness and to use appropriate leader behaviors and scores in the 30-36 range indicated a leader with a high degree of adaptability and a willingness of the follower to adjust accordingly. An ability to adapt and to not be rigid in leadership adaptability will result in higher scores indicating a more mature leadership style. It is this mature style of leadership ability that resulted in fewer deficiencies for the facility.

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As a leader, one should understand that leadership styles are developed over time based on experience, education, and training. It may be a difficult process, to evaluate ones leadership style and how others perceive the leader, but it is necessary to understand that individual leadership styles are affected by the choices they make related to self-concepts, or by engaging in behaviors that are consistent with goals, competencies, beliefs, and values. An important part of evaluating a leadership style is an ability to identify one's leadership adaptability. The use of the LEAD tool (Center for Leadership Studies, 2005) or other tools that identify leadership styles would be recommended for use by leaders for potential hires to leadership positions. The use of specific evaluation tools, allow for consistency in hiring practices and allows for learning to begin immediately. It also lends itself to deeper understanding of why and how leaders make decisions, leads to an understanding of style adaptability, and the helps to identify the need for adaptability in leadership roles.

For an employer, adaptability in a leader style is an asset. In the healthcare field, leadership adaptability can lead to improved quality of care, should be considered during the interview process, considered in hiring practices, and should be considered as a learning opportunity for employees at every level of the organization.

Further Research

This study in leadership was completed in an effort to explore the leadership styles and the effects of those styles on long-term care. Valuable information may be gleaned from this study related to the leadership style of an Administrator, but there is a

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need for further research to determine if this is information is specific to Minnesota or can be generalized to a larger geographical area. This study is similar to one completed by Hasemann (2003), and the results are similar in the fact that demographics and the leadership style did affect the number of deficiencies that the facility experienced in the recertification process. It was felt that this outcome would have an indirect relationship to the quality of care that was provided.

Further studies of this type can continue to provide information about the leadership styles in long-term care. The leadership style portrayed in this research was limited to these four types; selling, telling, participating, and delegating. However, leadership styles have been described in many ways, and further research into other leadership styles could provide information of value to leaders of the future.

There could be further research and education into how and why these leadership styles can have a positive rather than a negative influence on the care that is provided in the long-term care facilities. The number of elderly is increasing daily as the Baby Boomer population ages and aging citizens live longer. There is an increased need for quality services in health care and if one is able to identify leadership styles that have positive outcomes, then this information may be used in future hiring practices, education, and possibly in standards set by the state as a minimum requirement for licensure.

Research could include the number and kind of deficiencies that facilities experience related to the current focus of the Minnesota Department of Health. For example: several years ago the survey teams focused heavily on providing education in

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the reduction of restraints. One may wonder if the education provided by the Minnesota Department of Health is related to an increased or decreased number of restraint deficiencies, and what the relationship to the leadership style is. This may be significant if the education provided by the Department of Health leads the Administrator and Director of Nursing to act in a less effective leadership style in an effort to be more compliant with the Department of Health.

Summary

The numbers of elderly are increasing daily as the Baby Boomer population ages and aging citizens live longer. There is an increased need for quality services in health care, and if one was able to identify leadership styles that have positive outcomes, then this information may be used in future hiring practices, education, and possibly in standards set by the state as a minimum requirement for licensure.

Quality in the long-term care settings is going to be an ongoing learning process with serious implications if leaders do not understand that they can have a lasting effect on the outcomes. There is a need to understand leadership in long-term care as it does affect the quality and will affect the reimbursement rates in Minnesota. Also, there is a need for understanding as generations' age and make higher demands for quality in their lives.

Based on assumptions related to the data, leadership styles can make a difference in quality in the long-term care facility. A more flexible and adaptable leadership style can result in fewer deficiencies and improved quality of care. The numbers of

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deficiencies as well as the specific deficiencies make a difference in the perceptions of quality. However, the Administrator Leadership Score was not statistically significant associated with any of the quality measures. The Director of Nursing LEAD-Other Leadership Score showed a statistically significant, weak negative correlation with "Total deficiencies." The difference between a positive and negative correlation is the "direction of association" between the two variables. A positive correlation means as one variable increases, the other variable tends to also increase. A negative correlation means as one variable increases, the other variable tends to decrease. This data analysis indicates a negative correlation between Director of Nursing LEAD-Other Leadership Score and Total Deficiencies. That means the "Larger" or "Higher" DON Leadership Scores tend to be associated with "Fewer" total deficiencies. Assuming that larger or higher Director of Nursing Leadership Scores are a positive factor and that the Director of Nursing thinks the leadership is good, then it follows that there would be fewer deficiencies where the Director of Nursing thinks the leadership is good.

The style of leadership used by the leader can make a difference. By exhibiting an effective leadership style with a high degree of flexibility, one is able to affect the quality of care that is provided in the long-term care facility. The study of leadership is one way of being able to evaluate the present systems, to self-evaluate one's own leadership style and ability, and to gain from the knowledge and information that others can share.

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Appendix A

SURVEY COVER LETTER

October 25, 2005

Dear Administrator,

My name is Dawn Chiabotti and I am currently doing a research project for my Doctoral Degree through Capella University. I am a Registered Nurse and Nursing Home Administrator with an interest in knowing if the leadership styles that these professionals exhibit make a difference in the quality of care that is provided.

As a doctoral candidate and health care professional, I would like to invite you and your Director of Nursing Services to participate in this research. My first question is to determine if the leadership style of nursing home administrators can influence the quality of care in nursing facilities. The second question of the study focuses on the degree of flexibility in administrative leadership style range, effectiveness and if it is influencing of quality of care.

You will receive the study under separate cover in approximately two weeks. Your participation in this study will take about 15 minutes of your time and that of the Director of Nursing Service.

Thank you for your participation in advance. I appreciate the time and effort that you have put into the furthering of leadership research.

For questions or concerns, please feel free to contact me at (218) 741-9219 or write to:
515 Minnesota Ave. W., Gilbert, MN 55741

Respectfully,

Dawn Chiabotti,
Doctoral Candidate, Organizational Management and Leadership
Capella University, Minneapolis, MN

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Appendix B

SURVEY COVER LETTER

October 25, 2005

Dear Director of Nursing Services,

My name is Dawn Chiabotti and I am currently doing a research project for my Doctoral Degree through Capella University. I am a Registered Nurse and Nursing Home Administrator with an interest in knowing if the leadership styles that these professionals exhibit make a difference in the quality of care that is provided.

As a doctoral candidate and health care professional, I would like to invite you and the Administrator to participate in this research. My first question is to determine if the leadership style of nursing home administrators can influence the quality of care in nursing facilities. The second question of the study focuses on the degree of flexibility in administrative leadership style range, effectiveness, and if it is influencing of quality of care.

You will receive the study under separate cover in approximately two weeks. Your participation in this study will take about 15 minutes of your time and that of your Administrator.

Thank you for your participation in advance. I appreciate the time and effort that you have put into the assistance of furthering leadership research.

For questions or concerns, please feel free to contact me at (218) 741-9219 or write to:
515 Minnesota Ave. W., Gilbert, MN 55741

Respectfully,

Dawn Chiabotti,
Doctoral Candidate, Organizational Management and Leadership
Capella University, Minneapolis, MN

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Appendix C

LETTER OF INTRODUCTION

October 26, 2005

Dear Administrator,

Please find enclosed the steps required to ensure successful inclusion in this research study.

- The LEAD-Self packet is for Administrators.
- The LEAD-Other packet is for the Director of Nursing Services.
- Please read and sign the letters of consent.
- Please complete the Demographic Questionnaires.
- Please complete the LEAD assessment tools.
- Please place the letters of consent, the Demographic information and the LEAD tools in the enclosed self-addressed/stamped envelope and mail on or before November 20, 2005

Thank you for your time in this matter. I really appreciate the information and assistance that you have provided in this very special project.

For questions or concerns, please feel free to contact me at (218) 741-9219 or write to:
515 Minnesota Ave. W. Gilbert, MN 55741

Respectfully,

Dawn Chiabotti,
Doctoral Candidate, Organizational Management and Leadership
Capella University, Minneapolis, MN

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Appendix D

REQUEST FOR PERMISSION TO USE

June 17, 2005

Christina A. Hasemann,
President/CEO
NY-Penn Nutrition Services, Inc.

Dear Christina,

My name is Dawn Chiabotti and I am currently working on a Doctorate Degree from Capella University. I am also interested in leadership styles in Nursing Home Administrators and am planning to do a dissertation similar to yours, only in the state of Minnesota. I noted that you had a Demographic Questionnaire and I am wondering if I may use that Demographic Questionnaire for my own dissertation project.

I would appreciate your assistance in allowing me to utilize this same format. Thank you.

Respectfully,

Dawn Chiabotti,
Doctoral Candidate, Organizational Management and Leadership
Capella University, Minneapolis, MN

Sent per email on June 17, 2005

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Appendix E

PERMISSION FROM CHRISTINA HASEMANN

Hi Dawn,

I would love to hear more about your study and how it will parallel the one I did in Central New York. And, yes, I give you permission to use my demographic questionnaire for the sole purpose of your doctoral research. Please keep in touch and let me know if I can be of assistance.

At 08:49 PM 06/19/2005, you wrote:

June 17, 2005<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Christina Hasemann
President/CEO
NY-Penn Nutrition Services, Inc.

Dear Christina,

My name is Dawn Chiabotti and I am currently working on a Doctorate Degree from Capella University. I am also interested in leadership styles in Nursing Home Administrators and am planning to do a dissertation similar to yours only in the state of Minnesota. I noted that you had a Demographic Questionnaire and I am wondering if I may use that Demographic Questionnaire for my own dissertation project.

I would appreciate your assistance with allowing me to utilize this same format. Thank you,

Respectfully,

Dawn Chiabotti,

Doctoral Candidate, Organizational Management and Leadership

Capella University, Minneapolis, MN

Christina Hasemann, Ph.D., R.D., L./C.D.N.
President/CEO
NY-Penn Nutrition Services, Inc.
74 La Grange Street
Binghamton, NY 13905-1718
Phone/Fax (607) 770-6221

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Appendix F

INFORMED CONSENT ADMINISTRATORS

CAPELLA UNIVERSITY
Institutional Review Board
225 South 6th Street, 9th Floor
Minneapolis, Minnesota 55402

THE EFFECT OF LEADERSHIP STYLE OF NURSING HOME ADMINISTRATORS ON QUALITY OF CARE: AN EXPLORATORY STUDY IN MINNESOTA
Informed consent for Nursing Home Administrators
Two copies of each form are provided so you may keep a copy for yourself.

The purpose of this study is to investigate the relationships between the leadership style of nursing home administrators and the quality of care. The first question of the study is to determine if the leadership style of nursing home administrators can influence quality of care in nursing facilities. The second question of the study focuses on the degree of flexibility in administrative leadership style range and effectiveness and if it is influencing of quality of care.

Data collection will involve the nursing home administrator to complete a demographic questionnaire and the LEAD-Self assessment tool (Center for Leadership Studies, 2002). This tool determines leadership style. This should take about 15 minutes of your time. Recertification survey information will be collected from the www.medicare.gov website with respect to pressure ulcers, nutrition/hydration and restraint citations.

Please print your name and location at the top of the LEAD-self or LEAD-other form (Center for Leadership Studies, 2002). Your name and your facility name will not be associated with the research and will only be known to me. I assure absolute confidentiality.

Your decision to participate in this study will not affect your current or future relationship with the researcher. If you decide to participate, you are free to withdraw at any time without affecting those relationships. There are no known risks or discomforts associated with this study.

The researcher conducting this study is Dawn Chiabotti. If you have any questions or concerns during this research or at any time, please feel free to call 218-744-9219 (home) or 218-744-9807 (work), or email dchiabotti@mchsi.com. You may also contact Capella University.

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Statement of consent
I have read the above information. I have asked questions that I have and have received answers to those questions concerning the research study. I consent to participate in this study.

_____________________________ ___________________
Signature of Participant Date

_____________________________ __________________
Signature of Researcher Date

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Appendix G

INFORMED CONSENT DIRECTORS OF NURSING

CAPELLA UNIVERSITY
Institutional Review Board
225 South 6th Street, 9th Floor
Minneapolis, Minnesota 55402

THE EFFECT OF LEADERSHIP STYLE OF NURSING HOME ADMINISTRATORS ON QUALITY OF CARE: AN EXPLORATORY STUDY IN MINNESOTA
Informed consent for Directors of Nursing Services
Two copies of each form are provided so you may keep a copy for yourself.

The purpose of this study is to investigate the relationships between the leadership style of nursing home administrators and the quality of care. The first question of the study is to determine if the leadership style of nursing home administrators can influence quality of care in nursing facilities. The second question of the study focuses on the degree of flexibility in administrative leadership style range and effectiveness and if it is influencing of quality of care.

Data collection will involve the Director of Nursing Services to complete a demographic questionnaire and the LEAD-Other assessment tool (Center for Leadership Studies, 2002). This tool determines leadership style. This should take about 15 minutes of your time.

Recertification survey information will be collected from the www.medicare.gov website with respect to pressure ulcers, nutrition/hydration and restraint citations.

Please print your name and location at the top of the LEAD-self or LEAD-other form (Center for Leadership Studies, 2002). Your name and your facility name will not be associated with the research and will only be known to me. I assure absolute confidentiality.

Your decision to participate in this study will not affect your current or future relationship with the researcher. If you decide to participate, you are free to withdraw at any time without affecting those relationships. There are no known risks or discomforts associated with this study.

The researcher conducting this study is Dawn Chiabotti. If you have any questions or concerns during this research or at any time, please feel free to call 218-744-9219 (home) or 218-744-9807 (work), or email dchiabotti@mchsi.com. You may also contact Capella University.

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Statement of consent
I have read the above information. I have asked questions that I have and have received answers to those questions concerning the research study. I consent to participate in this study.

____________________________ __________________
Signature of Participant Date

___________________________ __________________
Signature of Researcher Date

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Appendix H

DEMOGRAPHICS DIRECTORS OF NURSING

CAPELLA UNIVERSITY
Institutional Review Board
225 South 6th Street, 9th Floor
Minneapolis, Minnesota 55402

Director of Nursing Services

Demographic Information Questionnaire

Gender: Male ________ Female__________

Age: ___________________

Race: Caucasian__________ African- American ________ Other __________

Facility Size/Number of Beds:______________________________

Facility Ownership: (Please check all that apply)

Private _________ Chain __________ Other __________

For Profit______________ Not for Profit _____________

Number of years as the Director of Nursing at this facility: _________________

Total number of years employed as a Director of Nursing:__________________

Total number of years employed in long-term care: _________________

Highest degree:

Associates_________ Bachelors_________ Masters_________ Doctorate__________

How long have you worked under the current Nursing Home Administrator?_________

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Appendix I

DEMOGRAPHICS ADMINISTRATORS

CAPELLA UNIVERSITY
Institutional Review Board
225 South 6th Street, 9th Floor
Minneapolis, Minnesota 55402

Nursing Home Administrator

Demographic Information Questionnaire

Gender: Male ________ Female__________

Age: ___________________

Race: Caucasian__________ African- American ________ Other __________

Facility Size/Number of Beds:_______________________________

Facility Ownership: (Please check all that apply)

Private _________ Chain __________ Other __________

For Profit______________ Not for Profit _____________

Number of years as the Administrator at this facility: _________________

Total number of years employed as an Administrator:__________________

Total number of years employed in long-term care: _________________

Highest degree:

Associates_________ Bachelors_________ Masters_________ Doctorate__________

Are you licensed a NHA in any other state? Yes __________ No _______________

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Appendix J

REMINDER LETTER TO DIRECTORS OF NURSING

November 22, 2005

Dear Director of Nursing,

Several weeks ago I sent you a letter requesting your assistance in a study regarding the leadership style of the administrator in long-term care. In order for me to include your facility in this study, I need to have responses from both the administrator and the Director of Nursing. Your administrator has taken the time to return the survey, but as of today I have not heard from you.

Please take a couple of minutes to complete that information and return it to me in the envelope provided. The LEAD-Other tool should be answered in relation to the actions of the Administrator. This information will be kept confidential.

As a former Director of Nursing, I understand that you are very busy and your time is valuable. I apologize for the inconvenience if you have already sent me the information.

Please return this information as soon as possible as my last date for data collection is November 30, 2005. Thank you for your time and support in my pursuit of further education.

If there are any questions, you may call me at:
(218) 741-9219- home
(218) 744-9807- work
or e-mail me at:
dchiabotti@mchsi.com or
dawn.chiabotti@bhshealth.org

Dawn Chiabotti

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Appendix K

MINNESOTA RULES

(http://www.benha.state.mn.us/Default.aspx?tabid=894)

Minnesota Rules 4658.0060 RESPONSIBILITIES OF ADMINISTRATOR.

The administrator is responsible for the:

A. maintenance, completion, and submission of reports and records as required by the department;

B. formulation of written policies, procedures, and programs for operation, management, and maintenance of the nursing home;

C. current personnel records for each employee according to part 4658.0130;

D. written job descriptions for all positions which define responsibilities, duties, and qualifications that are readily available for all employees;

E. work assignments consistent with qualifications and the work load;

F. maintenance of a weekly time schedule which shows each employee's name, job title, hours of work, and days off for each day of the week. The schedule must be dated and communicated to employees. The schedules and time cards, payroll records, or other written documentation of actual time worked and paid for must be kept on file in the home for three years;

G. orientation for new employees and volunteers and provision of a continuing in-service education program for all employees and volunteers to give assurance that they understand the proper method of carrying out all procedures;

H. establishment of a recognized accounting system; and

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I. the development and maintenance of channels of communications with employees, including:

(1) distribution of written personnel policies to employees;

(2) regularly scheduled meetings of supervisory personnel;

(3) an employee suggestion system; and

(4) employee evaluation.

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Appendix L

INTERNAL REVIEW BOARD APPLICATION

CAPELLA UNIVERSITY
Institutional Review Board
225 South 6th Street, 9th Floor
Minneapolis, Minnesota 55402

Institutional Review Board Application

Name: Dawn Chiabotti

Date: July 23, 2005

Address: 515 Minnesota Ave West
Gilbert, MN 55741

Phone (Work) 218-744-9807 (Home) 218-741-9219

Email Address(es) _dchiabotti@mchsi.com

Field of Study: Organization Management/Leadership Degree Program: Ph.D.

Supervisor Name: Dr. Edward M. Goldberg, DM

Supervisor Title: Mentor

Address: 91 Braman Road
Waterford, CT. 06385

Phone (Work) (860)444-2757 (Home) _

Email Address(es) goldbem@msn.com

Provost: Dr. Karen Viechnicki

May 14, 2005-_Fill in date you successfully completed the online IRB Training required modules and optional modules appropriate to research topic

1. **Project Title**: The Effect of Leadership Style of Nursing Home Administrators on Quality of Care: An Exploratory Study in Minnesota
2. **Inclusive dates of project**: October, 2005_**through**_December, 2005

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3. Abstract/Lay Summary

The purpose of this research is to examine if relationships exist between the leadership styles of nursing home administrators and the level of quality within their facilities. A quantitative study will be conducted utilizing demographic information and LEAD-Self questionnaires completed by the nursing home administrators in the sample; demographic information and LEAD-Other questionnaires completed by the director of nursing services working under the respective administrator; a review of the recertification results from the last years annual survey conducted by the Minnesota Department of Health.

The Sample

For the purpose of this study, licensed nursing home administrators who are in their current positions in facilities in Minnesota will be sampled. The initial population will include fifty facilities of the 413 nursing homes provided by the Minnesota Department of Health www.medicare.gov website. The sample will be selected by removing the location that this research is employed and then taking every name on the list and asking that location to participate. This would then mean there should be rural and urban locations, privately and chain owned, for profit and not for profit locations included in the sample. Administrators with less than one year at the facility will be excluded from the study.

Procedure

Approval for this study will be requested from Capella University Institutional Review Board. A current listing of 409 skilled nursing facilities has been obtained from the www.medicare.gov website on June 15, 2005.

A letter of introduction will be sent to the long-term care facilities two weeks prior to the letter of consent, demographic questionnaires, and assessment tools. If needed, a postcard will be mailed one week after the assessment tools have been mailed as a reminder to complete the information by the designated deadline date. If the response rate is low, a second mailing will be completed.

Instruments

Data collection will include demographic information questionnaires, and the LEAD-Self and LEAD-Other Leadership Style Inventories (Center for Leadership Studies, 2002). Collection of data will require a review of the past year recertification results issued by the Minnesota Department of Health. This can be obtained from the Minnesota Department of Health, from the www.medicare.gov website or from the facility. There are a possible 409 facilities in Minnesota and there is a possibility that the administrator may not have been in that location during the last survey process. Utilizing the demographic material will eliminate administrators that have been at facility fewer than two years and those locations will be eliminated.

Leadership Style Inventories

The LEAD-Self and LEAD-Other assessment tools are inventories of situational leadership styles created by Paul Hersey and Ken Blanchard (Fernandez & Vecchio, 1997). Each administrator will be asked to respond to the LEAD-Self assessment tool and each director of nursing services will be asked to respond to the LEAD-Other.

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Situational Leadership Theory is based on the interplay among the extent of leader directive (task) behavior, leader socioemotional (relationship) behavior, and follower readiness/maturity for performing a certain function

The LEAD-Self and LEAD-Other assessments are twelve-item questionnaires that are used to assess style, style range and style adaptability of a leader (Center for Leadership Studies, 2002). There are four leadership styles: high relationship/low task (participating), high task/high relationship (selling), high task/low relationship (telling) and low task/low relationship (delegating). The questionnaire is divided into four groups based on follower maturity. The level of maturity is on a scale of low to high. The four categories of question are split into three situations each with low, low to moderate, moderate to high and high maturity. The primary leadership style is determined by the style that has the most responses. A dominant style plus supporting styles determines a style range and is described in terms of task and relationship. This is the ability to vary a leadership style. Style adaptability is the degree to which leader behavior is appropriate to the demands of a given situation.

4. Subject Population

a. Number: Male: _____ Female: ___Total: Plan to submit a minimum of 84 surveys to a mixed sample of male and female participants

b. Age Range: ___ to ___Unknown-all should be working professionals

c. Location of Participants: Working professionals of long-term care in Minnesota. (Check all that apply)

____ business

____elementary / secondary school

____outpatient

____hospital / clinic

____university / college

_X___other special institution / agency: specify__ Working professionals of long-term care in Minnesota

d. Special Characteristics: None Known
(Check all that apply)

___adults with no special characteristics

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___Capella University learner, faculty, and/or staff

___inpatients

___outpatients

___prisoners

___students

___other special characteristics:
specify

If research is conducted through organizations or agencies, written documentation of approval / cooperation from each agency (e.g., business, school, hospital, clinic) must accompany this application.
application.
N/A

e. Recruitment of Participants/Subjects
Describe how participants/subjects will be identified and selected for recruitment. Attach recruitment information (e.g., advertisement, bulletin board notices, recruitment letters)

A list of long-term care facilities has been taken from the Medicare www.medicare.gov website and have been placed in alphabetical order based on facility name. Surveys will be sent to all facilities that are surveyed by the Minnesota Department of Health. This will exclude facilities that do not accept the Medicare or Medicaid payments from the state.

f. If subjects are chosen from records, indicate who gave approval for use of the records. If records and private medical or student records, provide the protocol for securing consent of the subjects of the records and approval from the custodian of the records. The information obtained from the Medicare www.medicare.gov website is public knowledge

g. Who will make the initial contact with subjects? Describe how contact is made. Contact will be made through a letter of introduction to be included with the survey sent for completion.
The researcher will send out a letter of introduction. See appendix A and B for information regarding this letter and demographics material appendix I and J.

h. Will subjects receive inducements before, or rewards after the study?
No

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i. Activity for Control Group
If some of the participants/subjects are in a control group, describe in detail the activity planned for that group. (This information must be included in the consent/assent forms.)
N/A

5. **Confidentiality of Data**

a. Describe what provisions will be made to establish and maintain confidentiality of data and who will have access to data. If anonymous surveys are distributed, provide all the information that would have been given in an informed consent form as a cover to the survey (see the checklist at the end of this form to verify that you have completed the cover to the survey).
Only this researcher will have access to the data. There will be no identifying marks on the information and self addressed stamped envelopes will be included in the mailing for return to a correct address. Appendix G and H are consent forms with confidentially of data noted.

b. Where will the data be stored and for how long? Whatever media (e.g., audiotape, paper, digital recording, videotape) are used to record the data, explain who will have access and how long the media will be retained. It is required that data be stored for a minimum of seven years after publication of results (such as a dissertation). If data will be destroyed, describe the secure method for destroying the materials that will maintain confidentiality.
Data will be stored at the location of this researcher in a three ring binder until such time it can be destroyed.

All documents relating to ethical treatment of human participants/subjects which will be used in the course of the research must be attached to this form. These documents include consent forms, cover letters and other relevant material.

See checklist at the end of this document to verify that the application form has been completed.

Submit completed checked checklists with this application form to your school's designated IRB reviewer.
Signature of Researcher

As a Researcher (e.g., Learner, Faculty Employee, Consultant, Directed Employee/Agent, Independent Contractor, Adjunct Faculty) you certify that:
- The information provided in this application form is correct and complete.
- You will seek and obtain prior written approval from the Committee for any substantive modification in the proposal.
- You will report promptly to your Supervisor any unexpected or otherwise significant adverse events in the course of this study.

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- You will report to the Supervisor and to the participants/subjects, in writing, any significant new findings which develop during the course of this study which may affect the risks and benefits to participation in this study.
- You will not begin the research until final written approval is granted.
- You understand that this research, once approved, is subject to continuing review and approval by your Supervisor. You will maintain records of this research according to Supervisor guidelines. Substantive change requires submitting an addendum to a previously approved application. An addendum is a totally new application form with attachments. The cover letter with the addendum describes the changes that were made from the originally approved application.

If these conditions are not met, approval of this research could be suspended.

Signature of the Researcher:

__________________ Date: September 18, 2005, 2005 _________

As a Supervisor (e.g., Mentor, Instructor, Practicum Supervisor, Internship Supervisor, Staff Supervisor) you certify that:

- The information provided in this application form is correct and complete.
- You will review and provide prior written approval to your Supervisee for any substantive modification in the proposal. You will inform the committee members appointed to oversee the research and its results.
- You will receive reports from your Supervisee about any unexpected or otherwise significant adverse events in the course of this study. You will
- inform the committee members appointed to oversee the research and its results.
- You will review research records maintained by your Supervisee until the final written document is produced and approved by you and the oversight committee.
- You will inform the oversight committee about the progress of your Supervisee from the time of developing research questions, through the proposal, IRB application, collection of data, writing results, and completing the documentation of the research.
- You will contact the Lead Subject Matter Expert (e.g., Chair of the Specialization, Faculty Director) if additional review is needed.
- You will make sure that this application has been completed by your Supervisee including all accompanying attachments before signing your name for approval.
- You assume responsibility for ensuring that the research complies with University regulations regarding the use of human participants/subjects in research.

If these conditions are not met, approval of this research could be suspended.

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Signature of the Supervisor:

Name ____ Date____________

Title ____

Signature of Provost or Designee
As Provost, or designee, I acknowledge that this research is in keeping with the standards set by the university and assure that the researcher has met all requirements for review and approval of this research.

Signature of Provost or Designee

Name ____ Date____________

____

Completed forms should be sent as email attachments. Scan signature pages and attach as files. Send email messages with attachments to the designated IRB reviewers in one of the following schools representing your specialization affiliation:

Harold Abel School of Psychology
School of Business
School of Education
School of Human Services
School of Technology

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Appendix M

HUMAN PARTICIPANTS IN RESEARCH FORM

CAPELLA UNIVERSITY
222 South 9th Street, 20th Floor
Minneapolis, Minnesota 55402

Human Participants in Research Form
(To be completed if human subjects are involved in the research)

Learner Name: Dawn Chiabotti Date: September 18, 2005
Address: 515 Minnesota Avenue West
Gilbert MN 55741 _

Phone (Work) 218 744-9807 (Home) 218-741-9219
Field of Study: Organizational Management Degree Program: Ph.D.
Mentor: Dr. Edward M. Goldberg, DM

222**Project Title**: The Effect of Leadership Style of Nursing Home Administrators on Quality of Care: An Exploratory Study In Minnesota2. **Inclusive dates of project**: September, 2005_**through**_November, 2005

222**Abstract/Lay Summary**

The purpose of this research is to examine if relationships exist between the leadership styles of nursing home administrators and the level of quality within their facilities. A quantitative study will be conducted utilizing demographic information and LEAD-Self questionnaires completed by the nursing home administrators in the sample; demographic information and LEAD-Other questionnaires completed by the director of nursing services working under the respective administrator; a review of the recertification results from the last years annual survey conducted by the Minnesota Department of Health.

The Sample

For the purpose of this study, licensed nursing home administrators who are in their current positions in facilities in Minnesota will be sampled. The initial population will include fifty facilities of the 409 nursing homes provided by the Minnesota Department of Health www.medicare.gov website. The sample will be selected by removing the location that this research is employed and then taking every name on the list and asking that location to participate. This would then mean there should be rural and urban locations, privately and chain owned, for profit and not for profit locations included in the sample. Administrators who have been at the facility less than one year will be excluded from the study.

Procedure

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Approval for this study will be requested from Capella University Institutional Review Board. A current listing of 409 skilled nursing facilities has been obtained from the www.medicare.gov website on June 15, 2005.

A letter of introduction will be sent to the long-term care facilities two weeks prior to the letter of consent, demographic questionnaires, and assessment tools. If needed a postcard will be mailed one week after the assessment tools have been mailed as a reminder to complete the information by the designated deadline date. If the response rate is low, a second mailing will be completed.

Instruments

Data collection will include demographic information questionnaires, and the LEAD-Self and LEAD-Other Leadership Style Inventories (Center for Leadership Studies, 2002). Collection of data will require a review of the past year recertification results issued by the Minnesota Department of Health. This can be obtained from the Minnesota Department of Health, from the www.medicare.gov website or from the facility. There are a possible 409 facilities in Minnesota and there is a possibility that the administrator may not have been in that location during the last survey process. Utilizing the demographic material will eliminate administrators that have been at facility fewer than two years and those locations will be eliminated.

Leadership Style Inventories

The LEAD-Self and LEAD-Other assessment tools are inventories of situational leadership styles created by Paul Hersey and Ken Blanchard (Fernandez & Vecchio, 1997). Each administrator will be asked to respond to the LEAD-Self assessment tool and each director of nursing services will be asked to respond to the LEAD-Other. Situational Leadership Theory is based on the interplay among the extent of leader directive (task) behavior, leader socioemotional (relationship) behavior, and follower readiness/maturity for performing a certain function

The LEAD-Self and LEAD-Other assessments are twelve-item questionnaires that are used to assess style, style range and style adaptability of a leader (Center for Leadership Studies, 2002). There are four leadership styles: high relationship/low task (participating), high task/high relationship (selling), high task/low relationship (telling) and low task/low relationship (delegating). The questionnaire is divided into four groups based on follower maturity. The level of maturity is on a scale of low to high. The four categories of question are split into three situations each with low, low to moderate, moderate to high and high maturity. The primary leadership style is determined by the style that has the most responses. A dominant style plus supporting styles determines a style range and is described in terms of task and relationship. This is the ability to vary a leadership style. Style adaptability is the degree to which leader behavior is appropriate to the demands of a given situation.

222Subject Population

222Number: Male: _____ Female: ___Total: Will plan to submit a minimum of 84 surveys to a mixed sample of male and female.

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b. Age Range: ___ to ___Unknown-all should be working professionals

c. Location of Subjects: Working professionals of long-term care in Minnesota.
Special Characteristics: None known
(Check all that apply)

____elementary/secondary schools

____outpatients

____hospitals and clinics

____university students

(Check all that apply)

___inpatients

___prisons/halfway houses

___patient controls

___normal volunteers (adults)

__X__ other special institutions: specify-Working professionals of long-term care facilities
____other hospitals: specify

d. If research is conducted through community agencies written documentation of approval/cooperation from such an agency (school, etc.) should accompany this application.
N/A

e. Describe how subjects will be identified or recruited. Attach recruitment information, i.e., advertisement, bulletin board notices, recruitment letters, etc.
A list of long-term care facilities has been taken from the Medicare www.medicare.gov website and have been placed in alphabetical order based on facility name. Surveys will be sent to all facilities that are surveyed by the Minnesota Department of Health. This will exclude facilities that do not accept the Medicare or Medicaid payments from the state.

222If subjects are chosen from records, indicate who gave approval for use of the records. If records and private medical or student records, provide the protocol for securing consent of the subjects of the records and approval from the custodian of the records.
The information obtained from the Medicare www.medicare.gov website is public knowledge

222Who will make the initial contact with subjects? Describe how contact is made. Contact will be made through a letter of introduction to be included with the survey sent for completion.

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The researcher will send out a letter of introduction. See appendix A and B for information regarding this letter and demographics material appendix I and J.

h. Will subjects receive inducements before, or rewards after the study? (Include this information in your consent documents.)
No

222If subjects are school children and class time is used to collect data, describe in detail the activity planned for non-participant. Who will supervise those children? (This information must be included in the consent form.)
N/A

222Confidentiality of Data
222Describe provisions made to maintain confidentiality of data. Who will have access to data?
Appendix G and H are consent forms with confidentially of data noted.

Only this researcher will have access to the data. There will be no identifying marks on the information and self addressed stamped envelopes will be included in the mailing for return to a correct address.

222Where will data be stored and for how long? If tape recordings are created, explain who will have access and how long the tapes will be retained.
Data will be stored at the location of this researcher in a three ring binder until such time it can be destroyed.

All documents relating to ethical treatment of human subjects which will be used in the course of the research must be attached to this form. These documents include consent forms, cover letters and other relevant material.

The signatures below certify that:

- The information provided in this application form is correct
- The learner (researcher) will seek and obtain prior written approval from the Committee for any substantive modification in the proposal.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to the Committee and to the subjects.
- The research may not be initiated until final written approval is granted.

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This research, once approved, is subject to continuing review and approval by the Committee. The learner (researcher) will maintain records of this research according to Committee guidelines.

If these conditions are not met, approval of this research could be suspended.

Signature of Learner: Dawn Chiabotti Date: September 18, 2005

As Mentor and Chair of the committee, I assume responsibility for ensuring that the learner complies with University and federal regulations regarding the use of Human Subjects in research

Signature of Faculty Mentor (Chair)__________________________Date______

Completed forms and attachments should be mailed to: Office of the Executive Director/Chair of the Human Subjects Committee at Capella University
222 South 9th Street, 20th Floor
Minneapolis, MN 55402

As Executive Director, or designee, I acknowledge that this research is in keeping with the standards set by the university and assure that the researcher has met all requirements for review and approval of this research.

Signature of Executive Director: ________________________ Date____________

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Supervisor guidelines. Substantive change requires submitting an addendum to a previously approved application. An addendum is a totally new application form with attachments. The cover letter with the addendum describes the changes that were made from the originally approved application.

If these conditions are not met, approval of this research could be suspended.

Signature of the Researcher:

Dawn Chiabotti ____________ Date: September 18, 2005, 2005 ________

As a Supervisor (e.g., Mentor, Instructor, Practicum Supervisor, Internship Supervisor, Staff Supervisor) you certify that:

- The information provided in this application form is correct and complete.
- You will review and provide prior written approval to your Supervisee for any substantive modification in the proposal. You will inform the committee members appointed to oversee the research and its results.
- You will receive reports from your Supervisee about any unexpected or otherwise significant adverse events in the course of this study. You will
- inform the committee members appointed to oversee the research and its results.
- You will review research records maintained by your Supervisee until the final written document is produced and approved by you and the oversight committee.
- You will inform the oversight committee about the progress of your Supervisee from the time of developing research questions, through the proposal, IRB application, collection of data, writing results, and completing the documentation of the research.
- You will contact the Lead Subject Matter Expert (e.g., Chair of the Specialization, Faculty Director) if additional review is needed.
- You will make sure that this application has been completed by your Supervisee including all accompanying attachments before signing your name for approval.
- You assume responsibility for ensuring that the research complies with University regulations regarding the use of human participants/subjects in research.

If these conditions are not met, approval of this research could be suspended.

Signature of the Supervisor:

Name ____ Date___________

Title ____

Signature of Provost or Designee

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N/A

5. Confidentiality of Data
a. Describe provisions made to maintain confidentiality of data. Who will have access to data?
Appendix G and H are consent forms with confidentially of data noted.

Only this researcher will have access to the data. There will be no identifying marks on the information and self addressed stamped envelopes will be included in the mailing for return to a correct address.

b. Where will data be stored and for how long? If tape recordings are created, explain who will have access and how long the tapes will be retained.
Data will be stored at the location of this researcher in a three ring binder until such time it can be destroyed.

All documents relating to ethical treatment of human subjects which will be used in the course of the research must be attached to this form. These documents include consent forms, cover letters and other relevant material.

The signatures below certify that:

- The information provided in this application form is correct
- The learner (researcher) will seek and obtain prior written approval from the Committee for any substantive modification in the proposal.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to the Committee and to the subjects.
- The research may not be initiated until final written approval is granted.

This research, once approved, is subject to continuing review and approval by the Committee. The learner (researcher) will maintain records of this research according to Committee guidelines.

If these conditions are not met, approval of this research could be suspended.

Signature of Learner: Dawn Chiabotti Date September 18, 2005

As Mentor and Chair of the committee, I assume responsibility for ensuring that the learner complies with University and federal regulations regarding the use of Human Subjects in research

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Appendix N

CITI COMPLETION RECORD

Saturday, May 14, 2005

CITI Course Completion Record for Dawn Chiabotti

To whom it may concern:

On *5/14/2005*, *Dawn Chiabotti* (username = dchiabotti; Employee Number =) completed all *CITI Program* requirements for the *Basic CITI* Course in The Protection of Human Research Subjects.

Learner Institution: *Capella University*

Learner Group: *Group 3.*

Learner Group Description: *Learners from the School of Business*

Contact Information:

Gender: Female

Department: Business

Which course do you plan to take?: Social & Behavioral Investigator Course Only

Role in human subjects research: Administrator

May we re-contact you to complete a course survey?: No

Mailing Address:

515 Minnesota Ave W

Gilbert

MN

55741

USA

Email: dchiabotti@mchsi.com

Office Phone: 218-744-9807

Home Phone: 218-741-9219

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The Required Modules for *Group 3.* are:	**Date completed**
Introduction	05/14/05
History and Ethical Principles - SBR	05/14/05
Defining Research with Human Subjects - SBR	05/14/05
The Regulations and The Social and Behavioral Sciences - SBR	05/14/05
Assessing Risk in Social and Behavioral Sciences - SBR	05/14/05
Informed Consent - SBR	05/14/05
Privacy and Confidentiality - SBR	05/14/05
CAPELLA UNIVERSITY	05/14/05
Additional optional modules completed:	**Date completed**

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

CR# 110491

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Appendix O

SURVEY DEMOGRAPHICS

Table O1. ADM Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Caucasian	83	97.6	98.8	98.8
	African-American	1	1.2	1.2	100.0
	Total	84	98.8	100.0	
Missing	System	1	1.2		
Total		85	100.0		

Table O2. ADM Facility Ownership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Private	32	37.6	38.1	38.1
	Chain	32	37.6	38.1	76.2
	Other	20	23.5	23.8	100.0
	Total	84	98.8	100.0	
Missing	System	1	1.2		
Total		85	100.0		

Table O3. ADM Facility Profit/Non

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not for profit	66	77.6	77.6	77.6
	For profit	19	22.4	22.4	100.0
	Total	85	100.0	100.0	

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Table O4. ADM Degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Associates	2	2.4	2.4	2.4
	Bachelors	52	61.2	61.2	63.5
	Masters	29	34.1	34.1	97.6
	Doctorate	2	2.4	2.4	100.0
	Total	85	100.0	100.0	

Table O5. ADM Licensed Other State?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	False	75	88.2	88.2	88.2
	True	10	11.8	11.8	100.0
	Total	85	100.0	100.0	

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Appendix P

LEAD

Self

Leadership Style/Perception of Self

Developed by Center for Leadership Studies, Inc.

Your Name ______________________________

Purpose

This instrument is used to evaluate the leadership behaviors you use when you are engaged in attempts to influence the actions and attitudes of others.

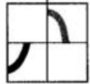
The information gathered with the ***LEAD*** *Self* provides insight into your current strengths--and areas for your leadership skill development. It supplies information about which leadership behaviors you use and the extent to which you match those behaviors to the needs of others.

Instructions - Using the Instrument

- Assume you are involved in each of the following twelve situations. Each situation has four alternative actions you might initiate.
- Read each item carefully.
- Think about what you *would* do in each circumstance.
- Circle the letter of the alternative action choice you think most closely describes what behavior you would use in the situation presented.
- Circle only *one* choice.
- Circle a choice for *each* of the twelve situations. Don't skip any.
- Move through the items quickly and stick with the first choice you make on each item. Your first choice tends to be the most accurate one.

Reminder: Circle what you think you *would* do, not what you *should* do. The goal is to evaluate what behaviors you *actually use*--not to get *right answers.* If there is no alternative action that describes what you would do in the situation, circle the item that *most closely* resembles what you would do.

Leadership **E**ffectiveness & **A**daptability **D**escription



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1. SITUATION
Your followers are not responding lately to your friendly conversation and obvious concern for their welfare. Their performance is declining rapidly.

ALTERNATIVE ACTIONS
You would ...
A. Emphasize the use of uniform procedures and the necessity for task accomplishment.
B. Make yourself available for discussion but not push your involvement.
C. Talk with followers and then set goals.
D. Intentionally not intervene.

2. SITUATION
The observable performance of your group is increasing. You have been making sure that all members were aware of their responsibilities and expected standards of performance.

ALTERNATIVE ACTIONS
You would ...
A. Engage in friendly interaction, but continue to make sure that all members are aware of their responsibilities and expected standards of performance.
B. Take no definite action.
C. Do what you can to make the group feel important and involved.
D. Emphasize the importance of deadlines and tasks.

3. SITUATION
Members of your group are struggling to solve a problem. You have normally left them alone. Group performance and interpersonal relations have been good.

ALTERNATIVE ACTIONS
You would ...
A. Work with the group and together engage in problem solving.
B. Let the group work it out.
C. Act quickly and firmly to correct and redirect.
D. Encourage the group to work on the problem and be supportive of their efforts.

4. SITUATION
You are considering a change. Your followers have a fine record of accomplishment. They respect the need for change.

ALTERNATIVE ACTIONS
You would ...
A. Allow group involvement in developing the change, but not be too directive.
B. Announce changes and then implement with close supervision.
C. Allow the group to formulate its own direction.
D. Incorporate group recommendations, but direct the change yourself.

5. SITUATION
The performance of your group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles and responsibilities has helped in the past. They have continually needed reminding to have their task done on time.

ALTERNATIVE ACTIONS
You would ...
A. Allow the group to formulate its own direction.
B. Incorporate group recommendations, but see that objectives are met.
C. Redefine roles and responsibilities and supervise carefully.
D. Allow group involvement in determining roles and responsibilities, but not be too directive.

6. SITUATION
You stepped into an efficiently run organization. The previous administrator tightly controlled the situation. You want to maintain a productive situation, but would like to begin humanizing the environment.

ALTERNATIVE ACTIONS
You would ...
A. Do what you can to make the group feel important and involved.
B. Emphasize the importance of deadlines and tasks.
C. Intentionally not intervene.
D. Get the group involved in decision making, but see that objectives are met.

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7. SITUATION
You are considering changing to a structure that will be new to your group. Members of the group have made suggestions about needed change. The group has been productive and demonstrated flexibility in its operations.

ALTERNATIVE ACTIONS
You would ...
A. Define the change and supervise carefully.
B. Participate with the group in developing the change, but allow members to organize the implementation.
C. Be willing to make changes as recommended, but maintain control of implementation.
D. Avoid confrontation; leave things alone.

8. SITUATION
Group performance and interpersonal relations are good. You feel somewhat insecure about your lack of direction of the group.

ALTERNATIVE ACTIONS
You would ...
A. Leave the group alone.
B. Discuss the situation with the group and then initiate necessary changes.
C. Take steps to direct followers toward working in a well-defined manner.
D. Be supportive in discussing the situation with the group, but not too directive.

9. SITUATION
Your boss has appointed you to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goals. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially, they have the talent necessary to help.

ALTERNATIVE ACTIONS
You would ...
A. Let the group work out its problems.
B. Incorporate group recommendations, but see that objectives are met.
C. Redefine goals and supervise carefully.
D. Allow group involvement in setting goals, but not push.

10. SITUATION
Your followers, usually able to take responsibility, are not responding to your recent redefining of standards.

ALTERNATIVE ACTIONS
You would ...
A. Allow group involvement in redefining standards, but not take control.
B. Redefine standards and supervise carefully.
C. Avoid confrontation by not applying pressure; leave the situation alone.
D. Incorporate group recommendations, but see that new standards are met.

11. SITUATION
You have been promoted to a new position. The previous supervisor was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.

ALTERNATIVE ACTIONS
You would ...
A. Take steps to direct followers working in a well-defined manner.
B. Involve followers in decision making and reinforce good contributions.
C. Discuss past performance with the group and then examine the need for new practices.
D. Continue to leave the group alone.

12. SITUATION
Recent information indicates some internal difficulties among followers. The group has a remarkable record of accomplishment. Members have effectively maintained long-range goals. They have worked in harmony for the past year. All are well qualified for the task.

ALTERNATIVE ACTIONS
You would ...
A. Try out your solution with followers and examine the need for new practices.
B. Allow group members to work it out themselves.
C. Act quickly and firmly to correct and redirect.
D. Participate in discussion of problem while providing support for followers.

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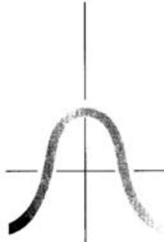

LEAD

Other

Leadership Style/Perception of Other

Developed by Center for Leadership Studies, Inc.

Purpose

This instrument is used to profile the leadership behaviors of the person named below.

The information gathered with the ***LEAD*** *Other* provides insight into your perception of their attempts to influence. It supplies information about which leadership behaviors they use and the extent to which they match those behaviors to the needs of others.

Instructions – Using the Instrument

- Assume ______________________ is involved in each of the following twelve situations. Each situation has four alternative actions that person might initiate.
- Read each item carefully.
- Think about what you believe this person *would* do in each circumstance.
- Circle the letter of the alternative action choice you think most closely describes what behavior this person would use in the situation presented.
- Circle only *one* choice.
- Circle a choice for *each* of the twelve situations. Don't skip any.
- Move through the items quickly and stick with the first choice you make on each item. Your first choice tends to be the most accurate one.

Reminder: Circle what you think this person *would* do, not what you think they *should* do. The goal here is to evaluate what behaviors they *actually use* – not to get *right answers.* If there is no alternative action that describes what they would do in the situation, circle the item that *most closely* resembles what you think they would do.

You are this leader's (check one):

❑ Manager, (Boss)

❑ Associate, (Colleague)

❑ Team Member, (Follower)

After you have completed this form, return it to: ______________________

Leadership **E**ffectiveness & **A**daptability **D**escription

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1. SITUATION
Followers are not responding lately to this leader's friendly conversation and obvious concern for their welfare. Their performance is declining rapidly.

ALTERNATIVE ACTIONS
This leader would ...
A. Emphasize the use of uniform procedures and the necessity for task accomplishment.
B. Be available for discussion but would not push for involvement.
C. Talk with followers and then set goals.
D. Intentionally not intervene.

2. SITUATION
The observable performance of this leader's group is increasing. The leader has been making sure that all members were aware of their responsibilities and expected standards of performance.

ALTERNATIVE ACTIONS
This leader would ...
A. Engage in friendly interaction, but continue to make sure that all members are aware of their responsibilities and expected standards of performance.
B. Take no definite action.
C. Do what can be done to make the group feel important and involved.
D. Emphasize the importance of deadlines and tasks.

3. SITUATION
This leader's group is struggling to solve a problem. The leader has normally left them alone. Group performance and interpersonal relations have been good.

ALTERNATIVE ACTIONS
This leader would ...
A. Work with the group and together engage in problem solving.
B. Let the group work it out.
C. Act quickly and firmly to correct and redirect.
D. Encourage the group to work on the problem and be supportive of their efforts.

4. SITUATION
This leader is considering a change. The leader's followers have a fine record of accomplishment. They respect the need for change.

ALTERNATIVE ACTIONS
This leader would ...
A. Allow group involvement in developing the change, but not be too directive.
B. Announce changes and then implement with close supervision.
C. Allow the group to formulate its own direction.
D. Incorporate group recommendations, but direct the change.

5. SITUATION
The performance of this leader's group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles and responsibilities has helped in the past. They have continually needed reminding to have their task done on time.

ALTERNATIVE ACTIONS
This leader would ...
A. Allow the group to formulate its own direction.
B. Incorporate group recommendations, but see that objectives are met.
C. Redefine roles and responsibilities and supervise carefully.
D. Allow group involvement in determining roles and responsibilities, but not be too directive.

6. SITUATION
This leader stepped into an efficiently run organization. The previous administrator tightly controlled the situation. The leader wants to maintain a productive situation, but would like to begin humanizing the environment.

ALTERNATIVE ACTIONS
This leader would ...
A. Do what could be done to make the group feel important and involved.
B. Emphasize the importance of deadlines and tasks.
C. Intentionally not intervene.
D. Get the group involved in decision making, but see that objectives are met.

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7. SITUATION
This leader is considering changing to a structure that will be new to the group. Members of the group have made suggestions about needed change. The group has been productive and demonstrated flexibility in its operations.

ALTERNATIVE ACTIONS
This leader would ...
A. Define the change and supervise carefully.
B. Participate with the group in developing the change, but allow members to organize the implementation.
C. Be willing to make changes as recommended, but maintain control of implementation.
D. Avoid confrontation; leave things alone.

8. SITUATION
Group performance and interpersonal relations are good. This leader feels somewhat insecure about not providing direction to the group.

ALTERNATIVE ACTIONS
This leader would ...
A. Leave the group alone.
B. Discuss the situation with the group and then initiate necessary changes.
C. Take steps to direct followers toward working in a well defined manner.
D. Be supportive in discussing the situation with the group, but not too directive.

9. SITUATION
This leader has been appointed to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goals. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially, they have the talent necessary to help.

ALTERNATIVE ACTIONS
This leader would ...
A. Let the group work out its problems.
B. Incorporate group recommendations, but see that objectives are met.
C. Redefine goals and supervise carefully.
D. Allow group involvement in setting goals, but not push.

10. SITUATION
Followers, usually able to take responsibility, are not responding to the leader's recent redefining of standards.

ALTERNATIVE ACTIONS
This leader would ...
A. Allow group involvement in redefining standards, but not take control.
B. Redefine standards and supervise carefully.
C. Avoid confrontation by not applying pressure; leave the situation alone.
D. Incorporate group recommendations, but see that new standards are met.

11. SITUATION
This leader has been promoted to a new position. The previous manager was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.

ALTERNATIVE ACTIONS
This leader would ...
A. Take steps to direct followers working in a well defined manner.
B. Involve followers in decision making and reinforce good contributions.
C. Discuss past performance with the group and then examine the need for new practices.
D. Continue to leave the group alone.

12. SITUATION
Recent information indicates some internal difficulties among followers. The group has a remarkable record of accomplishment. Members have effectively maintained long-range goals. They have worked in harmony for the past year. All are well qualified for the task.

ALTERNATIVE ACTIONS
This leader would ...
A. Try out solution with followers and examine the need for new practices.
B. Allow group members to work it out themselves.
C. Act quickly and firmly to correct and redirect.
D. Participate in problem discussion while providing support for followers.

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