

STAFF NURSE PERCEPTIONS OF NURSE MANAGER BEHAVIORS  
THAT INFLUENCE JOB SATISFACTION

Rebecca A. Feather

Submitted to the faculty of the University Graduate School  
in partial fulfillment of the requirements  
for the degree  
Doctor of Philosophy  
in the School of Nursing,  
Indiana University

May 2011

Accepted by the Faculty of Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

---

Patricia R. Ebright, PhD, RN, Chair

---

Tamilyn Bakas, PhD, RN

Doctoral Committee

---

Joanne R. Duffy, PhD, RN

April 26, 2011

---

Sharon L. Sims, PhD, RN

© 2011

Rebecca A. Feather

ALL RIGHTS RESERVED

## DEDICATION

I would like to dedicate this study to my family.

First, to my father-in-law, Arnold Feather, and my sister-in-law, Jill Feather, thank you for all of your support and for the many times you listened to me and offered words of encouragement, even during difficult personal times—especially for providing the support to Kurt during this time while I often was focused on writing and completing my degree.

Second, to my parents, Harold and Barbara Butcher, thank you for providing me with support in any way possible during this time by offering me words of encouragement and lending an ear the many times I needed to talk and share my feelings; also, for being there for my husband and children, even during your own challenging times with health issues and tremendous personal losses.

Next, thank you to my children, Austin and Cade, who endured this long process with me day in and day out as you watched me struggle, become frustrated, and then celebrate the meeting of each deadline with words of encouragement. This often occurred with a hug and a kiss, and then spending time together, to take a break to go out to eat or just watch a movie. Our time together often was limited and being young, you did not always understand why this endeavor was so important to me. My hope is that I have set an example for you of the importance of education and to never give up something that will be so rewarding in the end.

Last and most importantly, thank you to my husband, Kurt. You have been my ongoing inspiration, my cheerleader, and my ultimate support system while I have struggled through many long hours and days of research and writing. You have been my best friend when I needed someone to listen, my caretaker when I became very ill while

writing my dissertation, and a never ending shoulder for me to lean on when I needed the strength and encouragement to help me know I could accomplish such a great feat as this. We made it through this journey together, through all of the multiple challenges, including two parents suffering with cancer and ultimately the loss of one, your mother, Beverly Feather.

I truly cannot express the level of appreciation and love I feel for all of you! I am so happy to be able to share the celebration and joy we now all deserve, together as a family, as I did not earn this alone. You were all there with me!

## ACKNOWLEDGEMENTS

This dissertation would not have been achieved without the support of the following exceptional individuals. I want to express my heartfelt appreciation to the members of my dissertation committee: Dr. Patricia Ebright, Dr. Tamilyn Bakas, Dr. Joanne Duffy, and Dr. Sherry Sims. Each member provided unique knowledge and guidance to support my efforts in the success of this dissertation. I especially would like to thank Dr. Patricia Ebright, the chairperson of my committee, for her unending support as my academic advisor and her expertise with leadership and the nurse practice environment. Dr. Ebright was my champion as she guided me through each stage of my doctoral degree while providing a balance of support and autonomy. I am honored to work with her and value her as my mentor. A special thank you goes to Dr. Joanne Duffy for her valuable expertise and research in leadership and caring relationships with healthcare professionals as well as her continued guidance and support throughout the progression of this dissertation process. I am especially grateful to Dr. Sherry Sims, who guided me through the qualitative analysis research process with her invaluable knowledge of and expertise with qualitative inquiry. She broadened my knowledge in the area of utilizing the data from focus groups to enlighten and inform the profession of nursing. I am extremely grateful to Dr. Tamilyn Bakas for sharing her knowledge of and expertise with instrumentation and tool development. Her guidance in the pre-steps and beginning stages of new tool development were very valuable to me.

In addition, I would like to thank all of the registered nurses who took time out of their busy professional and personal lives to assist me with this study by participating in a focus group. These individuals were invaluable to me as they were open and honest in discussing their daily work lives as well as their perceptions of nurse manager behaviors

that influence their job satisfaction. Their willingness to share and discuss this information is greatly appreciated.

## ABSTRACT

Rebecca A. Feather

### STAFF NURSE PERCEPTIONS OF NURSE MANAGER BEHAVIORS THAT INFLUENCE JOB SATISFACTION

The Bureau of Labor Statistics projected a shortage of registered nurses (RNs) growing to an estimated 581,500 by the year 2025 (an increase of 22 percent since 2008). Recent economical downturns have found many healthcare organizations experiencing a positive effect with the stabilization of nursing turnover. Once the economy begins to recover, however, experts predict the profession of nursing will still face the largest shortage in history according to projections by the American Nurses Association. Because lack of job satisfaction is a precursor to resignation, additional research regarding the identification of interventions that increase RN job satisfaction may result in retaining professionally qualified and prepared staff. This study proposed to identify through focus groups, staff nurse perceptions of nurse manager behaviors that influence RN staff nurse job satisfaction. A sample of 28 RNs, each participating in one of five focus groups, answered questions related to satisfaction with nurse manager behaviors. The investigator used qualitative content analysis to identify patterns within and across focus group data.

Major findings of the study resulted in the identification of two conceptual categories (manager behaviors supportive of RNs and RN's perceived disconnect of work issues from the manager's role) and three major themes related to supportive behaviors



(communication, respect, and feeling cared for). The results suggest the following as staff nurse preferences for nurse manager behaviors: open and honest communication that involves listening, consistency, and confidentiality; an increased level of respect including fairness and recognition of a job well done; and the sense of feeling cared for as when a manager meets individual needs and supports staff as professionals. The investigator compared the categories and themes to previous tools used in healthcare, which indicate the need for further item and/or tool development as well as further research regarding RNs' perceived disconnect of work issues from the manager's role.

Patricia R. Ebright, PhD, RN, Chair

*If your actions inspire others to dream more, learn more, do more and become more, you are a leader.*

— John Quincy Adams

## TABLE OF CONTENTS

|   |    |
|---|----|
| Chapter One. Introduction .....                   | 1  |
| Purpose Statement.....                            | 5  |
| Specific Aims.....                                | 5  |
| Conceptual Definitions of Terms.....              | 7  |
| Procedures Used to Explore the Question .....     | 8  |
| Assumptions.....                                  | 9  |
| Summary .....                                     | 9  |
| Chapter Two. Literature Review.....               | 11 |
| Theoretical Model.....                            | 11 |
| Job Satisfaction .....                            | 13 |
| The Nurse Manager and Staff Job Satisfaction..... | 18 |
| Measurement Literature Review .....               | 23 |
| Article Inclusion.....                            | 24 |
| Analyses of Specific Instruments2.....            | 27 |
| Nursing management tool comments.....             | 27 |
| Change Production Employee tool .....             | 28 |
| EOM.....  | 28 |
| Immediate Supervisor Scale .....                  | 30 |
| MLQ.....  | 31 |
| NWI-R.....  | 32 |
| PES.....  | 33 |
| CAT-admin .....                                   | 34 |

|                                      |    |
|--------------------------------------|----|
| Job satisfaction tool comments ..... | 35 |
| IWS .....                            | 35 |
| JDI.....                             | 36 |
| MMSS .....                           | 37 |
| MSQ.....                             | 37 |
| Specific Satisfaction Scale.....     | 38 |
| WQI.....                             | 39 |
| Summary .....                        | 40 |
| Chapter Three. Methodology .....     | 45 |
| Design .....                         | 45 |
| Human Subjects Approval .....        | 46 |
| Participants.....                    | 47 |
| Data Collection .....                | 50 |
| Procedures.....                      | 50 |
| Focus Groups .....                   | 50 |
| Data Analysis.....                   | 54 |
| Qualitative Data Validation .....    | 55 |
| Limitations .....                    | 57 |
| Summary .....                        | 58 |
| Chapter Four. Results.....           | 59 |
| Demographic Data .....               | 60 |
| Focus Group Recruitment .....        | 63 |
| Individual Focus Groups.....         | 65 |

|   |     |
|---|-----|
| Group One.....  | 66  |
| Group Two .....   | 67  |
| Group Three .....   | 67  |
| Group Four.....   | 68  |
| Group Five .....  | 68  |
| Qualitative Content Analysis.....                                     | 68  |
| Specific Aims.....  | 68  |
| Manager Behaviors Supportive of RNs-Present or Absent .....           | 69  |
| Communication.....  | 69  |
| Respect.....  | 76  |
| Feeling cared for .....   | 80  |
| RN’s Perceived Disconnect of Work Issues from the Manager’s Role..... | 85  |
| The PES .....   | 89  |
| The MLQ .....   | 90  |
| The NMSS .....  | 90  |
| Communication theme.....  | 91  |
| Respect theme .....   | 93  |
| Feeling cared for theme .....   | 94  |
| Summary .....   | 99  |
| Chapter Five. Discussion and Conclusion .....                         | 102 |
| Conceptual Categories .....   | 102 |
| Manager Behaviors Supportive of RNs-Present or Absent .....           | 102 |
| RN’s Perceived Disconnect of Work Issues from the Manager’s Role..... | 103 |

|   |     |
|---|-----|
| Specific Aim .....  | 105 |
| Recommendations.....  | 106 |
| Study Limitations.....  | 108 |
| Suggestions for Further Research .....                                    | 108 |
| Summary .....   | 109 |
| Appendix A. Focus group interview questions.....                          | 111 |
| Appendix B. Revised Nursing Worklife Model .....                          | 112 |
| Appendix C. Management Behavior Instruments from Literature Review .....  | 113 |
| Appendix D. Job Satisfaction Instruments from Literature Review.....      | 116 |
| Appendix E. IRB and Institutional Approvals.....                          | 119 |
| Appendix F. Staff Nurse Focus Group Demographic Questionnaire .....       | 122 |
| Appendix G. Informed Consent.....   | 124 |
| Appendix H. Facility E-mail Announcement and Invitation .....             | 127 |
| Appendix I. Flyer .....   | 128 |
| Appendix J. Focus Group Themes.....                                       | 129 |
| Appendix K. Presence of Data in the PES, MLQ, NMSS, CAT-ADMIN TOOLS ..... | 130 |
| Appendix L. Comparison of Data to the NMSS and CAT-Admin.....             | 131 |
| References.....   | 133 |
| Curriculum Vitae  |     |

## LIST OF TABLES

|   |    |
|---|----|
| Table 1. Demographic Frequency and Percentage Distributions .....         | 60 |
| Table 2. Work Shift Frequency and Percentage Distributions .....          | 61 |
| Table 3. Unit Frequency and Percentage Distributions .....                | 62 |
| Table 4. Employment Duration Frequency and Percentage Distributions ..... | 63 |
| Table 5. Qualitative Data Analysis of Transcripts: Identified Codes ..... | 69 |

## ABBREVIATIONS

| Abbreviation | Term  |
|--------------|---|
| ANA          | American Nurses Association   |
| CAT          | Caring Assessment Tool  |
| EOM          | Essentials of Magnetism   |
| IWS          | Index of Work Satisfaction  |
| IRB          | Institutional Review Board  |
| JDI          | Job Description Index   |
| MMSS         | McCloskey/Mueller Satisfaction Scale  |
| MSQ          | Minnesota Satisfaction Questionnaire Short Form Specific Satisfaction Scale |
| MLQ          | Multi-Factor Leadership Questionnaire                                       |
| NDNQI        | National Database of Nursing Quality Indicators                             |
| NMSS         | Nurse Manager Support Scale   |
| NWI          | Nursing Work Index  |
| PES          | Practice Environment Scale  |
| RN           | Registered Nurse  |
| RNWM         | Revised Nursing Worklife Model  |
| WQI          | Work Quality Index  |



## CHAPTER ONE. INTRODUCTION

The profession of registered nurses (RNs) is the largest healthcare occupation, with 2.6 million jobs, and the United States (U.S.) Department of Labor, Bureau of Labor Statistics (2008) projects it to be an occupation with one of the largest expected job growths by the year 2012 (2008). The American Nurses Association (ANA) reports total job openings, which include job growth and net replacement of nurses, will be more than 1.1 million (2007). In addition, the U.S. Department of Labor (2010) projects a growing need for RNs approaching the year 2018, with an estimated shortage of 581,500 nurses (an increase of 22 percent since 2008).

Many healthcare organizations have experienced a positive effect through the recent economic downturns with the stabilization of nursing turnover. Many nurses have chosen to stay in their current positions or to increase the hours worked per pay period as a result of the loss of a job by a spouse or significant other (Buerhaus, 2008). Nonetheless, the previously stated projections predict that a long-term nursing shortage will persist, and the economic downturn threatens to exacerbate the possibility of the shortage in the coming years. The current recession in the U.S. may be creating a false impression that the shortage is over, generating complacency in the healthcare industry and prompting aspiring nurses to think twice before enrolling in nursing schools (Rother & Lavizzo-Mourey, 2009).

Even after economic recovery begins, ANA experts predict the profession of nursing still will face the largest shortage in history (2007). Past estimates indicated 116,000 unfilled RN positions in hospitals in the U.S. (Dunham, 2009). As a result of the instability of the healthcare environment, providers are concerned the past nursing

shortage will return. A study conducted by Buerhaus, Auerbach, and Staiger (2009) suggested that there is a “need to strengthen the current workforce before the recession lifts and imbalances in the supply and demand for RNs reappears” (p. 658). Kleinman (2004b) reported the Advisory Board Report by the New Jersey State Nurses Association in 2002 indicated that, based on costs associated with replacing a resigning nurse, an \$800,000 savings could be realized by reducing the turnover rate from 13 percent to 10 percent.

The ANA recognized that supply solutions for the nursing workforce must focus on both recruitment and retention of RNs (ANA, 2008). Because current research shows that job satisfaction may influence the retention of RN staff in light of the predicted shortage over the next 10 to 15 years, it is important to focus on the job satisfaction of those nurses currently working as well as those who are newly hired. According to a study by Aiken, Clarke, Sloane et al. (2001), more than 40 percent of hospital nurses reported lack of satisfaction with their jobs. Many factors may influence the job satisfaction of staff nurses, including physicians, peers, patients, tasks, surroundings, equipment, increased paperwork, and relationships. Decreased job satisfaction may occur with poor results in any one or all of these factors (Manojlovich & Laschinger, 2007). Nurses may find it difficult to be satisfied with their jobs not only in relation to patient care but in their relationships with the individuals who impact their jobs. Nursing literature reports a lack of consensus over the meaning of job satisfaction as it applies to nursing (Zangaro & Soeken, 2005). Examples in the literature define job satisfaction as the degree of positive affective orientation toward employment (Price & Mueller, 1986) or as the degree of positive affect toward a job or its components (Adams & Bond, 2000).

Regarding RN retention, the Institute of Medicine report (2004) recommended that in order for healthcare organizations to recruit and retain RNs in times of short supply, senior leaders must strengthen the nursing leadership within healthcare organizations and maintain qualified and effective nursing leaders. Managers as leaders may help their employees feel connected and competent at work (Huseman, 2009), therefore improving job satisfaction. Research cites the nurse manager's leadership behavior as the interaction most likely to improve retention of hospital staff nurses as a result of the manager's ability to improve job satisfaction (Andrews & Dziegielewski, 2005). A specific factor affecting job satisfaction involves the relationship between the nurse manager and the nursing staff. Nursing and human resource studies identify this relationship as invaluable to nurse job satisfaction. Researchers have reported that nurse managers provide a vital role in creating the type of work environment nurses work in daily and, therefore, have an effect on the retention of RNs (Shirey, Ebright, & McDaniel, 2008). Ultimately, the nurse manager is responsible for many factors involving the quality of the working environment of the staff. Therefore, managers have the power to make the changes that will improve the environment if they are made aware of what needs to be changed or addressed.

A study by McNeese-Smith (1997) reported that managers who use leadership behaviors in guiding their hospital departments have employees who report significantly higher levels of job satisfaction, productivity, and organizational commitment than those who do not. These behaviors included providing a vision for the unit, being growth oriented, empowering the staff, and helping the staff to believe they can *do it on their own* (McNeese-Smith, 1997). Staff also stated that managers influence job satisfaction

through behaviors of providing recognition and appreciation, meeting personal needs, helping or guiding the nurse, using leadership skills effectively, meeting unit needs, and supporting the team (Aiken et al., 2001). Herrin and Spears (2007) found a supportive environment to be one of the most important factors associated with job satisfaction for nurses, and nurse managers are important in structuring the type of environment critical to the satisfaction and retention of staff nurses (Force, 2005; Kramer et al., 2007).

Yet, a survey of 39 leading hospitals resulted in 100 percent of the participants reporting that the nurse manager was often the main factor when an employee decided to leave an organization, with lack of support by the immediate manager as the most cited reason for leaving (Taunton, Boyle, Woods, Hansen, & Bott, 1997). More recently, and consistent with Huseman's (2009) observation of the importance of nurse manager behaviors, many times in exit interviews staff nurses reported nurse manager behaviors as that which most influenced their decision to leave their positions (Kramer et al., 2007; Shobbrook & Fenton, 2002). While other researchers have studied the practice environment, the focus on nurse manager behaviors still is minimized as a direct component of job satisfaction for staff. Therefore, identification of nurse manager behaviors that influence RN staff job satisfaction is important for providing a clear measurement of those behaviors that will retain RN staff and decrease the need for new hires.

Research studies are limited that determine the relationship between nurse manager behaviors and RN staff job satisfaction based upon the perceptions of the individual nursing staff. Many research studies on job satisfaction include nurse managers and leadership as a minimal aspect through one or two questions or a small

subscale of the survey, lacking a main focus on the behavior of the nurse manager as a major predictor of job satisfaction for staff nurses. Because nurses indicate the behavior of the manager as one of many negative factors in their decision to leave, it is important to learn about manager behaviors that influence job satisfaction.

Throughout nursing research, job satisfaction is measured without an adequate definition based on the perceptions of the staff nurse. Job satisfaction may be interpreted in different ways by employees in all different fields of work. But, how does an RN define job satisfaction in relation to specific behaviors of the nurse manager? Are the perceptions of an RN different from those previously developed by researchers and managers? Some researchers have theorized about specific work factors relevant to job satisfaction, but no *gold standard* exists that indicates which job aspects should be taken into account when measuring job satisfaction (Saane, Sluiter, Verbeek, & Frings-Dresen, 2003).

### **Purpose Statement**

The purpose of this study was to describe RN perceptions of nurse manager behaviors that most influence RN staff nurse job satisfaction. The study used focus groups of RN staff participants to identify themes in relation to nurse manager behaviors that influence staff nurse job satisfaction. The investigator compared themes that emerged from the focus groups with themes and items of previous tools to measure whether development of a new tool was necessary.

### **Specific Aims**

The overall aim of this research was the discovery of relevant data to establish the need for development and testing of a new tool to measure current staff nurse perceptions

of nurse manager behaviors that influence job satisfaction. The researcher collected data from RN staff through focus groups.

The major question that guided specific focus group interviews and discussion was: What behaviors of nurse managers influence staff nurse job satisfaction?

These were the specific aims for this study:

1. Identify staff nurse perceptions of nurse manager behaviors that influence job satisfaction.
2. Compare data obtained from focus groups with the existing tools including the Practice Environment Scale (PES), the Transformational Leadership Survey from the Multi-Factor Leadership Questionnaire (MLQ), and the Nurse Manager Support Scale (NMSS)—a subscale of the Essentials of Magnetism (EOM) tool. The researcher located an additional instrument, the Caring Assessment Tool (CAT)-admin, after the initial literature search and review; the researcher also discussed it as part of the comparison.
3. Determine whether there is a need for item and instrument development to measure the current perceptions of staff nurses of nurse manager behaviors that influence their job satisfaction.

The conceptual definition of nurse manager behaviors that influence staff nurse job satisfaction is: Observable actions, activities, level of conduct, or job performance by the first line direct report supervisor that are perceived by staff RNs that influence their satisfaction with their jobs.

## Conceptual Definitions of Terms

*RN Staff Nurse.* This study defined an *RN staff nurse* as an RN on an assigned hospital unit with a minimum of six months' experience in patient care who is responsible for the care of the patients admitted to that unit. The RN must be employed under her/his current nurse manager for a minimum of six months.

*Staff Nurse Perceptions.* This research study defined *perception* as the process of using the senses to acquire information about the surrounding environment or situation; therefore, a *staff nurse's perception* is the RN's use of his/her senses to acquire information about how a nurse manager behaves in the present surrounding environment that directly or indirectly influences the staff nurse job satisfaction.

*Nurse Manager.* The study defined a *nurse manager* as a middle manager who has 24-hour responsibility for one or more hospital or clinic units, regardless of the title assigned to that position. This position includes direct supervision of charge and staff nurses on all shifts and accountability for those positions.

*Nurse Manager Behaviors.* Nurse manager is defined above; this study defines *behavior* as the way in which an individual behaves or acts in a particular way that expresses general character, state of mind, or response to a situation and the level of conduct or job performance in the day-to-day operations of the job.

*Job Satisfaction.* Job satisfaction is the degree of positive affective orientation toward employment (Price & Mueller, 1986) or as the degree of positive affect toward a job or its components (Adams & Bond, 2000) or as the difference between the amount of reward received and the amount the employee believes he/she should receive (Ma, Samuels, & Alexander, 2003). This study defines *job satisfaction* of the nurse as the staff

nurse level of contribution of cognitive and affective reactions of what the employee wants to receive compared to what is actually received in relation to a nurse manager's behavior while an individual is employed as a RN.

### **Procedures Used to Explore the Question**

This study used the procedure or method of focus groups. Focus groups explored issues and generated information. In this study, focus groups identified nurse manager behaviors that influence job satisfaction as perceived by staff nurses.

The focus groups were composed of RN staff nurses who currently work on units of community-based hospitals. These RNs met the inclusion criteria set forth in the methods chapter. The researcher asked the participants of the focus groups to respond to a series of questions regarding nurse manager behaviors that positively or negatively affect the participants' job satisfaction. Appendix A provides the focus group interview questions. As the focus groups answered questions and discussion occurred, the researcher audio taped the responses of the nurses then transcribed the responses by hand. The investigator completed analysis of data including identification of themes and definitions across focus groups that led to a comparison of the findings with current tools. The tools included the PES, the MLQ Transformational Leadership Survey, and the NMSS. The investigator chose these tools because of the strong representation and usage of the tools in the literature review; the research committee agreed upon these tools. The researcher completed the comparison of the data with current tools to determine if additional themes and concerns raised by participants of the focus groups occurred as a result of the discussions. The investigator's decision to use focus groups to collect the data was a major disadvantage of using an existing scale in that the data would have been



limited to only the ideas and items that the developers chose to place in their instrument (Spector, 1997), thus limiting the collection of new data and ideas related to current levels of job satisfaction of RNs. Most existing scales address generalized statements and not behaviors specific to areas of leadership behaviors related to satisfaction or dissatisfaction that are issues for staff nurses and nurse managers of a particular organization.

### **Assumptions**

The researcher of this study assumed that nurses would openly discuss their perceptions about job satisfaction in their current work environments. The investigator further assumed that nurses who participate in the focus group discussions would respond and answer questions honestly about the behaviors of their nurse managers.

### **Summary**

There is a gap in research related to RN perceptions of nurse manager behaviors that influence RN staff job satisfaction. Job satisfaction has been identified as an important factor in RN retention, but tools currently available to measure the effect of nurse manager behaviors on RN staff job satisfaction may not provide valid measures of the influence of nurse manager behaviors that are particularly relevant and supportive, given the increasing complexity of the practice environments in which RNs currently work.

Retention of a qualified and adequate workforce is a key component to healthcare organizations but is not always recognized when existing conditions of a tight labor market lessens the threat of turnover. However, increased job satisfaction could function as a buffer against conditions favoring high turnover because a small but significant

relationship exists between a low level of job satisfaction and turnover (Irvine & Evans, 1995; Lance, 1991).

It is important for organizations and nursing leaders to focus on how to increase staff nurse job satisfaction in order to retain an experienced workforce of RNs who may not be satisfied with their jobs, which may result in retirement or in leaving nursing once the economy begins to recover (Riley, Rolband, James, & Norton, 2009). It is because lack of job satisfaction is a precursor to resignation that additional research on nurse job satisfaction is vital in retaining professionally qualified and prepared staff. People who are happy with their jobs may be more inclined to work harder and perform better. There is strong evidence that people who perform better like their jobs better because of the rewards that often are associated with good job performance (Spector, 1997). Negative affect of organizations has tremendous effect on people who work in them. Negative feelings may lead to behaviors that are detrimental to nurses and to patient outcomes and potentially lead to adverse physical and psychological health of healthcare employees. Organizational practices that maximize job satisfaction likely will lead to employees who are more cooperative and willing to help the organization be successful (Spector, 1997).

## CHAPTER TWO. LITERATURE REVIEW

Low job satisfaction can be a precursor to resignation. Research regarding the identification of management behaviors that increase RN job satisfaction may result in findings that can be used to retain professionally qualified and prepared staff; therefore, it is important to identify the behaviors of nurse managers that will produce the outcome of high levels of RN job satisfaction. Currently an instrument does not exist which measures staff nurse perceptions of nurse manager behaviors that impact their job satisfaction in a hospital setting.

This chapter provides a review of the literature and tools used in the past to measure staff nurse job satisfaction and nurse management behaviors. The author presents literature that discusses how perceptions of nursing staff may differ from those of managers and administrators regarding behaviors which most influence nurses' job satisfaction. The chapter ends with a discussion of previously used tools and the need for new data to assess the need for a new measurement tool based on staff nurses' perceptions of the behaviors of nurse managers that influence job satisfaction.

### **Theoretical Model**

The revised nursing worklife model (Appendix B), hereafter referred to as the RNWM, serves as the theoretical framework that supports the need for this study because it examines the relationships of multiple variables including the link between nursing leadership and staff nurse job satisfaction. Researchers developed the original nursing worklife model to explain how organizational and nursing unit influences affect nurses' lives in the workplace (Laschinger & Leiter, 2006; Leiter & Laschinger, 2006). The RNWM model provides a guide to those interested in shaping a professional practice

environment in the hospital to enhance the quality of work for nurses (Manojlovich & Laschinger, 2007). Leadership is conceptualized as one of several factors in the revised model as the driving force that strongly influences other aspects of the work environment, including job satisfaction, and provides the basis for care on the unit (Lake, 2002).

A study conducted by Manojlovich and Laschinger (2007) tested a modification of Laschinger and Leiter's (2006) nursing worklife model. The original nursing worklife model is based on five domains of the hospital practice environment associated with nurses' perceptions of professional practice environments (Lake, 2002). The model helps to explain how organizational and nursing unit factors influence and affect the life of a staff nurse in the workplace. The domains of the original model included strong leadership as a linkage to adequate staffing and resources, collegial relations, and participation in hospital affairs; however, the domain of job satisfaction was not a part of the model (Laschinger & Leiter, 2006).

Modification of the nursing worklife model tested two possible extensions. First, the study investigated whether the nursing worklife model could be extended to explain the nursing outcome of job satisfaction by investigating the impact of structural empowerment on the professional work environment (Manojlovich & Laschinger, 2007). The study resulted in the RNWM (Manojlovich & Laschinger, 2007) indicating that nursing leadership was found to be the driving force of the model, strongly influencing the other professional practice environment factors. Nursing leadership influenced the degree of work engagement and job satisfaction. The seven domains of the revised model include: (a) Policy impact–staff nurse participation in hospital affairs; (b) Nursing model–use of a nursing model as the basis for care on a nursing unit;

(c) Leadership–nurse manager ability, leadership, and support; (d) Staffing–staffing and resource adequacy; (e) Nurse/physician relationships–quality relations for collegial nurse-physician relations; (f) Empowerment–work effectiveness and self-efficacy; and (g) Job satisfaction–personal fulfillment or contentment with one’s work or employment. According to Manojlovich and Laschinger (2007), all paths specified were statistically significant and the model fit the data well [ $\chi^2 (6, N = 276) = 54.7, p < 0.01$ , NFI: 0.93, CFI: 0.37, RMSEA: 0.17]. The model explained 49 percent of the variance in job satisfaction ( $r^2 = 0.49$ ). It provides a guide to those interested in shaping a professional practice environment in the hospital to enhance the quality of work for nurses (Manojlovich & Laschinger, 2007).

The benefit of the study by Manojlovich and Laschinger (2007) is that astute nurse managers immediately can apply these research results to their practice. One variable that was identified through studies involving the RNWM was that of management and managers’ leadership behaviors. The configuration of the practice domains of the RNWM suggests that there are points at which empowered nursing leaders can intervene to improve nurses’ job satisfaction (Manojlovich & Laschinger, 2007). The revised model is a template that can be utilized by nurse managers because it demonstrates how the seven practice domains are related to each other in a systematic way.

### **Job Satisfaction**

The RNWM is a strong indicator that job satisfaction is a critical issue for RNs and hospital administrators. Job satisfaction plays an important role in the ability of

healthcare organizations to recruit and retain professional nurses (Allen & Vitale-Nolen, 2005).

In 1998, the ANA established the NDNQI in order to collect and build on data obtained from earlier studies and to further develop nursing's body of knowledge related to factors that influence the quality of nursing care (Montalvo, 2007). The ANA pilot-tested the RN Job Satisfaction Indicator in 2001 and subsequently implemented it in 2002. The RN Satisfaction Survey is an important indicator to assist nursing leaders and staff in evaluating the work environment so as to facilitate nursing retention and recruiting efforts. The PES, the Index of Work Satisfaction (IWS), and the Nursing Work Index (NWI) are the tools used in the Job Satisfaction Survey section (ANA, 2009).

The NDNQI studies have demonstrated the value of nursing care and the significance of nursing's contribution to positive patient outcomes. Data from the NDNQI now has the validity and reliability to be used to evaluate nursing care, improve patient outcomes, and identify the linkages between nurse staffing and patient outcomes at the unit level (Montalvo, 2007). The mission of the NDNQI is to aid the nurse in patient safety and quality improvement efforts by providing research-based, national, comparative data on nursing care and the relationship of this care to patient outcomes. The inclusion of RN satisfaction as an indicator in the NDNQI database shows a clear link to the importance of job satisfaction in the organizational work environment.

While the NDNQI includes a section that measures job satisfaction, that is not its main purpose; it focuses on the evaluation of the work environment as a whole and is not specific to staff nurse perceptions of nurse manager behaviors. Many organizations now utilize the NDNQI surveys to provide data that aids in the process to assist in

organizational decision making. Tools utilized in the NDNQI studies addressing RN job satisfaction were developed from past data obtained from Magnet<sup>®</sup> studies in the early 1990s. The investigator included strengths and weaknesses of the NDNQI tools in the Literature Review section of the current chapter. Researchers state that nurse job satisfaction still has not been measured rigorously in most hospitals since the onset of organizational restructuring efforts, despite numerous and conflicting comments from RNs and nursing managers about satisfaction and dissatisfaction with these effects (Best & Thurston, 2004). There is a need for new and current information on RN staff nurse job satisfaction in relation to nurse manager behaviors. The perceptions of the staff nurses in this study provided a foundation for the improvement of work environment through feedback focused on the influence of the nurse manager. The findings of a study by Shader, Broome, Broome, West, and Nash (2001) suggested that nurse managers should try *to get inside* the nurse's head. This can be accomplished by ensuring that front-line managers are listening to individual nurses and focusing on their perceptions of the issues rather than relying on the interpretation of the data by nurse executives, hospital administrators, or personnel in the human resource department (Shader et al.). Thus, the NDNQI data and organizational annual satisfaction surveys may not be addressing the RNs' true perceptions of the nurse managers' effect on job satisfaction levels.

Past restructuring and downsizing negatively affected nurses' work life (Best & Thurston, 2004). Many experienced nurses associate restructuring with job loss, higher patient acuity, increased workload, change in skill mix, and loss of positions as a result of

seniority in unionized hospitals (Best & Thurston, 2004). The recent economic downturn has many nurses fearing the return of restructuring in healthcare organizations.

The term *job satisfaction* is one that is highly studied throughout the literature in numerous industrial and professional fields. It came to the forefront in the literature through the studies and publications of Fredrick Herzberg in 1959 (Herzberg, 1968/2002). Herzberg's two-factor theory addresses two different sets of factors that affect motivation at work. Herzberg claimed that motivation describes the factors that result in positive behaviors and, therefore, can lead to increased productivity.

In Herzberg's two-factor theory, one set of factors is based on lack of job satisfaction (job dissatisfaction) related to the job environment, otherwise extrinsic to the job itself. These are titled the Hygiene or Maintenance factors. The second set of factors is based on satisfaction and is related directly to the job. They are called Motivators or Growth factors. Herzberg believed that both factors are equally important and that leaders in management positions must enrich the work of the employee to increase job satisfaction (Herzberg, 1968/2002).

Herzberg was one of the first researchers to determine that salary is not a top motivator. In addition, he challenged previously held beliefs about the motivating factors of fringe benefits, communication, and job participation. Herzberg believed motivators to be intrinsic to the job and include achievement, recognition for achievement, the work itself, responsibility, and growth or advancement. Job dissatisfaction includes lack of Hygiene factors extrinsic to the job such as company policy and administration, supervision, interpersonal relationships, working conditions, status, and security. Deficits in these factors lead to increased absences, grievances, or resignations (Shortell &



Kaluzny, 2000). Herzberg's research indicated that the presence of positive Hygiene factors prevents dissatisfaction but does not lead to satisfaction or motivation. These occur only with the presence of Motivator factors (Herzberg, 1968/2002).

A study concerning job satisfaction by Samad and Alam (2005) utilized Herzberg's theory of motivation. The results of the study hypothesized that both organizational commitment and job satisfaction were related to job performance. The authors revealed that job satisfaction (Hygiene and Motivator factors) played roles in moderating the organizational–job performance relationship.

The causes and consequences of job satisfaction have been studied as one of the major domains of industrial–organizational psychology and organizational behavior for many decades. Job satisfaction is a major concern of management in the business and industrial fields to determine the physical and psychological well-being of employees. Spector (1997), in his book titled *The Nature of Job Satisfaction*, discussed how job satisfaction can be classified according to focus on the employee or on the organization. There is the humanitarian perspective which emphasizes that people deserve to be treated fairly and with respect; then there is the utilitarian perspective in which job satisfaction can lead to behavior by employees that can affect the function of an organization. Spector further states that job satisfaction can be a reflection of organizational functioning and, therefore, can be diagnostic of potential trouble. Managers in organizations who take the study of job satisfaction seriously may employ more productive and psychologically sound workers. Recent studies of job satisfaction involving multiple authors share similar results such as the correlation of job satisfaction with organizational commitment, communication with supervisor, autonomy, recognition, and communication with peers,

fairness, age, years of experience, and professionalism (Kramer et al., 2009; Schmalenberg & Kramer, 2009; Sellgren, Ekvall, & Tomson, 2008).

### **The Nurse Manager and Staff Job Satisfaction**

A great deal of attention was brought to the issue of nursing management in the United States as a result of the Institute of Medicine (2004) report which recommended that senior leaders in healthcare organizations must strengthen nursing leadership within organizations in order to improve recruitment and to maintain qualified and effective nurses. The RNWM indicated that nurse managers are in leadership roles and have an effect on the job satisfaction levels of the nursing staff. Nurse managers have a great challenge in dealing with the nursing shortage all over the world, and quality-nursing leadership is an important determinant in itself as a predictor of job satisfaction (McNeese-Smith, 1997; Taunton et al., 1997).

Organizations have been successful in attracting and employing both new and experienced nurses to the hospital environment but have difficulty retaining them (Upenieks, 2003). In order to retain nurses who already are employed nursing leaders need to be proactive in finding ways to make the work more appealing and to increase levels of job satisfaction. Based upon Herzberg's (1968/2002) theory, this would involve providing motivators or growth factors that involve recognition for achievement, control over their practice environments, responsibility and empowerment, and room for growth and advancement. These factors are in alignment with the RNWM (Manojlovich & Laschinger, 2007). While increased wages are important, they are considered only a short-term motivator. Nurse leaders have a measurable effect on the morale and job satisfaction of nurses by providing open channels of communication and ensuring that a

sufficient number of nurses are maintained in the clinical setting, such as in Magnet hospitals (Sullivan-Havens & Aiken, 1999).

A review of the literature by Kleinman (2004a) indicated there is limited evidence regarding the specific managerial leadership behaviors that contribute most to staff nurse job satisfaction. There is not clear evidence as to which leadership behaviors are strong deterrents to staff nurse job satisfaction and actually may stimulate higher numbers of turnover. Supervisor and employee relations, confidence in management, communication, and administrative effectiveness all are related to employee morale. One key suggestion for the success of management is to take time to assess staff needs, structure opportunities for focused staff process interaction, and speak constructively with staff about identified issues—invaluable in fostering an environment in which everyday challenges are discussed, and solutions are determined by the staff and the manager (DiMeglio et al., 2005).

The literature often reflects that managers/administrators know how to behave professionally and know the types of behaviors that influence the job satisfaction levels of their employees (Kramer et al., 2009; McGuire & Kennerly, 2006). The behaviors of nurse managers that staff nurses perceive as supportive may or may not be the same as the behaviors that nurse managers think are supportive (Schmalenberg & Kramer, 2009). Studies have compared opinions of the staff to those of managers and found the results of the two groups are not in agreement as to what positively impacts nurse job satisfaction. A study by Kramer et al. (2007) that asked managers and their staff to complete the same nurse manager support scale resulted in managers learning how similar or different they were professionally from that which staff expected of their managers. The results of the

assessment assisted managers in understanding the staff's expectations of managers' performance as important information for retaining staff. Only staff nurses can identify those behaviors and through valid measurement, provide the necessary feedback to nurse managers, who in turn have the power to change their behaviors and alter the work environment (Schmalenberg & Kramer, 2009). A primary goal of Kramer et al.'s (2007) study was to understand and communicate the perceptions of RN staff nurses' job satisfaction as it relates to the nurse manager's behaviors. The goal was to determine whether the results provided new information in place of replication of previous studies for nurse managers and administrators to increase job satisfaction of their nursing staff.

Employees often are asked to rate their managers' performances as part of the formal review process of an organization. Typically this evaluation can assess only the task (position description) portion of the job and not the observed leadership abilities and behaviors of the manager. Often, evaluation results are kept confidential and are not acted upon, in the opinion of the staff, by the administration. Lack of positive action by management or administration following an assessment can be extremely frustrating for those employees who took the time to participate in the process and to share their concerns, often leading to additional problems such as counterproductive behavior and turnover as a result of unfulfilled expectations (Spector, 1997). Therefore, it is important for administrators to provide a means for the staff members to provide feedback for the manager based upon their direct observations of how the manager behaves on the nursing unit and how this behavior affects job satisfaction of the individual nurse, as well as provide a plan on how the results may contribute to change in the organization.

Porter-O'Grady (2003) discussed the limited amount of time that nurse managers have to

complete all their necessary tasks. When that time is spent in activities not expected (valued more highly) by staff, managers lack sufficient time for other behaviors that are more highly valued by staff. Once managers know what these expected behaviors are, they are in a position to decide whether to meet these expectations by enacting the behavior or to initiate change agent activities to modify the expectations of the staff nurses (Kramer et al., 2007; Schmalenberg & Kramer, 2009).

The literature reports multifaceted and complex reasons that an employee leaves a job. Reasons for discontentment fall into four major categories: job satisfaction, supervision, work environment, and personal reasons (Strachota, Normandin, O'Brien, Clary, & Krukow, 2003). Organizations, administrators, and managers have no control over the personal reasons category as cause for a staff nurse to leave a job, but they can exert some control over issues with supervisors and the work environment that lead to decreased job satisfaction and job turnover. However, the review of the research literature conducted by McNeese-Smith (1997) revealed that none of the studies asked nurses to identify the factors that created job satisfaction, productivity, or organizational commitment for them.

In addition to financial and job security, managers demonstrate a commitment to career development for their nurses (Hutchinson & Mattice, 2000). According to Hutchinson and Mattice (2000), morale and moral support by nurse managers are identified as factors affecting nurse job satisfaction. Morale may be linked to many things in the nurse practice environment such as salary, recognition, opportunity for continuing education, and nurse practice models. The first-line manager is typically the individual held responsible for the management of nursing care and its quality within a defined

patient care area (Kelly & Joel, 1999). In exercising these responsibilities the nurse manager has been identified as key to nurse job satisfaction and retention (McNeese-Smith, 1997; Severinsson & Kamaker, 1999; Taunton et al., 1997).

Restrictions on the nurse manager's time, however, may limit the opportunity for concentrated focus on the efforts to increase the job satisfaction of staff nurses (Kimball, O'Neil, & Health Workforce Solutions, 2002). Each employee may not require the same level of managerial support (Severinsson & Kamaker, 1999). Some may require less time and attention, while others require more from managers; therefore, it is crucial that the nurse manager be able to predict which employees have the greatest need for individual or intensive attention and be able to identify those factors in the work environment that precipitate low job satisfaction. Nurse managers who deal with factors that cause low morale may increase staff perceptions of a more positive work place through amplified trust, increased communication, and improved relationships with management. But, in order to effect this change, nurse managers first must know the factors identified by the staff as those behaviors that influence job satisfaction.

Research by Strachota et al. (2003) included interviews of nurses who voluntarily terminated or changed their employment status. This study revealed that 37 percent of the nurses had been unhappy with management support and 52 percent shared concerns about hospital or nursing unit management, indicating a direct link between retention and the behaviors of the nurse leader.

From focused interviews of staff nurses, managers, and nurse executives in hospitals with Magnet designation, Kramer et al. (2007) developed a list of 54 supportive role behaviors. This list included Nurse Executive Competencies cited by the American

Organization of Nurse Executives as well as individual interviews with staff nurses and managers (2000).

Taunton et al. (1997) identified manager leadership behaviors as the intervention most likely to improve retention of hospital staff nurses because of the leaders' ability to improve staff satisfaction. Severinsson and Kamaker (1999) suggested that this satisfaction improvement occurs in part because of the nurse supervisor's ability to provide the moral support necessary to assist the nurse in the development of personal qualities, integrated knowledge, and self-awareness that will allow the nurse to handle the demands of the work environment. However, specific nurse manager behaviors were not identified for their influence on RN job satisfaction. Again, little research has been conducted to identify staff nurses' perceptions of nurse manager behaviors that influence their level of job satisfaction. Identification of those factors or behaviors can lead to increased awareness and education for nurse managers and to provide a means for nurse managers to take action to increase positive relationships with staff. However, these factors must come directly from RN staff nurses in order to increase the content validity of the measurement tool.

### **Measurement Literature Review**

The investigator conducted a literature search to identify journal articles for analysis that included studies involving instruments of nurse manager behaviors and staff nurse job satisfaction levels. The initial search included the Cumulative Index to Nursing and Applied Health (CINAHL) and Ovid databases. The investigator conducted additional searches in the Web of Knowledge and PubMed databases with no additional articles identified. Key words utilized in the database searches included nurse manager

(5,361 articles), behaviors (154,531 articles), nursing staff (89,779 articles), and job satisfaction (29,200 articles) resulting in a combined search of 67 articles. The author evaluated article titles and abstracts for inclusion in this literature review. The researcher also searched references of selected articles and selected nursing education journals for possible inclusion of additional articles.

### **Article Inclusion**

Criteria for article inclusion in this study involved the use of an instrument/survey of nurse managers and/or staff nurses indicating behaviors or variables that impacted nursing job satisfaction of the individual nurse or the nursing staff as a group. The instrument/survey must have occurred among nurses who work in a hospital setting and with a population including RNs alone or with other nursing staff. There were no limitations on the year of publication of the articles.

Eighteen studies met the inclusion criteria with three studies published in the late 1990s and the others published from 2001 to 2008. A different group of authors published each study, with two studies conducted by hospital management in nursing, seven studies conducted by university nursing faculty, and seven studies conducted by a combination of hospital managers and university faculty. Faculty with a degree in psychology conducted one study, and doctoral nursing students and doctoral candidates conducted one study. Each author held a minimum of a master's degree.

A synthesis of the existing nurse manager behaviors related to staff job satisfaction outcomes covering the time period from 1997 to 2008 suggests that research related to the post-reconstruction era of the early 1990s is limited. The reconstruction era of the 1990s led to changes within nursing management that included elimination of a



layer of middle managers in many healthcare organizations. Many of the changes that occurred during this period of time led to a nursing shortage which continues today, even with the recent economic events.

Literature published during the past decade concerning management behavior often focused on the leadership style or the nursing model in relation to nurse job satisfaction. Articles written in the late 1990s primarily investigated job satisfaction in relation to leadership style and empowerment (Morrison, Jones, & Fuller, 1997), recognition of employee job performance and staff nurse morale (Cronin & Becherer, 1999), and the direct and indirect effects of nurse managers' characteristics of power, influence, and leadership style on nurses' intent to stay in their current positions (Boyle, Bott, Hansen, Woods, & Taunton, 1999). While results of these studies identified types of leadership styles and means of recognition as pertinent to retention of staff, the authors utilized multiple instruments of measurement and did not identify or discuss specific behavior aspects of the nurse managers.

Research conducted in the first part of the decade, 2001–2006, continued to look at leadership effects on job satisfaction and productivity (Loke, 2001), multiple variables that affect nurse job satisfaction including salary and patient care issues (Fletcher, 2001), and nurse attitudes of empowerment and hardiness (e.g., the power of endurance) related to job satisfaction and intent to leave (Larrabee et al., 2003). One study focused specifically on the front line managers of the nursing unit and examined the relationship between quality focus of the manager in relation to patient and staff job satisfaction (Lageson, 2004).

Two studies measured nursing manager leadership, ability, and support using the PES scale (Lake & Friese, 2006; Manojlovich, 2005). Only one study explored nursing leadership by comparing opinions of the nursing staff to those of their nurse managers (Sellgren, Ekvall, & Tomson, 2006), with results showing significant differences in opinions of preferred leadership between managers and staff nurses. Results of these studies indicated the importance of leadership behaviors in relation to factors such as collaboration and group cohesion, but each recommended further investigation to identify specific issues and concerns as perceived by the RNs to focus on more potent satisfiers for the staff.

The nurse manager and staff job satisfaction literature published in 2007 and 2008 continued to focus on the relationship of the role of the nurse managers, their behaviors, and their educational preparation in relation to the current and future staff nurses and job satisfaction. A link was established between nurse job satisfaction and the quality of care provided to the patient, leadership behaviors, and the effect on employees' emotional experiences (Bono, Foldes, Vinson, & Muros, 2007). Other studies identified characteristics of a productive and satisfying work environment (Schmalenberg & Kramer, 2008), relationships among nurses, managers, and physicians to quality environments (Cummings et al., 2008), relationships to educational preparation, autonomy, and critical thinking (Zurmehly, 2008), multigenerational preferences and differences with shared governance and empowerment (Wilson, Squires, Widger, Cranley, & Tourangeau, 2008), and creative work environments related to leadership behaviors (Sellgren et al., 2008) each in relation to staff nurse job satisfaction.

The experience of low job satisfaction is positively associated with turnover, and those rates are increasing (Taunton et al., 1997). Individuals are assumed to have a set of job expectations; if these are not met by the agency, dissatisfaction results (Porter & Steers, 1973). These expectations are contained within psychological contracts that have reciprocal obligations for the employee and employer. Robinson (as cited in Best & Thurston, 2004) found that when either party violates the terms of the contract so that a discrepancy results between what individuals expected and what they received, satisfaction with the job and with the organization are reduced. Successful healthcare organizations have leaders and staff who possess a shared commitment to the vision and values of the organization and to the values of the caring relationship (Person, 2001).

Although the investigator conducted the initial literature search and review on literature published from 1997–2008, an additional instrument was found that was adapted from the CAT developed in 1992 (Duffy, 2009). Researchers administered the instrument, titled the CAT-admin, in 1993 to measure the caring behaviors of nurse managers and relationships to staff nurse satisfaction and retention. The researcher developed the by adding a qualitative question to the original CAT to expand and enrich data collection (Duffy, 2009).

### **Analyses of Specific Instruments**

**Nursing management tool comments.** This synthesis identifies the six instruments used in the literature review studies on nurse managers. Appendix C provides the name of the scale, test population, number of items, format, and scales, reliability evidence, and validity evidence. The instruments listed in Appendix C are Change Production Employee tool, EOM tool, Immediate Supervisor Scale, MLQ,

NWI-Revised, and PES. The author discusses the CAT-admin in this section as well even though the researcher found it after the initial literature search and review were conducted. Following is a review of the development of these instruments. Both nurse managers and job satisfaction studies utilized the EOM tool but is reviewed only once in the nursing management tool section.

***Change Production Employee tool.*** Ekvall and Arvonen (1991, 1994) developed and validated the questionnaire which consists of 30 items covering the three dimensions of change/development, production/task/structure, and employee/relations with 10 items per dimension.

Strengths: The basis of the questionnaire is the change, production, employee model used to assess *preferred* leadership behavior. The Change, Production, Employee Questionnaire has been tested in relation to influence of attitude (Sellgren et al., 2006).

Weaknesses: The authors developed the tool in the early 1990s during a different time period for healthcare; a time when Magnet status was beginning in the nursing profession and in healthcare organizations. Staff nurse perceptions of leadership behaviors may not be the same today, so further study is required to test for adaptation of the instrument during the current status of healthcare organizations.

***EOM.*** In 1999, the original authors of the NWI-R determined it to be outdated. Refinement of the NWI-R reduced the number of items from 75 to 37; remaining items included only those related to and indicative of a magnetic (e.g., an attractive) work environment, which the authors labeled *Dimensions of Magnetism*. Refinement of these items by staff nurses in 14 Magnet hospitals led to eight Essentials of Magnetism and the development of the EOM tool through observation studies and interviews of nurses

employed in Magnet hospitals. In 2000 and 2001, investigators visited 14 Magnet hospitals and conducted on-site interviews of 289 staff nurses, directors of education, chief nurse executives, and group interviews with managers and clinical directors. Investigators identified themes, taxonomies, typologies, and theories using a grounded-theory approach. Ranked category scales resulted for autonomy, control over nursing practice, and RN–medical doctor relationships. Further review led to item selection to measure an additional five EOMs: support for education, clinical competence, cultural values, nurse manager support, and adequacy of staffing (Kramer & Schmalenberg, 2004). Investigators psychometrically tested the EOM tool by administering it to 3,602 staff nurses in 26 hospitals. The 65-item tool created by Schmalenberg and Kramer (2008) generated 8 essentials and 10 factors: (a) Cultural Values, (b) Control of Nursing Practice, (c) Supportive Nurse Manager (leadership behaviors), (d) Supportive Nurse Manager (managerial behaviors), (e) Autonomy, (f) RN–Medical Doctor Relationships, (g) Clinically Competent Nurse/Support for Education, (h) Adequate Staffing, (i) Delivery Systems (old/new team nursing), and (j) Delivery Systems (primary and total patient care). Researchers developed the EOM tool to measure what staff nurses identify as essential to magnetism. Evaluation indicated that the EOM tool is a valid and reliable measure of aspects of magnetic work environments important to the staff for productivity of quality care (Kramer & Schmalenberg, 2004).

Strengths: A multi-method approach to study Magnet hospital staff to ascertain how staff nurses working in Magnet hospitals define the eight Essentials of Magnetism

established a foundation for the tool. The study involved a large sample of staff nurses in Magnet and non-Magnet hospitals.

**Weaknesses:** Interviews involved not only staff nurses, but directors of education and chief nurse executives. Investigators also conducted interviews and observations with patients, physicians, and nursing administrators. While this technique produced a large amount of data, it was not specific to staff nurse perceptions of nurse manager behaviors that influence their job satisfaction. The use of 23 nurses from six different Magnet hospitals determined content validity, but the nurse experts were divided between the scales and items, which did not provide a collective consensus of all items by the experts. Kramer et al. (2007) found the tool to be missing supportive behaviors of managers, which, therefore, led to the adaptation of the Nurse Manager subscale of the EOM into the NMSS.

***Immediate Supervisor Scale.*** This non-published six-item measure asks about such qualities as supervisor reliability, competency, and helpfulness (Fletcher, 2001). A study about nurse job satisfactions and dissatisfactions utilized this scale and asked RNs to indicate if their supervisors matched the qualities described in the items.

**Strengths:** The scale measures supervisor qualities such as reliability, competency, and helpfulness (Fletcher, 2001). The reference provided for development of this scale came from an unpublished dissertation (Ceria, 1992).

**Weaknesses:** Psychometric testing data are not available because the researcher of the current study did not choose the scale from a published reference. The referenced dissertation investigated absenteeism in nursing, which may or may not be related to job satisfaction of staff nurses.

*MLQ*. Development of this tool began in 1978 with the original factor structure based on the description of transforming leadership. Researchers asked 78 executives to describe a leader who had influenced what was important to them in their roles as leaders and how they thought the best leaders were able to get others to go beyond their own self-interests for the good of the group. Researchers added items from prior literature on charisma. Eleven judges sorted the original 142 items generated into transformational and transactional contingent reward leadership categories. Researchers retained an item only if there was at least 80 percent agreement about the item. One thousand seven hundred sixty-seven U.S. Army colonels described their superiors, which evaluated the finest of 73 items (Avolio, Bass, & Jung, 1999). Later researchers surveyed 198 U.S. Army field grade officers by asking each to rate their respective superior officers using the MLQ, which resulted in the development of the Bass six-factor leadership model based on the preliminary results of the survey. Investigators factor analyzed the ratings using principal components analysis into three transformational, two transactional, and a passive-avoidant laissez-faire factor (Bass, 1985). Nurse researchers know little about the psychometric properties and, especially, the factorial structure of the MLQ because only a few studies have been conducted involving nursing management (Vandenberghe, Stordeur, & D'hoore, 2002).

Strengths: The MLQ is a highly suitable instrument to measure multi-dimensional nursing leadership. The widely used instrument involves a range of leadership behaviors.

Weaknesses: Den Hartog et al. (as cited in Kanste, Miettunen, & Kyngas, 2006) reported that a major limitation to the widespread acceptance of the MLQ has been psychometric concerns based on studies that have produced differing factor structures.

Nurse researchers know very little about the psychometric properties and factorial structure (Kanste et al., 2006). Researchers criticize that the MLQ focuses on its discriminate validity in relation to transformation leadership subscales and contingent reward (Antonakis, Avolio, & Sivasubramaniam, 2003). Executives and leaders developed the scale, and military colonels and officers evaluated and tested it.

*NWI-R*. Research reported by Aiken and Patrician (2000) stated the importance in studying the practice environment of nurses, but the absence of instruments to measure these attributes empirically hindered research. In 1984, Kramer and Hafner (1989) developed the NWI. The initiative identified and studied 39 hospitals based on their reputation for good nursing care (Lake, 2007). The NWI measured the nursing working environment and the organizational traits influential on job satisfaction, ability to perform quality care, and perceived presence within the staff nurse's existing job. The NWI contained 65 items, based on a literature review of the measurement of job satisfaction, and the desirable traits of Magnet hospitals (Kramer & Schmalenberg, 2004). Three of the four original Magnet study researchers assessed content validity. Researchers also assessed face validity (Kramer & Schmalenberg, 2004). Since 2000, the NWI has been revised through extensive work (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken & Patrician, 2000; Aiken & Sloane, 1997a, b). The NWI-R contains 57 items (55 from the NWI in addition to 2 new items) and measures the presence of specific organizational traits, such as a manager being a good manager and leader, in contrast to measurement of nurse satisfaction and productivity associated with these traits (Lake, 2007). The NWI-R has strong measures of validity (face, content, and criterion-related) and internal



consistency in scoring as indicated by Cronbach's alpha scores (Slater & McCormack, 2007).

**Strengths:** The tool's strengths include being developed and designed to contain an all-inclusive list of factors having a bearing on staff nurse job satisfaction and quality nurse care comprised of organizational characteristics common to the Magnet hospitals or identified in the literature between 1962 and 1986.

**Weaknesses:** For each item the nurse responded to three statements, one of which was that the factor was present in the current job satisfaction level. The focus was a universal measure of the hospital nursing practice environment in the 1980s and has become outdated as a result of changes including restructuring of nursing models and nursing management. Also, many items lack a commonly shared and understood definition. The revised NWI no longer measures job satisfaction or productivity of quality care (Kramer & Schmalenberg, 2004).

**PES.** Researchers developed the PES from the NWI-R for the purpose of measuring the hospital nursing practice environment (Lake, 2002). Researchers conducted exploratory factor analysis with NWI data from nurses in the original Magnet hospitals and produced a five-subscale structure. Investigators found this to have good psychometric properties; using recent NWI data from hospital staff nurses throughout Pennsylvania confirmed these properties (Lake, 2002). Overall, researchers retained 31 of the 48 selected items from the NWI-R across five subscales that are key domains in the nursing practice environment of original Magnet hospitals. The subscales are Nurse Participation in Hospital Affairs, Nursing Foundations for Quality of Care, Nurse

Manager Ability, Leadership and Support, Staffing and Resource Adequacy, and Collegial Nurse–Physician Relations (Lake, 2007).

Strengths: Researchers developed the PES from the NWI with data from original Magnet hospitals. It measures the contribution of the practice environment to nurse and patient outcomes. The subscales and composite exhibited high reliability at both the individual and hospital levels (Lake, 2002) including the nurse manager ability, leadership and support factor ( $\alpha = .84$ ).

Weaknesses: The main focus is on the nurse practice environment as a whole but includes five items related to the nurse manager. The tool's author (who is a nurse/researcher), another nurse/researcher, and a hospital staff nurse selected 48 items out of the 65 NWI items by consensus; after conducting exploratory factor analysis 31 items remained, providing limited input. While all five subscales are important for nursing practice, researchers need additional information to determine the perceptions of the staff nurse specific to nurse manager behaviors that influence job satisfaction.

*CAT-admin*. The researcher designed the CAT-admin to reflect the perceptions of staff nurses regarding their managers for administrative purposes (Duffy, 2009). The tool was developed as an expansion of the original CAT by adding a qualitative question to the original tool. A sample of 56 full-time and part-time nurses was included in the tool revision. In 2008, the CAT-admin was further developed through an exploratory factor analysis which resulted in the CAT-admin II version of the tool.

Strengths: A Cronbach's alpha of .98 was reported for internal consistency. The author indicates the instrument is valid and reliable. To clarify the interrelationships

between the variables of unit type, number of employees, and nursing turnover, the researcher used stepwise regression (Duffy, 2009).

Weaknesses: The tool was initially adapted from the original CAT in 1993 by the addition of a qualitative question, while the interpretation of each item and meaning was left in its original form. Because researchers developed the original CAT to measure patient's perceptions of nurses caring behaviors, the items may not be specific to nurses' perceptions of caring behaviors of their nurse managers. Investigators addressed this in the CAT-admin II by asking graduate RNs to describe caring behaviors or attitudes of a nurse manager. However, additional information and testing of the tool is needed to further strengthen the relationship of the items to nurse job satisfaction in relation to the nurse manager's behavior.

**Job satisfaction tool comments.** This synthesis identifies the six instruments used in the literature review studies on nurse job satisfaction. Appendix D provides the name of the scale, the test population, number of items, format, scales, reliability evidence, and validity evidence. The EOM tool measured both management behaviors and job satisfaction; the author reviewed the tool in the previous section. The six instruments listed in the Appendix D are the IWS, Job Description Index (JDI), McCloskey/Mueller Satisfaction Scale (MMSS), Minnesota Satisfaction Questionnaire Short Form Specific Satisfaction Scale (MSQ), and Work Quality Index (WQI).

***IWS.*** The literature reports the IWS to be the most widely used measure of nursing job satisfaction. The four most important theories described as a theoretical basis for the IWS are Maslow's hierarchy of needs, Herzberg's dual-factor theory, the theory of need fulfillment, and the social reference group theory (Stamps, 1997). The IWS is a

norm-referenced instrument designed primarily to help identify satisfaction and dissatisfaction of nurses (Zangaro & Soeken, 2005). Part B of the instrument is an attitude survey composed of 44 items that yields an overall score of satisfaction.

**Strengths:** The instrument's measurement comes from theories and concepts including Maslow's hierarchy of needs, Herzberg's dual-factor theory, the theory of need fulfillment, and the social reference group theory. The IWS is norm-referenced and developed primarily to help identify satisfaction and dissatisfaction of nurses.

**Weaknesses:** The measured variables in the IWS are pay, autonomy, task requirements, organizational policies, interaction, and professional status. The researchers designed it to measure the degree of importance of the variables in relation to the work environment and job satisfaction but not in relation to nursing management. The author developed the tool based on the author's perceptions and not based on staff nurse perceptions.

**JDI.** The JDI is a scale used to measure five major factors associated with job satisfaction: (a) The Nature of the Work Itself, (b) Compensations and Benefits, (c) Attitudes Towards Supervisors, (d) Relations with Co-workers, and (e) Opportunities for Promotion. Researchers introduced the JDI first in 1969; since then it has been used by over 1,000 organizations in many sectors.

**Strengths:** Measurements of strengths and weaknesses within each factor will tell practitioners where improvements can be made (Ngo, 2009).

**Weaknesses:** The Social Services population developed this instrument. Researchers asked respondents to indicate how they would describe their job in general.

It is not specific to staff nurse perceptions of nurse manager behaviors in relation to their job satisfaction.

**MMSS.** Mueller and McCloskey (1990) developed the MMSS scale, a multidimensional job satisfaction questionnaire designed for hospital staff nurses. Six subscales emerged through factor analysis of data from an original 320 nurses in a medical center. One year later 150 (or 59 percent) of those who had not resigned, continued to participate. Researchers collected data from nurses shortly after hiring, at six months, and at one year from the time of hiring. Researchers assessed the scale on the data collected at six months. There are 31 items, with a five-point Likert scale ranging from *very dissatisfied* to *very satisfied*. The MMSS may be used to measure nurses' satisfaction for new and experienced nurses.

**Strengths:** The instrument, developed by a professor of nursing and a professor of sociology, measures three dimensions of nurses' job satisfaction.

**Weaknesses:** Of the 33 items divided between safety dimensions and social dimensions, a limited number of items addressed the immediate supervisor. Researchers tested the instrument on 150 nurses from an original sample of 320 nurses who had not resigned from a hospital one year after hire. Those who left might have offered significant information about lack of job satisfaction at the organization. The mean age of the nurses was 26 years of age with 4.4 years of experience, which disregards older nurses with more experience.

**MSQ.** Weiss, Dawis, England, and Lofquist developed the MSQ in 1967. The short form measured autonomy as well as job satisfaction. The MSQ measures an employee's satisfaction with his or her job. Three forms are available: two long forms

(1977 version and 1967 version) and a short form. The MSQ provides more specific information on the aspects of a job that an individual finds rewarding than do more general measures of job satisfaction. The MSQ is useful in exploring client vocational needs, in counseling follow-up studies, and in generating information about the reinforcers in job satisfaction (Weiss et al.).

Strengths: Researchers developed the MSQ to further improvement of measures of vocational abilities and vocational needs by providing counselors with better tools to evaluate the work personalities of vocational rehabilitation applicants (Weiss et al., 1967). The MSQ provides a quality outcome measure to test the effectiveness of counselors and/or specific counseling techniques with employees.

Weaknesses: Although it still may be used in research on job satisfaction, the questionnaire is outdated. Researchers developed the instrument in 1967 as a result of a work adjustment project for vocational rehabilitation. While the MSQ provides normative data collected from many different fields, including nursing, it is not based in healthcare nor does it speak to the work environment of staff nurses in relation to nursing management.

***Specific Satisfaction Scale.*** Developers took the questionnaire from Hackman and Oldham's JDI (as cited in Fletcher, 2001). (See the description of the JDI in this section.) They adapted the scale to survey five specific job satisfactions of nurses (Fletcher, 2001).

Strengths: The scale measures job satisfaction among nurses. Developers tested construct validity against an instrument with an organizational commitment scale.

Weaknesses: The researcher considered this to be a valid evaluation tool for intervention studies, but research data are not available to support this. The scale includes seven work factors with only one factor measuring the relation with a supervisor.

**WQI.** Whitley and Putzier (1994) developed the WQI from the literature to measure nurses' satisfaction with the quality of their work and work environment (Lake, 2007). Researchers developed the scale from a factor analysis of 245 nurses in a medical center.

Strengths: The WQI assisted nurses and nurse administrators to gain knowledge about nurses' satisfaction with their work and about the quality of the work environment (Whitley & Putzier, 1994).

Weaknesses: A limitation to this instrument is that it measures satisfaction with numerous characteristics in the work environment, rather than the extent of how nurse manager behaviors influence job satisfaction. The tool, developed 1994 by Whitley and Putzier, may not be up-to-date with current perceptions of staff nurses.

A synthesis of the literature finds that nurse managers' behaviors ultimately affect nurse job satisfaction. Therefore, all of these areas are worthy of further study. A review of job satisfaction instruments in *Occupational Medicine* (Saane et al., 2003) found seven instruments with adequate reliability and validity criteria but none that measured responsiveness of job satisfaction and, therefore, could be used as evaluative tools. The conceptual foundation of job satisfaction and content validity is an aspect that has received little attention in the literature on job satisfaction instruments (Saane et al., 2003).

Global instruments are less suitable for detecting high and low areas of job satisfaction (Saane et al., 2003). Research studies are needed with an updated and newly developed tool established through the study of staff nurse perceptions which identify those factors that most influence nurse job satisfaction. Although many different job satisfaction instruments exist, only a few meet several criteria for a high level of reliability and construct validity (see Appendix D). Whereas the NDNQI annual studies conducted by the ANA provide a combination of nursing instruments to measure job satisfaction, the researcher found no instruments to measure the perceptions of staff nurses in relation to nurse manager behaviors that influence job satisfaction. Therefore, new data are needed to provide managers and administrators with the information they require in order to provide a positive and healthy work environment for their RN staff nurses.

Results of this study indicated that an adapted scale of items is not sufficient to measure staff nurse perceptions of personal job satisfaction in relation to nurse manager behaviors. However, without the data which resulted from the focus groups in this study, the researcher could not make a conclusion that current and past instruments provide the measurement which is sufficient for nurse managers to be confident of their behaviors that influence staff job satisfaction. In the wake of the new challenges healthcare organizations are facing, a strong and more satisfied nursing staff may lead to high quality care and decreased organizational costs related to staff turnover.

### **Summary**

The nurse manager's leadership behavior has been indicated as the interaction most likely to improve retention of hospital staff nurses as a result of the manager's



ability to improve job satisfaction (Andrews & Dziegielewski, 2005). The RNWM indicates a link between nurse managers as leaders and staff nurse job satisfaction (Laschinger & Leiter, 2006; Leiter & Laschinger, 2006). It is the responsibility of the organization and the management to learn more about these factors through research in order to build and retain a professional work force of nurses who provide high quality care to their patients. In today's competitive healthcare environment, administrators must recognize the impact that nurse turnover has on the satisfaction and safety of nurses and other clinicians, the satisfaction and retention of healthcare customers, and customer perceptions of quality of care. If healthcare consumers perceive problems with nurse turnover or quality of care, customer loyalty will suffer. Thus, RN turnover is not simply a human resource issue but can be costly in terms of dollars—human capital losses, disruptions in the work environment, customer loyalty, and organizational performance (Kleinman, 2004b).

Because hospitals employ the majority of RNs, management must realize its role in the level of job satisfaction resulting in retention of the RNs as competitive aspects of the healthcare business (Andrews & Dziegielewski, 2005). Nurse administrators and managers must develop strategies to create work environments that allow nurses to practice according to professional standards, thereby increasing job satisfaction and assuring high quality patient care.

Literature shows a lack of consistency in definitions of job satisfaction, instrumentation for measurement, and conclusions that provide recognition and support of specific management behaviors which are effective for high levels of job satisfaction of RNs. Portions of the literature inconsistently defined job satisfaction. Several studies

measured job satisfaction as a factor in development of a nursing model (Cummings et al., 2008) or as supporting evidence for the Magnet setting (Schmalenberg & Kramer, 2008), yet provided no definition of job satisfaction. The research indicates that data are not readily available in healthcare that focus specifically on nurses as managers and their role in relation to the perceptions of staff nurses and job satisfaction.

Methods used in past studies involved instruments with minimal focus on specific behaviors of the nurse manager and the job satisfaction of the staff. The chosen literature review studies from 1990–1997 focused on leadership styles in general (Morrison et al., 1997), the nurse's intent to stay (Boyle et al., 1999), and ways to recognize the staff in order to increase job satisfaction (Cronin & Becherer, 1999). Studies from 2001–2006 examined several work-related issues such as the influence of nurse attitudes and direct and indirect relationships (Fletcher, 2001; Lageson, 2004; Larrabee et al., 2003; Loke, 2001; Manojlovich, 2005). The review also discussed the effects of nursing leadership in relation to the manager's job performance (Sellgren et al., 2006). Lastly, the literature review studies from 2007–2008 interpreted findings related again to the factors of the nurse practice environment and the creative work climate (McGillis-Hall & Doran, 2007; Sellgren et al., 2008). The review also explored generational differences (Wilson et al., 2008) as well as nursing leadership in Magnet hospitals, staff and management emotions, relationships, and managers' behaviors in relation to positive relationships with staff and physicians (Bono et al., 2007; Cummings et al., 2008; Schmalenberg & Kramer, 2008; Zurmehly, 2008).

While each of these studies include important aspects of what may or may not shape a healthy work environment for nurses that leads to high levels of job satisfaction,

no single study identified specific nurse manager behaviors in relation to staff nurse job satisfaction. In addition, the studies used multiple measurement tools, none of which involved an in-depth study of nurse manager behaviors (see Appendices C and D). Those tools that did include questions on manager behaviors were limited in number and mainly focused on leadership style.

The investigator's greatest challenge in reviewing the literature was the lack of consistent instrumentation. Researchers developed most instruments utilized outside of healthcare; most instruments are not specific to measuring nursing management/supervisors in a hospital setting. This is problematic and a concern for nursing because business organizational settings differ greatly from hospitals where nurse managers have continuous accountability with staffing and patient care. Nurse managers are responsible for life-and-death situations with patients on a daily basis and must ensure that adequate staffing, supplies, and support systems are in place at all times. This is not a factor for those in business settings that function in a typical eight- to ten-hour day. Research into the possible need for development of a new instrument specific to nursing and the current nursing work environment is necessary and will assist researchers in identifying behaviors of managers that particularly are perceived by staff to influence their job satisfaction levels and work productivity.

Because of the ongoing concern in relation to the increasing nursing shortage, the profession must find a way to identify behaviors in management that may lead to nursing retention through staff job satisfaction. Once these behaviors are identified, it may be possible to assist all nurse managers in the development of positive leadership behaviors that may increase the level of staff nurse job satisfaction and, therefore, have a positive

effect on RN retention. Instruments that measure the perceptions of staff nurses on how they are affected by their nurse managers' behaviors in regard to job satisfaction either do not exist or are a small subscale of an instrument which measures the overall practice environment or affects of the organization as a whole. There is an opportunity to improve the awareness and education level of nurse managers and how they may impact their staff. Research with focus groups may provide new data and provide a means by which the perceptions of the staff nurse in relation to her or his nurse manager and job satisfaction levels may be voiced. Results of focus group studies may also provide data that will lead to the development of a new measurement tool and new curriculum for nurse management development programs.

## CHAPTER THREE. METHODOLOGY

This study utilized a qualitative descriptive design to gather data that led to a description of RN perceptions of nurse manager behaviors that most influence RN staff nurse job satisfaction and a comparison of the data obtained from RN focus groups with instruments previously used to measure job satisfaction. Results of the comparison may or may not indicate the need for development of a new instrument to measure nurse manager behaviors that currently influence RN staff job satisfaction. The behaviors and leadership styles of nurse managers have been the focus of many research studies. However, there is a lack of research specific to the perceptions of staff nurses and nurse manager behaviors relating to staff job satisfaction. This study collected data specifically from RN staff nurses who practice in community-based organizations in southern Indiana.

### **Design**

This researcher used a qualitative descriptive design to achieve the purpose of this study. Qualitative descriptive studies offer a comprehensive summary and are the method of choice when straight descriptions of phenomena are desired (Sandelowski, 2000). The review of the literature identified the need for a better understanding of management behaviors that influence RN staff job satisfaction. The literature review indicated the lack of a consistent instrument used to identify management behaviors that impact staff job satisfaction. This study used a qualitative descriptive design to facilitate discussion in focus groups including RN staff nurses. Focus groups provide a fundamental way of listening to people and learning from them through guided discussions to generate a rich understanding of participants' experiences and beliefs (Morgan, 1998).

## **Human Subjects Approval**

The Indiana University–Purdue University Indianapolis (IUPUI) Institutional Review Board (IRB) for Protection of Human Subjects approved this study (Appendix E). The researcher also obtained approval from the two organizations in southern Indiana that agreed to allow employees to participate in the study.

The study consisted of a demographic questionnaire (Appendix F) administered by the researcher followed by a series of semi-structured questions (Appendix A) to each focus group. Patients were not a part of the study, and no planned interventions took place with the participants.

Participation in the study was voluntary and required an informed consent (Appendix G). The study used participant coding to safeguard confidentiality and anonymity. The study investigator asked participants to commit to confidentiality (not to discuss the content with each other or to quote the others in the group outside the focus groups). The researcher assured participants of the confidentiality of their comments and encouraged them to be open and honest.

The principal investigator (PI) maintained the data. No representative of either of the organizations employing participants in the study had access to the data. A locked file, available only to the PI and study co-investigators, stored a master list of each study participant's name, e-mail address, telephone number, and corresponding code number. The PI de-identified the master participant list, focus group transcripts, and audio recordings, keeping that data separate from the data following completion of the study and dissemination of the findings. The researcher checked the transcripts for accuracy of transcription then erased the audio recordings. Hardware firewalls and software insure the

password-protected computer used to store the study data, which is archived according to Indiana University computer archive policies.

Study participants received no specific monetary benefits for participation other than a \$20 gift certificate provided to each focus group participant. The researcher identified professional benefits as well as knowledge of the study results that are to be shared with the participants and management of each organization. The potential benefits of the proposed study outweigh the potential minimal risk to the individual study participants.

### **Participants**

The investigator recruited the study sample from the target population of available RN staff nurses currently employed by two acute care community-based hospitals in southern Indiana. Recruitment goals for the sample were to include staff nurse participants from each of the two organizations in focus groups of five to eight participants, with a minimum of two focus groups per organization, representing multiple units. For qualitative research, the goal of adequate sample size is to achieve saturation. Factors important in determining the sample size include: Scope of the study, nature of the topic, quality of the data, and study design (Burns & Grove, 2009). In this study, the scope was very specific and narrow, and there was a clear focus and specific research questions; RNs who were well informed about the topic and willing to share their experiences on a voluntary basis provided the data. The investigator chose the study design of focus group interviews because interviewing a group of individuals provides more data than one-on-one individual interviews.

Through contact with the chief nurse executive, nurse administrators, and nurse managers of each organization, the investigator invited hospitals to participate. To facilitate participation, the researcher chose hospitals located in the southern region of Indiana based upon the investigator's previous relationships and connections with those hospitals. Inclusion criteria included a minimum of 50 licensed beds and national accreditation.

For the purpose of this study, the researcher defined *nurse manager* as a RN who has 24-hour responsibility for the operations of one or more hospital or clinic units, regardless of the title given to that position. This position involves direct supervision of charge and staff nurses on all shifts and accountability for those positions. To be eligible for their staff to participate in this study, the nurse manager must have had one or more years of experience as a nurse manager. The required years of experience is important in order to establish that the nurse manager is not in the orientation or initial/transitional stage of learning the role of management. Lack of experience in this position could pose an external threat to the study.

The researcher defined *staff nurse* for the purpose of this study as an RN on an assigned hospital unit who is responsible for the care of the patients admitted to that unit.

The RN must have met the following requirements:

- Have a minimum of six months of experience in patient care.
- Be employed under his or her current nurse manager for a minimum of six months.

The inclusion of new graduates may prove to be vital to this research because they are in the *honeymoon phase* with management. While in this phase, management may



have a different relationship with the nurse than what is maintained with other staff who have been employed for a longer period of time. The requirement that a nurse have at least six months' experience of working under his or her current nurse manager is to enable the staff nurse to have formed a more informed opinion of his or her individual relationship with the manager, as well as the manager's relationship with the staff as a whole.

The use of subjects from diverse organizational cultures and varying levels of RN experience assisted the researcher in developing common themes across multiple units and shifts. To increase the likelihood of diverse participants, the investigator sought an equal number of subjects from each of the organizations with varying levels of experience to represent the diversity component. The culture of the organization may vary from unit to unit and shift to shift. It is important to include a diversity of subjects to assist in finding a consistency in the behaviors of nurse managers that may affect the job satisfaction of the staff as a whole.

The PI identified a purposive sampling of potentially eligible participants through contact with nursing staff at each organization with the permission of the facility's chief nurse executive and made contact through e-mail (Appendix H) as provided by the organization. The investigator provided a flyer (Appendix I) and/or contact information to interested staff nurses and provided nurses with options for dates, times, and locations of the focus groups. Each focus group enrolled at least five and no more than eight participants in the order in which they volunteered. The study proposed to enroll no more than three RNs from the same unit or with the same manager per group. This increased the likelihood of diversity across staff with different managers from each organization.

Based upon availability, the investigator selected and enrolled in the study staff nurses who called or e-mailed to volunteer and who met the inclusion criteria. Three to five days prior to the scheduled date of the focus group, the researcher initiated a follow-up call or e-mail message, dependent upon the preference of the individual staff nurse, to encourage attendance.

## **Data Collection**

### **Procedures**

The researcher conducted the five focus groups on-site at each facility in the evenings when management was not likely to be present. Each group met in a conference room located away from the nursing units. All participants in each group faced one another around a table in a circular formation; the investigator was part of the circle. Upon arrival, the researcher invited participants to partake in the provided refreshments and to read and sign an informed consent (Appendix G). The investigator administered a one-time demographic questionnaire (Appendix F) and asked participants to place each document in a separate provided envelope. The researcher audio taped the semi-structured interview of each focus group consisting of three and no more than eight participating staff nurses. The minimal number changed from five to three in one group as a result of the lack of attendance of two participants. The researcher scheduled each focus group for one and one-half hours.

### **Focus Groups**

A focus group is a method of conducting a group interview of specific people who give their opinions, impressions, or perceptions about the phenomenon of interest

(Congdon, 2003). Morgan (1998) described the use of focus groups in comparison to individual interviews as the midpoint in larger part of the communication process:

- (1) The decision of what is to be heard from the participants is made by the research team members;
- (2) The chosen topic creates the conversation among the participants; and
- (3) A summary is made by the research team on what was learned from the participants. (p. 9)

The importance of using a focus group interview method is that people are more likely to explore and clarify their views in a way that may not be as easily accessible in a one-to-one interview (Kitzinger, 1995).

A focus group provides the opportunity for a comfortable group dynamic to provide a discussion of the proposed topic. Focus groups may be used to refine information previously known about a topic or to elicit new insight and information by examining a topic from a different angle (Nassar-McMillan & Borders, 2002). However, it is the responsibility of the investigator to create the environment that is conducive to an open-ended exploration of the participants' thoughts and experiences (Morgan, 1998). The grouping of individuals to discuss a topic that is a commonality and of interest to them may provide key information that otherwise would not be discovered by individual interviews. A group can conduct a conversation within itself, whereas an interview requires the participation of the investigator and the participant. A focus group process allows for sharing and comparing of experiences and for explicit use of group interaction in relation to the topic among the participants that would be less accessible without the interaction found in a group (Morgan, 1998). Kitzinger (1995) identified the following seven main aims of focus groups as a result of participant interaction:

1. To highlight the respondents' attitudes, priorities, language, and framework of understanding;
2. To encourage research participants to generate and explore their own questions and develop their own analysis of common experiences;
3. To encourage a variety of communication from participants – tapping into a wide range and form of understanding;
4. To help to identify group norms and cultural values;
5. To provide insight into the operation of group social processes in the articulation of knowledge (possibly to examine what information is censured or muted within the group);
6. To encourage open conversation about embarrassing subjects and to permit the expression of criticism;
7. Generally to facilitate the expression of ideas and experiences that might be left underdeveloped in an interview and to illuminate the research participants' perspectives through the debate within the group. (p. 302)

The topic of manager behaviors covers a wide range of activities and roles, including a large range of responsibilities. Focus groups provide an opportunity for a wider range of responses as a consequence of one participant possibly triggering the memory of another when responding to questions and, therefore, instigating more discussion. With individual interviews, participants may have more limited recall of manager activities and behaviors and do not have the possibility of the triggering of memories by other participants as provided by a focus group. In addition, if negative feelings are present, participants may be more willing to express negative comments if others in the group do so; whereas in interviews, individuals may not feel comfortable expressing criticism of the manager.

Congdon (2003) recommends the size of the focus group to be five to eight people who have been selected because they share qualities that can inform the study's questions. An advantage of focus groups is that the researcher can benefit from the interaction of the participants in the group. Lederman (1990) identifies five assumptions underlying focus groups:

- Each individual provides valuable information about himself or herself.
- The environment provides opportunity for individuals to report personal thoughts and feelings.
- Group dynamics provides important information.
- Individual interviews can be inferior to group interviews.
- The use of focused questions to the group recalls relevant information by group participants.

The research question informed questions used in the semi-structured focus group interviews. The investigator administered a demographic questionnaire (Appendix F) at the beginning of each focus group to all participants prior to any discussion related to the interview questions.

The interview questions and additional probes (Appendix A) used by the researcher during each focus group session incorporated components and technique suggested by Lederman (1990) on the use of focus group interviews for data collection. The following assumptions about focus groups forms the foundation of this technique: (1) People can be a valuable source of information about themselves; (2) People are capable of being good reports of the information they have, and they have the capacity to articulate that information; (3) People may need help in *mining* the information they have through facilitation by a professional posing questions to elicit the information to arrive at a conclusion; (4) The group dynamic approach can enhance the ferreting out of valuable information, encouraging honesty as part of the therapeutic assumption of the focus group environment; and (5) The interview of a group is superior to the interview of an individual because it leads to brainstorming and provides a group energy that results in

more than the sum of what individuals alone might generate (Lederman, 1990). Data collection continued until a predetermined number of participants (established by the researcher's committee) was reached. Prior to the initiation of the focus groups, the investigator and members of the dissertation committee experienced in conducting individual interviews and/or focus groups established content validity of the demographic questionnaire and interview guide.

### **Data Analysis**

Qualitative content analysis is a dynamic form of analysis for focus group data that lends to summarizing the information contents of that data through visual and verbal documentation (Sandelowski, 2000). Hsieh and Shannon (2005) defined qualitative content analysis as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (p. 1278). This type of analysis is data-derived, using systematic coding generated from the focus group data.

All focus group discussions were confidential and audio-recorded for transcription purposes. The evolving pattern of discussion helped to guide probing questions to supplement responses in subsequent groups. Upon completion of the first focus group the PI and chair of the committee discussed the need for alteration of the questions to provide a more direct discussion among the participants in relation to nurse managers. The revised questions are included in Appendix A. The data from the first group was included in the analysis. The investigator created a transcript from each audio recording, which became the raw data that was subject to analysis (Sandelowski, 1995).

The PI proofed the transcripts for accuracy by comparing the content while simultaneously listening to the audio-recordings and reading the transcripts.

The researcher analyzed the data of each focus group separately. After review of the audio tapes, the investigator generated a group theme summary with supporting quotes for each focus group, underlining textual data of staff descriptions of nurse manager behaviors as previously defined. The researcher identified the core meanings from these descriptions and established thematic groups. The investigator performed thematic analysis to increase the reliability of the analysis.

After completing a synthesis of data across focus groups and coding with significant statements extracted, categorized, and analyzed for content and themes, the researcher then compared data with current tools including the MLQ transformational leadership questionnaire and the PES to assess differences between the focus group results and those themes included in current instruments. Qualitative content analysis of the data was achieved through collaboration and discussion with the dissertation committee, which included qualitative and instrument development experts.

### **Qualitative Data Validation**

The data analysis occurred through a process involving the investigator and the chair of the committee to ultimately determine major themes. The process to determine the themes was as follows:

A professional court reporter transcribed the audio tapes and e-mailed the transcriptions to the investigator. The investigator reviewed each transcript while listening to the audio tapes to verify content and accuracy of the transcripts. The investigator made any additions or corrections at that time.

The investigator reviewed the transcripts a second time for all content that surfaced as a major discussion by the group in response to the research questions asked by the investigator.

The investigator sent transcripts to the research committee chair person; the chair and the investigator reviewed the transcripts a third time for clarification and refinement of theme labels.

The investigator created a table including all initial codes per focus group for a comparison of commonalities across the five groups. Initial code identification resulted in the following: Group One had 29 codes; Group Two had 35 codes; Group Three had 31 codes; Group Four had 47 codes; and Group Five had 36 codes.

The investigator reviewed the transcripts a fourth time and highlighted specific statements that related to the codes identified in the table for each focus group.

The investigator created a list of the statements and labeled them in correlation to each code.

The researcher reviewed the table of codes to compare commonalities across all five focus groups and highlighted those codes, which appeared in three out of the five focus groups, with different colors, resulting in two conceptual categories: manager behaviors (11) and work issues (6).

With the research committee chair, the investigator reviewed the table an additional time to determine major categories and themes among the codes, resulting in two conceptual categories, one of which contained three distinct themes. Each major category and theme occurred in at least three out of the five focus groups (over 50



percent). The investigator developed definitions for the conceptual categories, and analysis descriptions for each major theme based upon the data.

Through iterative discussion, the investigator compared the literature, present tools, and major themes resulting from the focus groups. This occurred because the focus groups' analyses provided alternate data and themes from those already in the literature.

### **Limitations**

The nature of self-reporting, the convenient sample, and the use of focus groups with the potential for *groupthink* are the primary limitations to this study. Self-reporting by staff nurses may provide only a small scope of the phenomenon of interest and not a full picture of nursing job satisfaction related to management behavior. Groupthink is a process that occurs when certain members of the group control or strongly influence the responses of others in the group. Through prolonged association, group members begin to think alike and have similar views of others and outsiders. Encouraging open inquiry, with each member of the group being provided an opportunity to share her or his viewpoint, helps to prevent groupthink (Sullivan & Decker, 2009). Limiting participation in this study to only two participants from any individual unit helped to prevent groupthink.

A threat to validity also may occur if participants offer no response as a result of perceived threats or group pressure. Others may exaggerate contributions to impress or convince the group. The investigator encouraged participation of all members of the focus group to minimize this phenomenon. Also, the larger context of the study must be considered by the investigator and seen from the perspective of the participants to determine validity of the data (Krueger, 1998). The researcher provided an opportunity

for all participants to summarize their thoughts and feelings of the discussion prior to the end of the focus group session and asked each RN to summarize the greatest take-away thought from the group discussion.

### **Summary**

The collection and compilation of focus group data using participants from two community-based healthcare organizations and cultures with varying levels of experience as RNs assisted in development of common themes across differing nurse practice environments. Utilizing participants from diverse and differing nursing culture environments provided richer and more detailed data to better describe and elicit nurse managers' behaviors that influence RN job satisfaction. From this data specific themes led to a comparison with current tools and determined if a need exists for an updated tool that will enhance the development of nurse managers through identification of behaviors perceived by RN staff nurses that influence their job satisfaction.

## CHAPTER FOUR. RESULTS

The purpose of this study was to describe RN perceptions of nurse manager behaviors that most influence RN staff nurse job satisfaction. The study used focus groups of RN participants to identify themes in relation to nurse manager behaviors that influence staff nurse job satisfaction. The researcher compared themes that emerged from the focus groups with themes of previous tools to determine if development of a new tool is necessary (Appendix K). Data collection involved focus groups in which the investigator asked participants to reflect on things that affect job satisfaction in relation to their managers' behaviors. Additional probes used throughout the discussions elicited specific details regarding each RN's perceptions and opinions (Appendix A). The researcher used a qualitative descriptive design for the focus groups and interview question data and used a descriptive analysis for data collected from the demographic questionnaire.

The following sections present a description of the sample and qualitative analysis findings from focus group data. The researcher achieved qualitative content analysis of the data through iterative discussion with the dissertation committee members for identification of themes (as described in Chapter Three). Analysis of the focus group transcripts resulted in identification of two conceptual categories (manager behaviors supportive of RNs—present or absent, and RN's perceived disconnect of work issues from the manager's role). With the conceptual category of manager behaviors supportive of RNs—present or absent, three major themes emerged: communication, respect, and feeling cared for.

## Demographic Data

A sample of 28 staff RNs working in two community-based hospitals in southern Indiana (hereinafter noted as Organization A and Organization B) participated in five focus groups. Of the participants in the sample, all but two were Caucasian and all but one were female. Participants ranged in age: five participants were 20 to 29 years of age and one was over 60 years of age. Almost half of the participants (46.5%) were 50 years of age and over. Over three fourths of the participants were married (78.6%) (Table 1).

Table 1

### *Demographic Frequency and Percentage Distributions*

| Variable                  | Total Sample    |                   |
|---------------------------|-----------------|-------------------|
| <u>Age<sup>a</sup></u>    | <u><i>n</i></u> | <u>Percentage</u> |
| 20–29                     | 5               | 17.9              |
| 30–39                     | 4               | 14.3              |
| 40–49                     | 6               | 21.4              |
| 50–59                     | 12              | 42.9              |
| 60 and over               | 1               | 3.6               |
| <br><u>Gender</u>         |                 |                   |
| Female                    | 27              | 96.4              |
| Male                      | 1               | 3.6               |
| <br><u>Race</u>           |                 |                   |
| Hispanic                  | 1               | 3.6               |
| Asian                     | 1               | 3.6               |
| White                     | 26              | 92.9              |
| <br><u>Marital Status</u> |                 |                   |
| Single                    | 1               | 3.6               |
| Married                   | 22              | 78.6              |
| Divorced                  | 5               | 17.9              |

---

*Note.*  $N = 28$ .

<sup>a</sup>In years.  $M$  age = 45.54. Age range = 24–62.

The participants had 1 to 40 years of experience in nursing, with the highest single number (39.3%) falling in the 1–10 years of experience category and a combined number (39.3%) having 21–40 years of experience. Over half (60.7%) worked 12-hour shifts, with the highest number (35.7%) working from 7 a.m.–7 p.m., with a combined number (74.4%) working day shifts that end by 6 p.m. (Table 2).

Table 2

*Work Shift Frequency and Percentage Distributions*

| Variable                                       | Total Sample |                   |
|--|--------------|-------------------|
| <u>Length of Time in Practice</u> <sup>a</sup> | <i>n</i>     | <u>Percentage</u> |
| 1–10   | 11           | 39.3              |
| 11–20  | 6            | 21.4              |
| 21–30  | 7            | 25.0              |
| 31–40  | 4            | 14.3              |
| <br><u>Hours Worked per Shift</u>              |              |                   |
| 8  | 9            | 32.1              |
| 12   | 17           | 60.7              |
| Other  | 2            | 7.1               |
| <br><u>Shift Times</u>                         |              |                   |
| 8:00 A <sup>b</sup> – 4:30 P <sup>c</sup>      | 1            | 3.6               |
| 7:00 A– 3:30 P                                 | 6            | 21.4              |
| 7:00 A– 7:00 P                                 | 10           | 35.7              |
| 7:30 A– 6:00 P                                 | 1            | 3.6               |
| 8:00 A– 6:00 P                                 | 2            | 7.1               |
| 8:00 A– 8:00 P                                 | 1            | 3.6               |
| 11:00 A–11:00 P                                | 1            | 3.6               |
| 12:00 A–12:00 P                                | 1            | 3.6               |
| 3:00 P– 3:00 A                                 | 1            | 3.6               |
| 7:00 P– 7:00 A                                 | 3            | 10.7              |
| 10:30 P– 7:00 A                                | 1            | 3.6               |

*Note.* *N* = 28.

<sup>a</sup>In years. *M* length of time in practice = 16.04. Range of time in practice = 1–35. <sup>b</sup>A = a.m. <sup>c</sup>P = p.m.

The participants represented a variety of hospital units (12 unique) with the highest number specific to medical/surgical units (17.9%). Over half (53.6%) of the RNs reported having one to five years of experience on their unit (Table 3).

Table 3

*Unit Frequency and Percentage Distributions*

| Variable  | Total Sample    |                   |
|---|-----------------|-------------------|
| <u>Unit</u>                                     | <u><i>n</i></u> | <u>Percentage</u> |
| Medical/Surgical                                | 5               | 17.9              |
| Psychiatric                                     | 2               | 7.1               |
| Critical Care                                   | 2               | 7.1               |
| Surgery   | 1               | 3.6               |
| Neurology                                       | 1               | 3.6               |
| Maternal Child Health                           | 2               | 7.1               |
| Emergency Department                            | 2               | 7.1               |
| Progressive Care                                | 1               | 3.6               |
| Cardiovascular                                  | 3               | 10.7              |
| Oncology  | 1               | 7.1               |
| Rehab   | 1               | 7.1               |
| Pediatrics                                      | 1               | 7.1               |
| Other   | 6               | 21.4              |
| <u>Length of Employment on Unit<sup>a</sup></u> |                 |                   |
| < 1   | 4               | 14.3              |
| 1–5   | 15              | 53.6              |
| 6–10  | 7               | 25.0              |
| 11–15   | 1               | 3.6               |
| 16 and over                                     | 1               | 3.6               |

*Note.*  $N = 28$ .

<sup>a</sup>In years.  $M$  length of employment on unit = 5.14. Range = <1–22.

The majority of participants (67.9%) reported having one to five years of work time under the current nurse manager, and almost half (46.4%) reported one to five years of employment at the current organization, with an additional third (28.6%) reporting six to ten years of employment at the current organization. Almost two thirds had a

baccalaureate degree (64.3%) in nursing and over half (57.1%) were certified in nursing (Table 4).

Table 4

*Employment Duration Frequency and Percentage Distributions*

| Variable                                 | Total Sample    |                   |
|--|-----------------|-------------------|
| <u>Length of Employment</u>              |                 |                   |
| <u>Under Current Manager<sup>a</sup></u> | <u><i>n</i></u> | <u>Percentage</u> |
| < 1                                      | 6               | 21.4              |
| 1–5                                      | 19              | 67.9              |
| 6–10                                     | 3               | 10.7              |
| <u>Length of Employment</u>              |                 |                   |
| <u>at Organization</u>                   |                 |                   |
| < 1                                      | 0               | 0.0               |
| 1–5                                      | 13              | 46.4              |
| 6–10                                     | 8               | 28.6              |
| 11–15                                    | 2               | 7.1               |
| 16–20                                    | 1               | 3.6               |
| 21–25                                    | 2               | 7.1               |
| 26–30                                    | 2               | 7.1               |
| <u>Highest Nursing Degree</u>            |                 |                   |
| Associate                                | 8               | 28.6              |
| Baccalaureate                            | 18              | 64.3              |
| Master                                   | 2               | 7.1               |
| <u>Certification</u>                     |                 |                   |
| Yes                                      | 16              | 57.1              |

*Note.* *N* = 28.

<sup>a</sup>In years. *M* length of employment under current manager = 2.46.

Range = <1–8. *M* length of employment at organization = 9.

Range = 1–28.

### **Focus Group Recruitment**

An e-mail message from the investigator through contact with the chief nurse executive initiated the recruitment process at each organization. The investigator obtained permission letters from the chief nurse and included in the submission of documents for

IRB approval (Appendix E). Upon approval by the Indiana University–Purdue University Indianapolis (IUPUI) IRB for protection of human subjects, the IRB committees at each organization reviewed and accepted the documents and waived further IRB approval.

After obtaining the IRB waiver, the investigator requested both organizations to provide a list of RNs and their e-mail addresses. Contact with RNs in the organizations occurred through e-mail. The human resources department director for Organization A e-mailed the list of RN e-mail addresses to the investigator. The investigator initiated contact with RNs in this organization. The director of nursing at Organization B initiated contact with RNs at that location. Each e-mail contact provided the same content and attachments as described below.

The e-mail message included a description of the study along with an invitation to participate (Appendix H). The e-mail message described the strategies for maintaining confidentiality for those agreeing to participate in the study. The message also included the informed consent (Appendix G). A flyer (Appendix I), attached with the e-mail message, requested that RNs reply through e-mail to the investigator directly if interested in participating in the study.

Upon receiving responses from interested RNs, the investigator included each volunteer's name and contact information on a list and assigned a code number. The investigator replied to each interested RN by an e-mail message requesting the nurse's availability on potential dates for the focus groups. Upon receiving availability responses from the RNs, the investigator determined the schedule of focus group dates. After choosing a date, the researcher sent an e-mail confirmation to individual RNs, including the time and location for the focus group.



The investigator conducted a total of five focus groups with three participants at the Organization A and two at Organization B. Four focus groups met with enough participants to meet or exceed the requirements of the study as designed (five to eight participants). Two scheduled participants in one of the first four scheduled groups did not attend resulting in only three available participants. The investigator decided to proceed with the data collection with the three remaining participants in that group and included this group's data in the analysis. However, the investigator scheduled a fifth focus group to increase the total number of participants in the study. The investigator contacted the remaining volunteers on the list who were unable to participate in the originally scheduled four focus group dates and repeated the initial e-mail recruitment process with a good response to allow for the fifth group to be conducted. Ultimately, 28 out of 45 RNs who responded participated in the five focus groups. Those volunteers who were not included in the study were unable to be present on the agreed upon dates and times. In addition, the researcher excluded three of the volunteers because they were charge nurses, which did not meet the inclusion criteria of the study.

### **Individual Focus Groups**

To maintain the confidentiality for the study participants, this study describes focus groups independent of their organizational identifier, A or B. The investigator observed that some groups did not readily share information and opinions at the beginning of the group but after one participant *broke the ice* the others appeared to become more open to discussing situations that were uncomfortable as well as other negative experiences that occurred on their units. This may have been the result of the

participants not knowing each other and not feeling safe about the confidentiality of the environment and trust among the group participants.

### **Group One**

The investigator conducted the first focus group using the original questions (Appendix A). The RNs in focus group one appeared to be comfortable with sharing information of their day-to-day routines related to the first question, “Tell me about a typical day for you at work.” However, initial review of the transcript revealed that this question elicited very little information from participants about their managers. In fact, the participants rarely mentioned their managers until specifically asked in the fifth question, “What part do you think your manager plays in how your day goes at work?” They engaged readily in discussing teamwork and patient care but hesitated when discussing the manager’s role in their work life. The investigator resorted to using the question probes to encourage more discussion about the manager’s behavior.

Due to the length of time allotted for the discussions of focus group one to address the questions involving manager behaviors, the investigator and the chair of the research committee decided to change the number and sequence of the questions as described in Chapter Three as follows: They removed question one, “Tell me about a typical day for you at work.” They combined questions three, “What do you think makes a day go well for you?” and four, “What do you think makes a day go poorly for you?” They removed question six, “What might your manager do to affect your day at work?” They reversed the sequence of questions seven, “What might your manager do to improve your day at work?” and eight, “What might your manager do to worsen your day

at work?” They removed the first probe, “Describe your nurse manager’s leadership style/behaviors.”

### **Group Two**

The RNs in the second focus group did not connect the manager to the operations of the unit. At times, the nurses engaged in sharing thoughts and opinions about their managers but did not always make the direct connection as to how the manager may or may not attend to issues on the unit.

The participants discussed the importance of the manager’s presence on the unit as well as respect and responsiveness. They thought it would be valuable for the manager to continue to maintain the same skill level as that of the staff on the unit.

The discussion involving the nurse manager’s behavior occurred much sooner in focus group two in comparison to focus group one. The investigator saw this as a direction result of the changes made in the focus group questions after the conclusion of focus group one.

### **Group Three**

The participants in this focus group openly and honestly discussed managers’ behaviors, connection to the unit, and ability to meet the needs of the nursing staff. However, they felt at times that there is a definite disconnect between the staff of different units throughout an organization. They expressed a level of apprehension in the discussion because trust is a major issue between the nurses and the managers in relation to communication and decision-making in the organization.

### **Group Four**

The participants in this group also made a very strong connection between the managers and the unit issues in the organization. They spoke often of a strong lack of trust and being very frustrated with the lack of communication and shared governance in the organization. The RNs expressed their apprehension when sharing stories of others who had been outspoken in meetings, for example, and consequently either disciplined or terminated for voicing their opinion.

### **Group Five**

The discussion in this focus group involved the lack of managers' involvement in the day-to-day work of the staff nurses. The participants expressed the general opinion that managers spend too much time in meetings and not enough on the units communicating with the staff and patients. They voiced their need for more recognition from management and administration of a job well done as well as responding to the individual and professional needs on the unit.

## **Qualitative Content Analysis**

### **Specific Aims**

The investigator conducted five focus groups with a total of 28 RN staff nurse participants. Each participant completed a demographic questionnaire. The investigator guided the focus group discussions by asking interview questions and frequent probes to elicit specific details regarding participants' perceptions of nurse manager behaviors. The following is a discussion of results related to specific aims 1 and 2.

Specific Aim 1. Identify staff nurse perceptions of nurse manager behaviors that influence job satisfaction. Analysis of the focus group transcripts resulted in

identification of two conceptual categories: manager behaviors supportive of RNs—present or absent, and RN’s perceived disconnect of work issues from the manager’s role. Within the conceptual category of manager behaviors supportive of RNs—present or absent, three major themes emerged related to communication, respect, and feeling cared for (Appendix J). Table 5 identifies codes resulting from the data analysis.

Table 5

*Qualitative Data Analysis of Transcripts: Identified Codes*

| Initial Focus Group Codes |                     |               |
|---------------------------|---------------------|---------------|
| Advocate                  | Fear                | Recognition   |
| Trust                     | Co-worker attitudes | Flexibility   |
| Respect                   | Visibility          | Communication |
| Lack of breaks            | Staffing            | Consistency   |
| Listening                 | Support             | Fairness      |
| Physician relationships   | Teamwork            |               |

**Manager Behaviors Supportive of RNs—Present or Absent**

The focus group transcript content analysis resulted in agreement in this category of three major nurse manager behavior themes (i.e., communication, respect, and feeling cared for) that are addressed within the group discussions in response to the research questions posed in this study (Appendix A). To be identified as a major theme, data reflecting similar meaning must have occurred in at least three of the five focus group transcripts (Appendix J).

**Communication.** The investigator identified the theme of communication through the RN participants’ discussion as they spoke regarding communication—that is, when communication is present, RNs are more aware of the decision-making that is occurring within the organization. Managers are consistent in what they say and do, listen

to the personal and professional needs of the staff, respond by promoting open discussion within the unit, and maintaining confidentiality, which promotes trust. Communication is absent when the staff feels excluded and unaware of the results of decisions being made within the organization. This type of behavior by the nurse manager, as perceived by the RNs, results in a lack of trust between the staff and the management.

Dictionary.com (n.d.) defines *communication* as the exchange of information. Staff nurses in three of the five focus groups discussed the importance of communication and indicated that it is an important way to eliminate misunderstandings. The majority of communicating is done as an interpersonal process between individuals. Communication can occur in many ways such as between two individuals face-to-face or over the phone or among individuals in groups. Many times the receiver of written communication such as e-mail messages can misconstrue the message and verbal communication is necessary to make the message clearer.

In an organization, hierarchical communication is important between managers and employees. The majority of the RNs in the focus groups discussed the importance of direct verbal communication between the nurse manager and the staff. The nurses expressed the need for a manager to communicate to the staff what is occurring in the organization and to discuss decisions made in administrative committees, which may affect the unit and staff. Direct verbal communication helps the staff to be more informed, better organized, and *on the same page*. One RN explained it in this way:

I guess communication is a big issue when I see managers that are more open with their communication, both interacting with people on the units, communication, talking to them, how's their day, what are their needs, what's going on, and then the lack of that, when people don't do that, I think that's a real barrier.

Another nurse reiterated the importance of communication by stating, “I think that with communication that’s letting me know what’s going on and so if we have an issue in our department that they will fix things.”

The RNs discussed the need for managers to respond to requests by staff nurses in a timely manner either through verbal or written communication. They felt that a timely response from the manager recognizes the individual’s needs and demonstrates that the individual is valued as part of the team. They also felt that it is important for managers to verbally acknowledge and appreciate the staffs’ hard work during difficult times on the unit. One nurse expressed the frustration that occurs when the manager does not respond in a timely manner by stating, “I keep coming back to communication. I mean I e-mail her something and it’s weeks before I get a response, if that.” Another nurse explained how the lack of communication makes her feel: “Something I think is never really noted enough—the communication piece when something really goes bad and how hard that was for you.”

Many of the nurses felt that at times managers may avoid verbal communication when the topic is about something negative. They stated that a manager may leave a note in the staff nurse’s mailbox instead of approaching the nurse face-to-face about the problem. Communication of this type can lead to negative relationships for managers with staff nurses. Many of the RNs felt that a bad attitude or a verbal disagreement with their managers will result in a bad relationship and/or may lead to a bad work environment. Therefore, nurses may limit verbal communication in lieu of confronting the manager. One RN commented on the importance of communication between staff and the nurse manager:

I think communication is key and I think anybody who has the communication skills and really promotes those is a better manager and the nurses that are better communicators are happier in their job because they get their needs met.

Based on the discussion involving communication, the staff stated they perceive a manager who communicates openly and honestly as a better manager, even if he or she is not a good task manager. They felt that when a lack of communication exists, the staff perceives the manager as a poor performer, one who is detached and uncaring even though this may not be the case, resulting in a barrier between the staff and the manager. During the discussion, one nurse described how it feels to her when the manager does communicate with the staff:

For me communication is a big deal and when I feel best about what my manager is doing on my unit and having that communication and knowing that they're supporting me and that they recognize how difficult things are.

The staff shared other comments related to consistency in communication. A manager is perceived by staff as being consistent with communication when all employees are held accountable in the same manner for following policies and procedures. Staff nurses discussed the need for consistency with communication in four out of five focus groups. When a manager is perceived as favoring one individual over another, one unit over another, or not enforcing policy in certain situations, this is inconsistent behavior and may result in a barrier of negative feelings between the staff and the manager. One nurse commented about a manager's lack of consistency: "I have seen some inconsistencies; you know, on certain policies, certain things. I wish there would be more consistency." Another nurse commented on a manager's behavior by stating, "She will say one thing and do another." While yet another nurse commented on



consistency with accountability, “General consistency with other staff and holding people accountable to things that you implement and carrying those things out, lack of that is not a good thing.”

Many of the staff nurses expressed a fear with communication and voicing their opinion in relation to introducing information about a problem or concern on the unit or within the organization. This occurred in three out of the five focus group discussions. The nurses felt that upon voicing their opinion they are perceived by the manager or administrators as *being negative*. This creates a fear of repercussions of discipline and ultimately possible termination, resulting in a barrier to effective verbal communication between staff and management. The RNs felt that a leader with a negative attitude breeds fear among the employees. A nurse who is fearful of expressing her opinion to the manager made this comment:

I don't want the repercussions of what might happen, because I don't want to be treated any differently than anybody else, I am fearful to say 'I don't really support how you behave and I don't know how to tell you to change.'

Another nurse commented on being fearful and anxious:

The people on our floor are afraid to say anything. I mean we used to joke a lot but now if someone jokes you think you might offend somebody. It is just the opposite of when it used to be. I had anxiety attacks because every time I would step into her office I started sweating and would have hives.

*Listening* was perceived in the discussions by the staff as a manager who is receptive to their suggestions and responds in a way that is timely by actually doing something in response to the nurse. This was discussed in four out of five focus groups. The RNs felt that nurses perceive managers as *bad managers* when they do not listen to their staff and are not involved in the day-to-day operations of the unit. They perceive

bad managers as those who do not acknowledge the staff for hard work on a bad day. One nurse described a manager who listens in this manner:

A good listener. They take it in and they get back to you in a timely manner, but they truly hear, respond and you can tell when somebody is truly listening to what you're saying and gets back with you.

The lack of listening is related to a bad manager by another nurse: "The worst managers don't listen to their staff, especially if they are not involved and they don't know what goes on in the day-to-day basis. They don't listen to the staff."

The focus group discussions often focused on a manager's ability to create an environment of trust by allowing the staff nurses to feel comfortable with admitting their mistakes and sharing their feelings and opinions. This was identified as crucial in the healthcare environment where staff nurses do not always feel they can report an error or make a complaint and not suffer negative consequences. Nurses discussed in three out of the five focus groups how too often they do not trust the proposed *no blame* environment because they often are aware of employees being disciplined after disclosing a problem on the unit. The following statement by one of the staff nurses emphasizes the importance of being able to share an opinion:

It also has to be okay to bring up a problem. If we become a system where it's not okay to bring a problem, then that's an issue. If you're told in a meeting, 'Okay, you're negative because you brought up a problem,' then how do we change things if we're not even allowed to have a problem in the first place? I think that is an issue sometimes, because I've been in situations where that's happened and it's not pleasant.

To create trust, RNs felt that a nurse manager should allow staff nurses to be involved with making day-to-day decisions without always first checking with the manager. This provides an environment of shared governance on the unit level and allows

those closest to the patient to make pertinent decisions involving patient care. Shared governance also allows staff nurses to make decisions regarding policies, scheduling, and other important issues that affect their professional and personal lives. One nurse discussed the importance of being allowed to make decisions on the unit: “I think it is a trust thing. If she trusts me to make adjustments to the schedule for tomorrow based on something that I perceived, different issues, that she trusts me to handle those, and that’s positive feedback.”

Many of the nurses described trust as being created when a nurse manager shares information that is pertinent to the unit and to the employees so that the perception of the staff is not an environment of secrecy. They felt that when employees learn about information from other sources or after a decision has been made that directly affects them, trust is diminished. One RN described her feelings about the manager sharing information:

I mean, if they communicate well with you and tell you what’s happening and why things are happening...and if they don’t communicate then there is secrecy, then you don’t have respect. You have more of a trust and respect when you understand why certain things are happening.

The nurses discussed ways for nurse managers to increase levels of trust including being available to staff to share personal information or a problem about an occurrence on the unit and keeping it confidential. The nurses felt that managers need to know what to share and what not to share with others and when to share information on a need-to-know basis. This maintains a level of trust with the employees. One of the staff nurses verbalized a concern in relation to sharing information with the manager by stating, “Probably trust that I can go and tell them, whether it’s family-related or whether

it's something that happened that day with a patient or with a provider. I don't feel like I have that.

Managers must learn to avoid the *grapevine* by not listening or joining in gossip about their employees. While at times vital information can be learned in this manner, if the nurses perceive the manager is gossiping, a trusting relationship can be destroyed. The RNs perceive managers who *walk the walk and talk the talk* as remaining professional.

However, the staff nurses felt there are times that it is acceptable to be *one of the gang* with employees. Nurse managers should not hesitate to share the work with their staff on the unit. The nurses discussed the importance of sharing the responsibility on the unit, especially when a shift is very busy and times are tough for staff who feel overwhelmed. Nurse managers who make themselves available are accepted as one of the team and a bond of trust is built.

**Respect.** The investigator identified the theme of respect through the RN participants' discussion as they spoke of respect being present when the manager promotes fairness in interacting with the employees on the unit by treating everyone the same in all aspects of enforcing policy and discipline, by holding each individual accountable, and by providing fairness with weekend, holiday, and vacation time scheduling. Respect also is present in the manner in which the manager acknowledges the good work of the staff on an individual basis for the contributions made on the unit by providing good patient care. Respect is absent when the nurse manager is not equitable in staff discipline or prioritized scheduling, as well as a demonstrating a lack of recognition

for the level of care and compassion that is shown to the patients and their families on a daily basis.

Often the saying *respect is not given, it is earned* is heard in relation to individuals in leadership positions. Dictionary.com (n.d.) defines *respect* as being considerate toward somebody. Respect is having consideration for self and others. In the workplace in general, respect includes consideration for employee privacy, physical space and belongings, different viewpoints, individual beliefs, and personality.

Discussion by staff nurses in three out of five focus groups included the idea of mutual respect. Many of the nurses discussed the way respect occurs between the staff and their manager. When a person has respect for his or her manager and feels it is reciprocated, the person wants to do a good job and impress the manager. When there is a lack of respect, often productivity decreases and the relationship between the nurse and the manager suffers. One staff nurse remarked:

It is the same as teaching, if you tell a kid they're great, you're going to do well, you're wonderful, I'm glad you're here, it's the same thing. That person is going to be happy and productive and satisfied rather than if you had someone that you didn't respect.

The nurses discussed the importance of how a manager handles a difficult situation with the staff. If a situation occurs wherein a manager needs to speak to an employee about a performance issue, the manager does so with respect, not in a demeaning manner, and in private. A good general rule is to praise publicly, punish privately. Staff nurses felt the manager should first discuss positive issues about the employee and then the areas that need improvement. Staff were aware that at times the manager may provide a performance improvement plan for an employee, which shows an interest in the individual's development as a professional. The manager should maintain

confidentiality and not share this information with other employees. One staff nurse described how a manager should handle respect regarding a confidential problem by stating, “If there’s a problem she won’t announce it to the world, she will take you aside and tell you what happened and how you can do better and why that happened.”

Many of the nurses felt that nurse managers who show respect for their staff nurses display positive behaviors when they refrain from making jokes or negative comments about an employee’s ability, skills, or performance to other individuals. Confidentiality is taken very seriously. Nurses stated that a respectful manager avoids labeling the staff nurses because this encourages stereotypes and false assumptions.

Managers also must model the kind of behavior they expect from employees. It is disrespectful to the employees to show up late for meetings or for work, blame administration or the unit when problems occur, use their time at work improperly with personal tasks, or gossip about employees. The RNs felt expectations should be made clear and enforced through policies by management in all circumstances, including their own behavior.

Staff nurses discussed the importance of nurse managers earning the respect of the employees by being fair, providing recognition where deserved, and being available to their employees. Managers should involve the employees in unit decision making. Staff nurses often have the most appropriate ideas on how to best take care of their patients and noted that managers who utilize these ideas will foster the respect of the employees. Managers also should share with staff the credit and complements received and acknowledge the employees’ contribution, efforts, and ideas in order to build respect. One nurse described the need for mutual respect as follows: “I feel like a lot of it has to

do with respect in anything and if you respect your manager you don't want to disappoint them, you want to do a good job.”

As discussed in the literature review, employees often leave a position or organization because of their lack of satisfaction with a manager. Frequently this is the result of a lack of respect on both a personal and professional level. For a manager, respect is an essential leadership quality and is an expectation of the position.

Staff nurses discussed fairness in four out of the five focus groups. The RNs perceived managers as being fair to the staff when they hold each individual accountable for her or his actions and address performance issues promptly, regardless of their relationship with an employee. One staff nurse commented about treating everyone equally:

If there is a policy set in place, you know, it's held up again every single time, then it is easier for you to accept, but if it changes based upon the recipient, then that kind of affects how others perceive things or feel.

The manager should always expect the best from employees regarding patient care and not require them to treat some patients more importantly than others, such as with a designated very important patient (i.e., VIP). One nurse shared the following statement concerning equal treatment of patients on the unit:

I've kind of gotten a sour taste sometimes; they're very overly concerned and hyped up when there's some VIP person or patient where there's been a major issue so we need to be sure that you're going over and above two hundred percent. I think that there's no place for that. That sounds like an insult. I always do my best.

Often the discussion of the focus groups involved how and when the nurse manager recognizes the staff. The staff perceived the nurse manager as appreciating the staff for hard effort through verbal communication as well as written statements in

evaluations. In all five of the focus groups, a good manager was acknowledged as one who goes out of the way to show appreciation for staff individually and collectively with gestures such as a pat on the back, a card, a piece of chocolate, or a word of simple praise. One RN, when discussing the lack of recognition for the positive things, stated, “The things that are mistakes are always recognized, but the things you feel like you really pushed to accomplish with a lot of effort most times are not recognized.” Another nurse stated her feelings about how even the smallest level of acknowledgement is appreciated: “I guess I’m just a sucker for, you know, just simple praise.”

The discussion included the need for managers to reward exceptional performance with opportunities for advancement or recommendations for new projects. The nurses discussed how managers could empower productive nurses to improve themselves personally and professionally. The discussion led to the following comment about a manager who takes the time to verbally recognize the staff: “I noticed the more she comes out and tells us how we are doing, that helps tremendously. That makes me want to work harder and makes me want to do better.”

**Feeling cared for.** The investigator identified the theme of *feeling cared for* through discussion of the RN participants as they spoke of how it makes them feel to have a nurse manager who is willing to defend them in situations with other employees, patients, and physicians. The participants described feeling cared for when the manager is aware of their personal needs while working and provide adequate staffing to ensure staff get breaks and meals when the unit is busy or provides schedule flexibility and allowing time off to care for themselves or the needs of their families. In general, just being visible on the unit shows the staff that the manager is interested in their needs and aware of their



workload and willing to help in any way possible. When the unit is always short-staffed and the nurses do not have sufficient time to take a break, eat a meal, or simply go to the restroom and the nurse manager is absent, the participants feel uncared for. They also feel uncared for when managers are invisible on the unit as a consequence of meeting attendance or simply remaining in their offices with doors closed and not having a presence on the unit.

Nurse managers' support of staff nurses has a direct effect on the work environment but is dependent upon what the staff perceive as a feeling of being cared for by the manager. Dictionary.com (n.d.) defines *care* as being concerned or tending to somebody or something. In the focus groups that were conducted in this study, feeling cared for was a topic that occurred in four of the five groups. One RN noted during the discussion of the nurse manager caring about how the nurses provided for patient care that:

We do a lot to care for family members and we do a lot of end of care planning with family and patients. That was a time when I felt like, you know, I needed, I wish there was more of a support system.

Another RN commented regarding the nurse manager that, "She is there, she rounds, and she asks you if you're doing okay. If she sees that you're about to go, she pulls you in a room and says, 'Sit down for a minute. Drink something. Catch your breath.'"

Perceptions of lack of caring by the manager may lead to decreased levels of job satisfaction for the RN. When employees have low job satisfaction, many things such as a decreased productivity, diminished quality of care, and decisions to leave their positions

can occur. One RN shared a decision she made to leave a position as a result of low job satisfaction and the lack of feeling cared for:

I left the last unit because of my manager. Maybe that wouldn't have happened; maybe it could have been avoided. I loved the patient population so it wasn't that I was dissatisfied there, it was just a lot of it was that we needed support from the manager and that needed to change.

Discussion among the RNs about feeling cared for by the manager included situations in which a manager acted as an advocate for the staff, supported them, and represented them in conflict resolution with physicians, peers, administration, and patients. The discussion concerned how the nurse manager can set the tone on the unit by letting the staff know he/she *has their back*, and will *go to bat* for the nursing staff when necessary. The staff nurses discussed their need to know the manager is an advocate for them in situations where others may attack their professional skills and decision-making abilities in relation to patient care. A nurse stated the importance of the manager-as-advocate in caring about the needs of the staff in a manner that allows them to get their job done:

She finds out what's going with you personally and what you thought of the situation, and she always makes sure everything is there for you so you can do your job and if you don't have it and you need it, she'll find it.

The RNs also discussed the importance of the nurse manager being an advocate for them with physicians. One nurse shared an experience when the manager defended a call to a physician in the middle of the night:

'Well I can tell you why she called you in the middle of the night, because that was your call order and if it had been me I would've called you too.'  
When she told me she had that conversation with him, I felt very good.

Another area of feeling cared for that was discussed in three out of the five focus groups was the manager's ability to be flexible with the staff in meeting their needs for their personal life, such as scheduling, family emergencies, and vacation time. One RN who works night shift discussed her inability to attend staff meetings that occur during the day by stating that "You know, after twelve and a half hours you don't want to stick around for another hour and a half, and yet in the middle of the day I'm sleeping."

Another nurse describes how the manager cares by showing flexibility with the schedule: "She's just been good about...moving things around or knowing that I can do this day or not that day or, you know, doing twelve here or whatever."

Often the RNs shared feelings related to lack of caring by the nurse manager such as when nurses did not get their personal needs met during their shift. The staff nurses' discussion included lack of breaks/meals in three out of the five focus groups. When staff does not get supported by managers to take a break or even have a bathroom break, they feel the manager does not care about them and does not support them as a professional.

One nurse described what a day is like for her on the unit:

On a typical day I work it's always hectic and always a struggle to get my lunch or dinner in. I'm lucky if I've got it in. Half the time I don't and the other half I'll just take a break and you know, shove something down my throat.

Staffing is an area of concern for staff nurses that has a direct effect on perceptions of their ability to provide excellent quality care for their patients. The nurses discussed being very aware of the levels of staffing when things go wrong or when emergencies occur and the nurse manager is not there to lend a hand or to call in additional staff. Low staff levels that occur consistently on a unit can lead to nurse burnout and low job satisfaction, which again affects patient outcomes and turnover on

the unit. During the discussion about staffing, one nurse explained how the manager could be supportive when the unit is short staffed:

You can have a good day when you're short-staffed, it just depends on the support that you do get from the people that are there and if your manager can come out and support you while you're having that bad day—it just kind of alleviates that.

Another nurse shared how decreasing the staff on the unit increases the level of stress that occurs:

I think she just didn't realize the strain that it puts on our department. I don't think she's there enough to realize when they pull people like that, you still have the staff maybe, and the numbers look good, but the strain that it's putting on those nurses while they are working could be alleviated maybe a little bit better.

Discussion also involved the manager caring about the level of staffing and the possible effects on the nurse as a professional as evidenced by this statement: “You need to be adequately staffed, for safety reasons, so you don't have to give up that license you worked so hard for.”

Nurse managers who are visible to their staff are perceived as being more involved and more caring about how the unit shift is going according to the responses by the nurses during the focus groups. The discussion in the focus groups regarding nurse manager visibility occurred in all five of the focus groups, showing this to be a very important topic related to how simply seeing the manager on the unit increases the feeling of support and feeling cared for as perceived by the staff nurses. Discussion also involved the positive aspects of the manager's role as caring even at times the manager was not present, if the nurses perceived the climate on the unit as one of caring for one another, like a family. One nurse stated:

I think what my manager does for me even when she's not there every day, is the climate of, you know, we're a family and we're going to work together or I've been in other places where there's a climate of, if you do something wrong then you're going to be punished.

An RN, regarding how the manager not being visible often affects the night shift staff, made the comment, "I see my manager when she comes in the morning with her smile. I don't see her to be able to give an opinion of what part she has played, because I work nights." Another nurse shared her perception of a manager who is not visible as not interacting with or caring about the staff: "Negative behavior would be unprofessionalism and staying in their office and keeping the door shut and being standoffish and just not being visible."

Observations were noted by staff nurses who are aware of the importance of seeing their managers on the unit and as being helpful:

I don't even see my manager most of the time. I know that she usually comes and stands at the desk for a little bit and asks how it's going, but she is not hands on. I've seen others that are like up and down the hallway and do things and she's friendly, she's very nice, if you need to change a day or something like that. I don't have a problem with her per se in that regard, but is she helpful on the floor or unit? No.

Visibility was often expressed by the RNs by how the manager interacts with the staff and shows concern about sharing the load as shown by this comment:

I think it is really positive when the manager's round and come out on the floor and, you know, just see what's going on, see what our day is like, see what problems we're having that are the type of thing that they can fix.

### **RN's Perceived Disconnect of Work Issues from the Manager's Role**

Each of the five focus groups discussed the RN's typical day at work and the problems that often occur on a daily basis. However, most of the discussion did not include the nurse manager's role in the every-day life on the unit. There seemed to be a

disconnect between the perceptions of the RNs regarding their actual work issues and the nurse manager's role on the hospital unit. Dictionary.com (n.d.) defines *disconnect* as one part being detached from another. A disconnect was apparent when often the RNs stated that the nurse manager does not play a role in their day-to-day job in providing patient care. One RN stated:

The only time that she's really involved in what we're doing is when we're full and there's patients that need to be placed and she's harping on us to constantly call the doctors, get them transferred, and that's hard to do when you've got critical patients that are critical.

A second RN did not relate the manager to the daily needs of the unit: "Our manager is fantastic, the one we have right now, but as far as my day to day, it does, she doesn't really have an effect on my day."

The discussion often targeted the amount of time the nurse managers spend in meetings and how this part of their role keeps them from being active participants on the unit to solve problems with patient care or simply to show the staff they are there to support them. One RN's perception of the nurse manager and the number of meetings attended each day was demonstrated by this statement:

They're going to come and they're going to come flying to the unit if there's something wrong and they're going to be there for you, which is great, but these meetings I think preclude them being able to help on a daily basis in a way that they might be able to help even more, which would be nice. And I also think by virtue of having all these meetings that it pulls them away from the day-to-day activity of what really happens on a unit sometimes, so that when you're making policy, but you're not there as much, it's harder for you to really see how what you're doing is going to impact that person and that's what scares me about the number of meetings that they have to attend.

Another commented that a “negative [behavior] would probably just be not being available.” Others also shared concerns that meetings hindered managers’ effectiveness because “that’s basically all they do is just meetings from the time they get here until the time they go home mostly” and “if you’re in different meetings all the time, how can you be effective? I don’t know.” One nurse perceived that managers attended “meetings about meetings, exactly” and believed that “they kind of need to be on the floor.”

Other discussions by nurses who work nights or weekends involved a disconnect between the manager’s role and the function of the unit. A nurse who works mainly weekends commented that “I never see her on the weekends. When I’m there during the week or before I went weekend option, you would see her Monday through Friday—every morning that she wasn’t already in meetings.”

Finally, a perception by the nurses during the focus group discussions highlighted a disconnect between the manager and the job of nursing in itself. The nurses often shared opinions in relation to the manager no longer knowing how to be a nurse, such as this comment:

She’s there. She makes an appearance and she’s nice. I’ve just heard other people, when it’s been really busy like, she’ll say she’ll get them some help and then the help she gives is saying, ‘You’re doing a great job,’ but doesn’t jump in and put on a pair of gloves or do anything like that.

Another nurse shared feelings about how the manager loses that connection with the clinical aspect of the job when taking on the manager role:

They have more administrative things than really nursing things. Like they’re not held together. The connection is broken, when they step up. I see it being different when you are a clinical nurse and you go one step up. Most of them when they are managers, they are managers, not clinical managers.

Often the discussion led to RNs sharing their expectations of the nurse manager. For example,

Just actually physically being in front of somebody, you know. Listening to report, just so you kind of get a feel for, you know, what the staff's day is going to be. That would be nice. Showing up on the off shifts and just being in that full-time slot and you know, you could set your watch by when she's going to get there and when she's going to go home. Answering the cell phone when staff calls, and you know, I think we are expected to only call when it's something that's really out of the ordinary.

The RNs felt the managers are not able to relate to the many problems the nursing staff have on a day-to-day basis, including the physical stress and strain of being directly involved in patient care. One RN commented that "I'd just like some feedback because I feel like my boss has no idea what kind of a job I do because she's...there's a big gap in between what she does and what happens on the floor."

Another described a level of frustration when staff perceive the nurse manager as being disconnected from the demands of the job of an RN:

I do wish the managers...could put their self in our shoes sometimes. Because, you know, we do have limits, not only physically but emotionally too. I mean, sometimes at the end of the day when I know when we go home we're just wiped out. We're usually there 'til 6, sometimes later. We stay until the patients are done and it can be a long day. It's mentally exhausting as well as physically.

One RN described her perception of the role of the nurse manager in comparison to the charge nurse:

I think the charge nurse actually plays a bigger role than your manager. Our manager is there, but if something goes down you're going to go to your charge nurse first, so they are more important. That's just me, not in the step-by-step involvement. With my manager, only if something major goes wrong do you ever see them.



Yet another nurse described how it affects the staff when the manager does provide assistance during a time when they are short staffed:

Even if, you know, you're short staffed, I mean, you can have a good day when you're short staffed, it just depends on the support that you do get from the people that are there and if your manager can come out and support you while you're having that bad day it just kind of alleviates that.

Specific Aim 2. Compare data obtained from focus groups with the existing tools including the PES, the transformational leadership survey from the MLQ, and the NMSS, a subscale of the EOM tool.

The investigator identified two conceptual categories from the focus group data: (a) nurse manager behaviors supportive of RNs, and (b) RN's perceived disconnect of work issues from the manager's role. In addition, qualitative analysis identified three themes of nurse manager behaviors (communication, respect, and feeling cared for) supportive of RNs. The investigator compared the two conceptual categories and three themes to scales and subscales of current job satisfaction tools (the PES, MLQ, and NMSS) utilized by healthcare organizations to measure staff nurse job satisfaction and discusses them below. A summary of the inclusion of the conceptual categories and themes that emerged from the data and represented in the PES, MLQ, NMSS, and the CAT-admin is provided in Appendix K.

***The PES.*** The PES has five subscales, one of which addresses the nurse manager ability, leadership and support of nurses. The subscale contains five items that provide an opportunity for nurses to respond, ranging from *strongly agree* to *strongly disagree*, regarding their manager on general areas of support and recognition. The items do not contain the manager's specific behaviors identified by the RN participants in this study.

**The MLQ.** The MLQ contains two forms: the leader form (45 items) and the rater form (45 items). The forms are the same except for the wording dependent upon to whom the form is administered. The leader self-form measures the self-perception of leadership behaviors. The forms measure passive leaders to leaders who give contingent rewards to followers, while identifying the characteristics of a transformational, transactional, and a passive/avoidant leader (Bass & Avolio, 2004). There is a hierarchical pattern of results, with transformational leadership having the most positive impact on employees (Bass & Avolio, 2004). Additionally, the tool allows individuals to identify how they measure in their own eyes as well as in the eyes of those with whom they work.

The individual completes the forms responding to the frequency in which they exhibit the item behaviors, ranging from 0 (*not at all*) to 4 (*frequently, if not always*). There are multiple items listed for the MLQ Measurement of Leadership that allow for comparison with the themes which emerged from the focus group analysis. The result measures the effectiveness and employee satisfaction with the leadership style of the supervisor.

**The NMSS.** The NMSS subscale of the EOM tool is worthy of comparison in this study. Kramer and Schmalenberg (2004) developed the EOM through observation studies and interviews of nurses employed in Magnet hospitals. Through additional research, Kramer et al. (2007) found the EOM subscale for nurse manager support to be accurate but did not include all pertinent supportive behaviors. Therefore, Kramer et al. (2007) constructed a tool that contained a more comprehensive list of well-defined supportive role behaviors of nurse managers called the NMSS. They adapted this from the original nurse manager scale of the EOM and revised it through additional interviews with staff

nurses, managers, and nurse executives. Role behaviors identified in the NMSS are as follows: approachable/safe, adequate and competent staff, walks the talk, watches our back, group cohesion/teamwork, caring, conflict resolution, self-confidence, and feedback.

The following is a comparison of the themes (communication, respect, and feeling cared for) with the scales and subscales of the PES, MLQ and NMSS.

*Communication theme.* The behaviors identified from the focus group data included the theme of communication on an individual and on a group level. This involves communication that is open in both directions, giving and receiving of information from the manager to the staff and vice versa. The RNs stated they want a relationship with the nurse manager that is open and honest.

The PES subscale addresses whether the manager is a good manager or leader but does not represent how this might occur such as with the level of communication between the manager and the nursing staff. The RN focus group participants discussed their need to be able to rate their manager on a more intimate level than just whether they are a good manager or leader in general.

The MLQ addresses the theme of communication through the items in the ideological behaviors/influence characteristics by asking if managers share their values and beliefs as well as making individuals aware of consequences of decisions when made. These characteristics of the leader involve a level of communication that is more group oriented than individual and a style that portrays one-way communication rather than the two-way communication desired by the RNs in this study. While the RN participants expressed the need for communication on all levels, they were specific about

the importance of the individual level and one-to-one communication between the staff nurses and their nurse managers. The MLQ includes this as part of the individual characteristics of a leader as one who meets the needs and builds the strengths of others.

The NMSS more clearly approaches the importance of the role of communication as it addresses being approachable and listening, while keeping things confidential when speaking with staff. It also depicts the need for speaking with staff on a daily basis.

The RN focus group participants in this study shared their need to receive communication from the nurse manager that is consistent for all employees on all shifts. This type of communication promotes trust by providing evidence the manager is listening to the RNs and responding appropriately in a timely manner, while protecting their privacy by not sharing confidential information with others. They also discussed the importance of being able to speak freely without repercussions from the manager and not being labeled as negative when identifying a problem on the unit or within the organization.

The PES does not include the level of consistency of the manager or the protection of private information but does ask whether the manager uses mistakes as an opportunity to learn and not be critical of the staff. The MLQ addresses the effectiveness of the leader by following policies/procedures and how the leader meets the needs of others but does not directly approach protecting the individual from fear of rejection or exposure due to breach of confidentiality. The NMSS addresses the need for the manager to provide a safe environment for the staff, respecting personal opinions while maintaining confidentiality. This clearly is in alignment with the results from the focus groups involving the RN participants.

The RNs in this study emphasized the importance of these very specific manager behaviors in relation to their job satisfaction and a positive relationship with their nurse managers. They need to trust the practice environment as a safe, comfortable place to work. A study by Bono et al. (2007) investigated the role which leadership has on employees' emotions and found that managers who have a positive mood maintain an ongoing influence on the optimism and enthusiasm of the employee but noted that when employees feel the need to regulate their emotions as a response to fear of repercussions they are less satisfied with the job and more stressed.

*Respect theme.* Respect for the nursing staff by a nurse manager can be displayed in many ways. The RN participants described respect as the manager letting the employee know he/she is valued as an individual by being fair, treating everyone the same, and holding everyone accountable as well as providing recognition for nurses for their individual contributions to the unit and patient care. A study about nurse perceptions of respect by Laschinger (2004) supported the opinions of the participants. The study found that nurses feel managers do not show respect when there appears to be a lack of concern by not dealing with the staff in a sensitive manner and not being truthful. This behavior leads to a lack of recognition, poor interpersonal relationships, and unreasonable workloads resulting in stress in the workplace and, ultimately, decreased job satisfaction (Laschinger, 2004).

The PES does not include questions specific to fairness and treating everyone equally. However, the scale does ask if the manager provides praise and recognition for a job well done. This is related directly to the data from the RN participants in this study in that they value being recognized for their hard work. The MLQ addresses leader

characteristics including building respect and going beyond self-interest and displaying power and confidence but is not specific to the recognition and contributions of others. The NMSS role behaviors, similar to the theme of respect in this study, include being approachable/safe (being consistent and fair), demonstrates that he/she cares (appreciates staff's hard work and quality of care), and gives genuine feedback (cites examples in a timely manner, and gives positive and negative feedback).

The publication, *The Hallmarks of the Professional Practice Environment* (AACN, 2002), includes recognition of contributions of nurses and support of professional development, which is in agreement with the opinions offered by the participants in the focus group discussions. The RNs in this study spoke of the importance of recognition by the manager not only through annual performance appraisals but also on a day-to-day basis as an acknowledgement of their hard work and contribution to safe, quality patient care. Expressions of respect and recognition by the manager for the knowledge and contribution to the healthcare process are more important than financial rewards for professional nurses (McGuire, Houser, Jarrar, Moy, & Wall, 2003).

*Feeling cared for.* Feeling cared for means nurses know managers are there for them and supportive of their needs as professionals and as individuals outside the work environment. A study by Manojlovich and Laschinger (2007) found nursing leadership as the driving force behind job satisfaction and emphasized the need for strong management support of staff. They found that if the level of support decreases or if there is a lack of support, there is a negative effect on the nursing staff causing them to become disengaged and decreasing the level of job satisfaction. When the staff becomes disengaged, they

become detached from their jobs, which may lead to a decreased ability to care for others and ultimately affects quality patient care. This is in agreement with the discussion by the RN participants in this study who shared their need to feel cared for by the nurse manager in a way that is more personal and meets their needs on an individual basis, which leads to improved job satisfaction. They repeatedly shared feelings and emotions that involve the manager who they perceive as not caring or being supportive when the staff are not able to care for themselves, which in turn leads to stress, lack of motivation, burnout, and potential poor patient outcomes as staff are forced to make decisions to remain on a unit or leave.

The RN participants perceived feeling cared for when adequate staffing was provided so they were able to take breaks and eat meals, take time for themselves and their families when necessary, have support by the manager when conflict occurs with a physician or patient situation as well as see the manager as an active participant in patient care by being visible on the unit. A study by Sellgren et al. (2008) of nurse managers' behavior and job satisfaction that found staff whose managers were invisible on the unit had mean significant values of job satisfaction lower than those who had more visible managers supports the findings of this study. The RNs in this study also expressed their need to feel the manager is approachable and provides a means of support so the staff feels they have an advocate.

The PES addresses one area of this theme for rating the manager as *backing up* the nursing staff in decision-making (being an advocate). The RN participants' discussion of the topics defining the theme feeling cared for is found throughout the MLQ in several different areas or characteristics as the leader encourages individuality and meets the

needs of individuals versus the group, inspires success, and builds the strengths of others. This appears to be related to a professional level and not a personal level and does not address all of the concerns of the RN participants in this study. The role behaviors of the NMSS similar to the theme of feeling cared for in this study are: the manager demonstrates he/she cares (feels our pain, gets food for staff and is on the unit), provides adequate and competent staffing (not only numbers but competence, steps in and helps, is there on other shifts), watches our backs (builds trust, can be counted on, and represents staff) as well as promotes groups cohesion and teamwork (keeps staff informed and makes expectations known and clear), and resolves conflicts constructively (conflict resolution, is diplomatic and negotiates). The NMSS in this case is closely aligned with the data and discussion from the focus groups.

According to Shader et al. (2001), two out of the five reasons employees voluntarily leave positions are unhappiness with the boss/supervisor and the need for a more flexible schedule. This supports the concerns of the RN participants who throughout the focus group discussions spoke of occurrences where children or other family members were sick and the importance of the manager providing flexibility in scheduling to accommodate the need to be with their family. The RNs in this study also spoke of their dissatisfaction with the nurse manager when they did not receive a reply to a voicemail or e-mail message concerning a conflict with scheduling. While all of the tools discussed in the comparisons above show similarities to the themes identified in this study by the RN participants, they are not specific to the staff nurse perceptions of the nurse manager's behavior with communication, respect, and feeling cared for.



In summary, all of the themes discussed in this study are not addressed on the PES tool because it does not provide information related to RN perceptions of behaviors by nurse managers regarding communication and respect, and the items are not specific enough to connect the nurse manager behaviors to RN job satisfaction. The theme of feeling cared for and the category of the RN's perceived disconnect of work issues from the manager's role are not addressed on the PES scale.

Many of the themes that resulted from the RN focus group discussions can be found in the MLQ tool. However, tool does not present the items in such a manner that allows the individual to be specific as to how the characteristics influence personal job satisfaction. The MLQ has been a principal means to reliably differentiate highly effective from ineffective leaders in the military, government, education, manufacturing, high technology, church, correctional, hospital, and volunteer organizations (Bass & Avolio, 2004). The items are general in nature as a consequence of the need for the tool to be utilized in many different types of organizations and at many levels of leadership; they are not specific to the health care environment.

A study by Kanste et al. (2006) conducted on the psychometric properties of the MLQ among nurses found that a modified version of the MLQ is more suitable to measure leadership in nursing than to measure job satisfaction. This means that the MLQ in its current state does not provide the results and information that is needed when utilized in a healthcare environment with staff nurses and nurse managers as well as when it is utilized in other industries or professions. Also, authors did not develop the tool specifically to measure job satisfaction. While measurement of leadership styles is a highly sought after requirement for most organizations, the MLQ is not a tool that can

have the positive impact which is needed to identify the specific behaviors of a nurse manager that are related directly to the job satisfaction of their RN staff nurses.

The themes identified as a component of this dissertation (communication, respect, and feeling cared for) are similar to the revised EOM subscale, the NMSS. However, there are differences in themes and descriptions as identified by the investigator in this study in comparison to the identified role behaviors of the NMSS. The investigator identified the theme of communication in this study as a result of the RN participants in this study discussing their need for consistency in how managers do what they say they will do, demonstrate to the staff that they are listening by offering appropriate responses, develop a trusting relationship by using appropriate communication strategies, and maintain an open door policy without sharing confidential information with others. The RN focus group participants also spoke of being fearful of repercussions when bringing up problems or concerns on the unit because they were perceived as being negative and not supportive of the organization. In comparison, the NMSS study found the manager role of walks the talk involving behavior as reflective of beliefs and values of the unit/organization and the role of approachable/safe as listening and following through as well as being consistent and fair, respecting others opinions, maintaining confidentiality, and speaking with each staff member daily/each shift. The themes of communication, respect, and feeling cared for and the examples representative of these themes provided by the RNs in the focus groups are similar to some of the behavioral roles of the NMSS listed above. However, the RN's perceived disconnect of work issues from the nurse manager role is not represented in the NMSS. This perceived

disconnect is an area for further research to determine if this is a defining factor in how RNs determine their level of job satisfaction.

Specific Aim 3. Determine whether there is a need for item and instrument development to measure the current perceptions of staff nurses of nurse manager behaviors that influence their job satisfaction. Given the comparison of the data and the themes identified in this study to the categories of the NMSS, there is not a need for new tool development (Appendix K). The NMSS offers categories relating to communication and respect as a way the manager supports the nursing staff. Also, the finding of another tool after the completion of data collection, the CAT-admin, supports the NMSS and the results of this study and therefore the decision to not develop an additional tool at this time. However, there is a need for possible revisions, additional item development, or an adaptation of the current items in these tools. The decision to not develop a totally new tool as a result of this study, the NMSS, and the CAT-admin are further discussed in Chapter Five.

### **Summary**

The investigator calculated frequency and descriptive statistics to describe the demographic characteristics of the RN staff nurse participant sample. In general, the RNs were mostly middle-aged, married, Caucasian females with the majority having over 10 years of experience in nursing.

The educational preparation of the RNs was mostly at the baccalaureate level with some earning advanced degrees at the master's level. The majority of the participants held a certification in nursing. A variety of hospital units were represented with the highest representation from medical/surgical practice. Most of the RNs worked day shifts

that were either 10 or 12 hours in length and had five years or fewer on their current units, under their current managers, and as an employee of their current organizations.

The perceptions of the RNs that influence their job satisfaction as presented in this chapter involved situations with nurse managers and co-workers. Content analysis of the focus group transcripts produced agreement on two categories: manager behaviors supportive of RNs and RN's perceived disconnect from the manager's role.

The category of manager behaviors supportive of RNs resulted in three major themes: communication, respect, and feeling cared for. The RNs discussed the importance of having a nurse manager who is respectful, communicates well and often with the staff, and provides a caring and supportive work environment through staffing that in turn allows for appropriate time for breaks and time off for vacation and family.

The positive manager behaviors described by the RNs included managers who listen and respond to issues and requests by the staff and who recognize the staff for their hard work through thank you notes, cards, and verbal communication.

Negative manager behaviors described by the RNs included the lack of visibility of the nurse manager, especially with RNs who work nights or the weekend option shifts. Often the discussion involved staffing issues such as insufficient number of nurses on shifts and floating to other units. The RNs often felt that managers who supervise multiple units did not display equal support to those units and were often inconsistent with enforcement of hospital staffing and discipline policies.

The category RNs perceived disconnect of work issues from the manager's role involves the reality that RNs often do not know the role their nurse manager plays in supporting their patient care and the work environment. The RNs often perceive the nurse

manager as no longer being a nurse because the role has changed. They perceive the manager as an administrator who attends daily meetings and one who no longer understands the role of the nurse as a patient care provider. The RNs perceive a disconnect between the role of the nurse manager and the role of the nurse on the unit. When a nurse assumes a managerial role, the staff often does not envision the individual as any longer *being clinical* and, therefore, no longer associate the manager with patient care. Many of the RNs do not perceive the nurse manager as their *go to* person for assistance in resolving ordinary problems on the unit or in addressing their needs and concerns. Others felt that it remains the responsibility of the manager to take on the new duties of the job but also to maintain the skills of a staff nurse with patient care. All of these perceptions led to the discussion that identified the disconnect many RNs have with the role of the nurse manager and the nursing staff on a hospital unit.

## CHAPTER FIVE. DISCUSSION AND CONCLUSION

The purpose of this qualitative study was the discovery of relevant data through focus groups to determine RN perceptions of nurse manager behaviors that most influence RN staff nurse job satisfaction. The major question that guided specific focus group interviews and discussion was: What behaviors of nurse managers influence staff nurse job satisfaction?

This chapter provides a discussion of the results of the focus group data including the two conceptual categories, Specific Aim 3 of the study, and recommendations for administration, education, and research. Two conceptual categories emerged from the data: manager behaviors supportive of RNs and RN's perceived disconnect of work issues from the manager's role. This section also discussed recommendations, focus group limitations, and implications for further research.

### **Conceptual Categories**

#### **Manager Behaviors Supportive of RNs—Present or Absent**

Consistent with the IOM report (2004), the RNs in this study emphasized the need for managers in healthcare organizations to strengthen their leadership skills in order to increase job satisfaction of RNs and, therefore, improve nurse retention. As suggested by Herrin and Spears (2007), a supportive environment is one of the most important factors associated with job satisfaction for nurses. In addition, Lake and Friese (2006) found nurse practice environments to have poor ratings on nurse manager supportiveness and staffing adequacy. The results of the focus group discussions indicated a staff nurse need for more supportive behaviors by nurse managers in order to improve communication, increase levels of respect, and provide a feeling of being cared for to the staff. The

following is a brief overview of the three scales or subscales chosen to be compared to the themes resulting from the focus group data based on the connection in past studies to manager behaviors. The investigator chose the PES because of the subscale specific to measurement of nurse manager behaviors, the MLQ because of the measurement of effective leadership behaviors, and the NMSS because it measures nurse manager support of staff nurses.

### **RN's Perceived Disconnect of Work Issues from the Manager's Role**

The second conceptual category emerging from this study was the RN's perceived disconnect of work issues from the manager's role. Managers as leaders have two consistent broad and independent behavioral dimensions as described by Hersey and Blanchard (1997). One dimension is production or task oriented, and the other is employee oriented with a focus on relationships, building teamwork, and employee identification with the organization. The RN participants in this study recognized the expectation of the role of the manager as being task oriented in relation to attending meetings and scheduling staff, for example, but did not discuss the role of the manager in solving problems on the unit. In fact, many of the nurses did not make a connection between the daily tasks of the manager and the manager's role in solving work issues when they occur during a shift. The reality that nurses disconnect their managers from the role of being there to solve the work issues on the unit implies that they themselves or the organization as a whole may be the source for problem solving; therefore, when problem solving does not happen, frustration remains and RNs turn inward or toward the organization as a whole to seek support as opposed to their nurse managers.

The RN participants in this study often spoke of the importance of being a team and the importance of being able to depend on each other to work things out because there was no one else to do this for them. Many of them did not mention the manager as their *go to* person to assist them in problem solving their issues and concerns with staffing, patient care, and negative physician relationships. Participants made several statements during the discussion regarding the fact that because the manager is not there on night shift, he or she does not impact the nurses' work on a daily basis. This leads to the conclusion of *out of sight, out of mind*, which in this case, the manager is perceived as not being there to provide support for patient care or to meet the individual needs of the staff. Some focus group discussions centered on the day-to-day activities of the nurses on their units and the many problems they encountered with high acuity patients, lack of staffing, and lack of emotional support of the nurse manager when the manager is not visibly available to assist on the unit.

A study by Sellgren et al. (2006) found that subordinates preferred different leadership behaviors than those leadership behaviors which managers think are appropriate when both were provided the same survey on leadership behaviors. This shows a disconnect between the perceptions of the nurses and the beliefs of the nurse managers.

This study discovered a disconnect between RNs' expectations of the nurse manager maintaining the same skill level as the bedside nurse and those skills they perceived the manager to possess and maintain. The staff expressed the desire for the managers to maintain the same skill level of patient care as the staff and to attend all required competency training on an annual basis. This expectation may demonstrate a



lack of understanding of the manager's role and the level of responsibility required of the nursing staff. While it may be an expectation for the manager to be present or visible on the unit during emergencies or at times when staffing is insufficient in order to provide a desired level of patient care, it may be unrealistic given the other roles of the nurse manager. Because the nurses believed this should be an expectation of the nurse manager, when the manager does not fulfill this role, the level of job satisfaction for the RNs decreases because they do not feel the manager cares about their level of stress during busy times on the unit. They feel the manager has forgotten how to be a nurse and therefore no longer understands their needs and frustrations as staff nurses. The perceived disconnect from the manager's actual role responsibilities results in the lack of the communication, respect, and feeling cared for factors that are important to job satisfaction.

### **Specific Aim**

Specific Aim 3. Determine whether there is a need for item and instrument development to measure the current perceptions of staff nurses of nurse manager behaviors that influence their job satisfaction.

The investigator identified two tools that contain scales or items similar to the conceptual categories and themes that resulted from the focus group data (Appendix L). One tool is the NMSS, which measures management supportive behaviors of staff, and was discussed in the Literature Review and the Data Analysis sections. Duffy (2009) developed another tool not included in the literature review but identified by the researcher as being specific to the theme of feeling cared for: the CAT-admin. Authors developed the CAT-admin from the original CAT, which measured patients' points of

views in relation to nurses' caring behaviors, based on Watson's (2009) theoretical framework of human caring. Duffy (2009) developed the CAT-admin for administrative research on staff nurse perceptions of their managers and reported the tool as having a correlation between nurse manager caring and staff nurse job satisfaction (Watson, 2009). Researchers revised the CAT-admin in 2008, now known as the CAT-admin II (Watson, 2009). The investigator of this study originally did not identify the CAT-admin as part of the literature review herein because it is specific to measuring caring of the nurse manager whereas the literature search was specific to nurse managers, staff nurses, and job satisfaction.

Given that the NMSS measures supportive behaviors of nurse managers and has been connected to job satisfaction by Schmalenberg and Kramer (2009), and the CAT-admin has been shown to have a correlation to job satisfaction (Duffy, 2009), there is no need to develop a new tool to measure RN perceptions of nurse manager behaviors that influence job satisfaction (Appendix L). Both tools support the original premise that staff perceptions of manager behaviors are important to job satisfaction of RNs. However, there is a need for possible revisions or an adaptation of the current items in these tools to support the conceptual categories and themes identified in this study.

### **Recommendations**

Lake and Friese (2006) found that few hospitals have practice environments that are favorable for nurses. Increased awareness of what determines the gap between the nursing staff perceptions and the nurse manager role is an area in need of investigation. The PI of this study identified two conceptual categories related to RN perceptions of nurse manager behaviors that influence their job satisfaction. Reporting and sharing of

these results is vital to increase awareness of nurse managers and administrators to behaviors that effect job satisfaction of their nursing staff.

In order to accomplish this, the first step would be to share the results of this study with RNs, nurse managers, and hospital administrators to assist them in recognizing the importance of the perceptions of the RNs on how their nurse managers influence their job satisfaction. The findings of this study have implications for nursing practice, administration, and education, particularly in relation to bridging the gap between RN staff nurse perceptions and the nurse manager's role on the unit.

It is vital to the support of a healthy work environment that the nurse manager is fully aware of how she or he is perceived by the nurses. The second step involves educating the nurse manager on the importance of being aware of the expectations of the staff and how the manager can better address the needs and work issues to increase job satisfaction of the staff. If nurse managers are not aware of what is important to RN staff job satisfaction it may not be an area that they focus on in their managerial role.

The third step would be to provide education to the RNs on the nurse manager roles and expectations as related to their job description. A way to accomplish this task is in the development of educational programs for RN staff nurses. The RNs are in need of becoming more aware of the required roles of the nurse manager including the competencies of the job description and of the expectations of the organizational administration for the nurse manager.

The fourth step is to develop an education module that brings together the RN staff nurses with the nurse mangers to discuss the differences between the RNs' perceptions and the nurses managers' roles and competencies. This would provide a

means for issues to be resolved and for role playing and problem-solving activities to occur. Increasing communication and understanding between the two groups will lead to higher levels of relationship building and, thus, increase job satisfaction.

### **Study Limitations**

The author discussed recruitment of RNs for participation in the focus groups in Chapter Four. Recruitment was more difficult at one of the organizations, possibly as a result of the initial contact having been made by the director of nursing. Because the investigator did not make the contact, this may have led to issues or concerns by the RNs regarding confidentiality, even though the response regarding interest in participating was to be made directly to the investigator and not the director of nursing.

Additionally, in several of the focus groups the RN participants were familiar with the investigator while others were not. This connection may have influenced the level of comfort of the participants in sharing and discussing information.

### **Suggestions for Further Research**

Because the nurse practice environment is one that operates 24 hours per day, seven days a week, and involves life-and-death situations with patient care, it is very different from the environment of a business office, a factory, or the military base; therefore, tools that are developed by individuals in those types of settings are not appropriate for use in the healthcare environment. Consequently, there is a strong need for a distinctive tool that allows nurses to voice their perceptions and desires to their nurse managers and the organizations in which they are employed. The comparison of the data with the NMSS and the discovery of the additional tool addressing caring (CAT-admin) identify a need for further research to be conducted by the PI to determine

a stronger correlation between these tools and RN job satisfaction. The need exists to further psychometrically test and validate each of the current instruments (NMSS and CAT-admin II) across a larger sample of RNs for job satisfaction and to determine if the tools specifically measure the current perceptions of RNs of nurse manager behaviors that influence job satisfaction. If they are found to not fully do so, then testing of newly developed and adapted items will be necessary to create a tool specific to the results identified from the focus group discussions conducted as part of this study.

### **Summary**

This study explored the perceptions of RNs of nurse manager behaviors that influence their job satisfaction. While the literature review demonstrated there are a number of studies and tools in the past that have measured nurse manager leadership styles in relation to the nurse practice environment as well as studies that have looked at the effect of positive role behaviors of nurse managers in Magnet hospitals, there is a gap in the knowledge of how RNs perceive the nurse manager behaviors in relation to their job satisfaction. While nurse managers have specific competencies related to their job descriptions and expectations by hospital administration, RN's perceptions of nurse manager behaviors that influence job satisfaction may be different from those competencies.

Because of the current state of the economy and the unstable environment of health care, it is vital for organizations to learn what RNs perceive as effectively increasing or decreasing their job satisfaction in relation to the nurse manager's behavior. Strategies such as further research and education for nurse managers and RNs will help to bring awareness to the gap that exists between these two roles and to help resolve this

issue by providing a means to close the gap and, therefore, improve the stability of the nurse practice environment through a more stable and fulfilled workforce.

## APPENDIX A. FOCUS GROUP INTERVIEW QUESTIONS

### Initial Focus Group Interview Questions (Focus Group 1)

1. Tell me about a typical day for you at work.
2. Tell me about a really memorable day for you at work, good or bad.
3. What do you think makes a day go well for you?
4. What do you think makes a day go poorly for you?
5. What part do you think your manager plays in how your day goes at work?
6. What might your manager do to affect your day at work?
7. What might your manager do to improve your day at work?
8. What might your manager do to worsen your day at work?

#### Possible Probes

Describe your nurse manager's leadership style/behaviors.

Describe manager behaviors that you view to be positive.

Describe manager behaviors that you view to be negative.

Talk about behaviors of nurse managers that make you feel good about your job.

Talk about behaviors of nurse managers that make you feel bad about your job.

### Revised Focus Group Interview Questions (Focus Groups 2–5)

1. Tell me about a really memorable day for you at work, good or bad.
2. What do you think makes a day go well and go poorly for you?
3. What part do you think your manager plays in how your day goes at work?
4. What might your manager do to worsen your day at work?
5. What might your manager do to improve your day at work?

#### Possible Probes

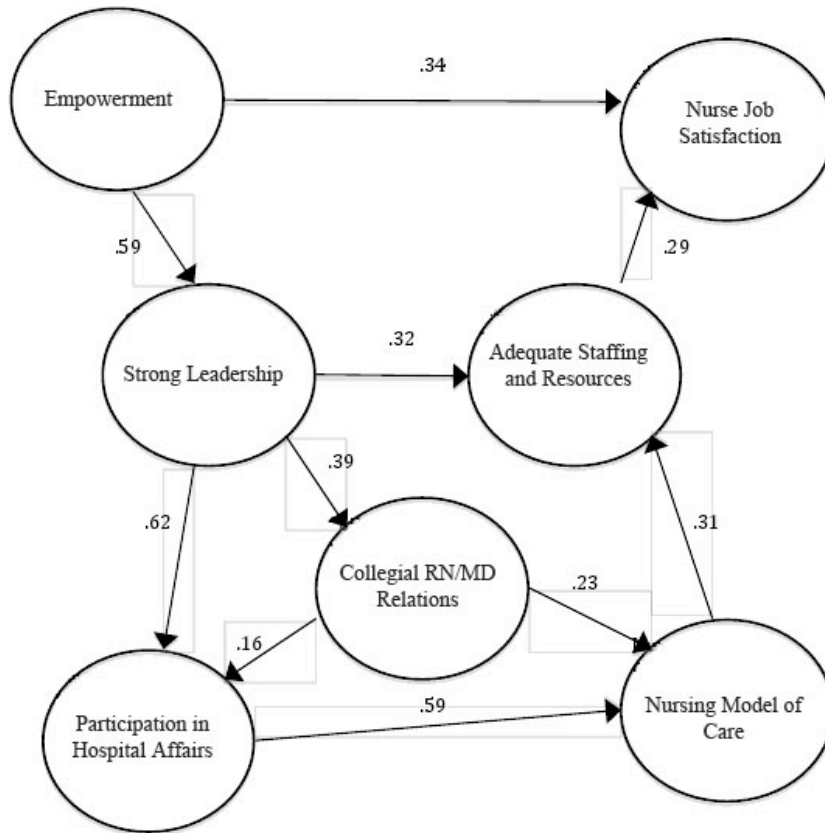
Describe manager behaviors that you view to be positive.

Describe manager behaviors that you view to be negative.

Talk about behaviors of nurse managers that make you feel good about your job.

Talk about behaviors of nurse managers that make you feel bad about your job.

APPENDIX B. REVISED NURSING WORKLIFE MODEL



Standardized regression coefficients for each path are provided.  
(Manojlovich & Laschinger, 2007)



APPENDIX C. MANAGEMENT BEHAVIOR INSTRUMENTS FROM  
LITERATURE REVIEW

| Name of Scale/Reference                                   | Initial Test Population   | Items, Format, Scales  | Validity Evidence  | Reliability Evidence   |
|---|---|--|--|--|
| Change Production Employee Sellgren et al., 2006          | <ul style="list-style-type: none"> <li>– developed and tested in Sweden;</li> <li>– initial population not provided</li> <li>– current study included 66 nurse managers and 426 subordinates with 268 being nurses</li> </ul> | <ul style="list-style-type: none"> <li>– 30 items</li> <li>– 6-point Likert scale</li> <li>– 3 scales</li> <li>– production (task-oriented)</li> <li>– employee (relation-oriented)</li> <li>– change-oriented</li> </ul>  | <ul style="list-style-type: none"> <li>– validity not documented but stated to be demonstrated in several large studies (Arvonen, 2002; Ekvall, 2002)</li> </ul>   | <ul style="list-style-type: none"> <li>– reliability tested with Cronbach's alpha with coefficients between 0.86 and 0.94</li> </ul>   |
| Essentials Of Magnetism (EOM) Kramer & Schmalenberg, 2004 | <ul style="list-style-type: none"> <li>– 289 hospital staff nurses</li> </ul>   | <ul style="list-style-type: none"> <li>– 65 items</li> <li>– 4-point Likert scale</li> <li>– EOM Scales:               <ul style="list-style-type: none"> <li>• adequacy of staffing</li> <li>• support of education</li> <li>• RN–MD relationships</li> <li>• working with clinically competent nurses</li> <li>• autonomy</li> <li>• control over nursing practice</li> <li>• values</li> <li>• nurse manager support</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>– content validity conducted by 23 nurses from 6 different Magnet hospitals</li> <li>– assigned ranks and weights of items conducted by 392 nurses in 7 different Magnet hospitals</li> <li>– Spearman rho rank order correlations coefficients ranged from 0.659 to 0.978, all significant at &gt;0.05 level.</li> </ul> | <ul style="list-style-type: none"> <li>– test-retest method conducted over a 2–3 week interval with a convenience sample of 42 staff nurses in a variety of hospitals; mean scores on time 1 ranging from 8.17 to 28.57 and time 2 from 8.31 to 28.67</li> <li>– Inter-item alphas ranged from 0.689 to 0.937</li> <li>– internal consistency reliability ranged from 0.80 to 0.90 for all scales</li> </ul> |

Table continues

| <b>Name of Scale/Reference</b>   | <b>Initial Test Population</b>   | <b>Items, Format, Scales</b>  | <b>Validity Evidence</b>  | <b>Reliability Evidence</b>   |
|--|--|---|---|---|
| Immediate Supervisor Scale<br>Fletcher, 2001   | – 1,780 RNs employed by 10 hospitals in Michigan<br>– Unpublished scale                  | – 6 items<br>– 4-point Likert scale   | – no content validity reported  | – mean rating was 2.45 with a <i>SD</i> of 0.82 and Cronbach's alpha overall reliability of 0.93  |
| Multi-factor Leadership Questionnaire (MLQ)<br>Bono et al., 2007; Larrabee et al., 2003; Morrison et al., 1997 | – 78 executives developed the items  | – 63 items<br>– 5-point Likert with subscales: <ul style="list-style-type: none"> <li>• charisma</li> <li>• intellectual stimulation</li> <li>• individualized consideration</li> <li>• contingent reward</li> <li>• management-by-exception</li> <li>• laissez-faire leadership</li> </ul> | – original items sorted by 11 judges into transformational and transactional contingent reward leadership categories<br>– items retained only with at least 80 percent agreement<br>– final set of 73 items evaluated by 176 U.S. Army colonels | – Cronbach's alpha ranged from 0.67–0.96 in studies included in literature review   |
| Nursing Work Index-Revised (NWI-R)<br>Cummings et al., 2008; Slater & McCormack, 2007                          | – developed from literature reviews, measurement of job satisfaction in Magnet hospitals | – 55 items<br>– 4 subscales of autonomy: <ul style="list-style-type: none"> <li>• control over practice</li> <li>• nurse-doctor relationship</li> <li>• organizational support</li> </ul>   | – content and face validity of original Magnet researchers<br>– criterion-related validity with retention statistics and high correlation with subscales within the instrument  | – reliability mean scores of 1.97–2.78<br>– reliability of Cronbach's alpha for all factors reported as 0.78<br>– correlation is significant at level $p < 0.01$ , in a one-tailed test |

Table continues

| Name of Scale/Reference  | Initial Test Population  | Items, Format, Scales   | Validity Evidence  | Reliability Evidence   |
|--|--|---|--|--|
| Practice Environment Scale (PES)<br>Lake, 2002;<br>Lake & Friese, 2006;<br>Manojlovich, 2005 | <ul style="list-style-type: none"> <li>– survey data used from 2 samples of hospital staff nurses</li> <li>– 2,299 nurses surveyed in 1985–1986 by Kramer &amp; Hafner, 1989</li> <li>– 11,636 staff nurses from Pennsylvania hospitals</li> </ul> | <ul style="list-style-type: none"> <li>– 31 items</li> <li>– 5 subscales of nurse participation in hospital affairs-nursing foundations for quality care               <ul style="list-style-type: none"> <li>• nurse manager ability</li> <li>• leadership and support for nurses</li> <li>• staffing and resource adequacy</li> <li>• collegial nurse-physician relations</li> <li>• nurses responded by answering “this is present in my current job”</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>– validity supported by the salient loadings of all 5 separate subscales on a one-factor model</li> <li>– construct validity supported by higher scores of nurses in m</li> <li>– Magnet versus non-Magnet hospitals in original study</li> </ul>   | <ul style="list-style-type: none"> <li>– high reliability exhibited at individual and hospitals levels with internal consistency of alpha .80 except for collegial nurse-physician relations</li> <li>– moderate at alpha .71</li> </ul> |
| Caring Assessment Tool-Admin (CAT-admin)<br>Duffy, 2009                                      | <ul style="list-style-type: none"> <li>– survey data used from a sample of 56 full and part-time nurses in 1993</li> <li>– revised version in 2008 involved 1,850 nurses from four U.S. hospitals</li> </ul>                                       | <ul style="list-style-type: none"> <li>– 94 items</li> <li>– 5-point Likert scale</li> <li>– ranged from low to high caring with low indicating the perception of less caring from the manager</li> </ul>   | <ul style="list-style-type: none"> <li>– content validity established by an expert panel</li> <li>– validity to establish staff nurse perceptions differed from patients’ perceptions of nurse caring was conducted by asking 17 RN graduate nurses to describe behaviors or attitudes of a nurse manager who conveyed caring to them</li> </ul> | <ul style="list-style-type: none"> <li>– Alpha internal consistency measured at .9849</li> </ul>   |

APPENDIX D. JOB SATISFACTION INSTRUMENTS FROM LITERATURE

REVIEW

| Name of Scale/Reference   | Initial Test Population                                | Items/Format/Scale   | Validity Evidence   | Reliability Evidence   |
|---|--|--|---|--|
| Index of Work Satisfaction (IWS) Part B; Zangaro & Soeken, 2005 | – 246 staff nurses in an acute-care community hospital | – 41 items<br>– 7-point Likert scale<br>– 6 subscales: <ul style="list-style-type: none"> <li>• autonomy</li> <li>• pay</li> <li>• professional status</li> <li>• interaction</li> <li>• task requirements</li> <li>• organizational policies</li> </ul>   | – content validity and construct validity through factor analysis have been established | – reliability of subscales for Cronbach’s alpha coefficients ranging from 0.35–0.90 with total scale reliability of 0.82–0.90<br>– overall reliability score was Cronbach’s alpha of 0.82. |
| Job Description Index (JDI); Saane et al., 2003                 | – 21 different industrial samples in 18 organizations  | – 72 standardized employee job satisfaction questions plus 6 demographic questions relating to the employee's managerial status, job level, age, gender, education level, and job tenure<br>– yes/no format<br>– 5 subscales<br>– the work itself<br>– pay<br>– opportunity for promotion<br>– supervision<br>– co-workers | – convergent validity with Minnesota Satisfaction Questionnaire (MSQ) 0.49–0.70         | – internal consistency of 0.81<br>– test-retest reliability of 0.62–0.79   |

Table continues

| Name of Scale/Reference   | Initial Test Population   | Items/Format/Scale   | Validity Evidence  | Reliability Evidence  |
|---|---|--|--|---|
| McCloskey Muller Satisfaction Scale (MMSS); Lageson, 2004; Mueller & McCloskey, 1990; Wilson et al., 2008 | – 320 nurses hired by a large medical center  | <ul style="list-style-type: none"> <li>– 31 items</li> <li>– 5-point Likert scale</li> <li>– Measures 8 work factors:               <ul style="list-style-type: none"> <li>• extrinsic rewards</li> <li>• scheduling satisfaction</li> <li>• family/work balance</li> <li>• co-workers</li> <li>• interaction</li> <li>• professional opportunities</li> <li>• praise/recognition</li> <li>• control/</li> <li>• responsibility</li> </ul> </li> </ul>   | <ul style="list-style-type: none"> <li>– construct validity indicated with a criterion validity coefficient</li> <li>– authors correlated the instrument with the Job Diagnostic Survey</li> <li>– convergent validity of 0.53–0.75</li> </ul>   | <ul style="list-style-type: none"> <li>– test-retest reliability for subscales ranged from 0.08–0.64</li> <li>– internal consistency of 0.89</li> </ul>   |
| Minnesota Satisfaction Questionnaire Short Form (MSQ); Weiss et al., 1967; Zurmehly, 2008                 | <ul style="list-style-type: none"> <li>– initial population of 1,460 employed men</li> <li>– current study sample of 140 RNs</li> </ul> | <ul style="list-style-type: none"> <li>– 20 items</li> <li>– 5-point Likert scale</li> <li>– 20 subscales:               <ul style="list-style-type: none"> <li>• ability utilization</li> <li>• achievement</li> <li>• activity</li> <li>• advancement</li> <li>• authority</li> <li>• company policies</li> <li>• compensation</li> <li>• co-workers</li> <li>• creativity</li> <li>• independence</li> <li>• security</li> <li>• social service</li> <li>• social status</li> <li>• moral values</li> <li>• recognition</li> <li>• responsibility</li> <li>• supervision (2)</li> <li>• variety</li> <li>• work conditions</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>– evidence of construct validity obtained by validation studies with the Minnesota Importance Questionnaire based on The Theory of Work Adjustment</li> <li>– concurrent validity derived from the study of group differences and was statistically significant at the 0.001 level for both means and variances for all scales</li> </ul> | <ul style="list-style-type: none"> <li>– Hoyt median reliability coefficient ratings ranged from 0.78–0.93</li> <li>– Hoyt reliability coefficient ranged from 0.59–0.97</li> <li>– test-retest correlation of general satisfaction scale coefficients ranged from 0.70–0.89</li> </ul> |

Table continues

| Name of Scale/Reference   | Initial Test Population   | Items/Format/Scale   | Validity Evidence   | Reliability Evidence  |
|---|---|--|---|---|
| Specific Satisfaction Scale;<br>Fletcher, 2001                              | <ul style="list-style-type: none"> <li>- 1,780 RNs employed by 10 hospitals in Michigan</li> <li>- adapted from the Job Diagnostic Index (above)</li> </ul> | <ul style="list-style-type: none"> <li>- 14 items</li> <li>- 7-point Likert scale</li> <li>- 5 subscales               <ul style="list-style-type: none"> <li>• pay</li> <li>• job security</li> <li>• social</li> <li>• supervisory</li> <li>• growth satisfaction</li> </ul> </li> </ul>       | <ul style="list-style-type: none"> <li>- no content validity reported</li> </ul>                    | <ul style="list-style-type: none"> <li>- reliability rated with Cronbach's alpha ranging from 0.47–0.86</li> <li>- mean rating overall 5.040 with a <i>SD</i> of 0.99 and Cronbach's alpha overall reliability of 0.90</li> </ul> |
| Work Quality Index (WQI);<br>Larrabee et al., 2003; Whitley & Putzier, 1994 | <ul style="list-style-type: none"> <li>- Factor analysis of 245 nurses in a medical center</li> </ul>   | <ul style="list-style-type: none"> <li>- Six subscales               <ul style="list-style-type: none"> <li>• professional work environment</li> <li>• autonomy</li> <li>• work worth</li> <li>• professional relationships</li> <li>• role enactment</li> <li>• benefits</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- Construct validity confirmed by factor analysis</li> </ul> | <ul style="list-style-type: none"> <li>- published Cronbach's alpha ranges from 0.72–0.94</li> <li>- current study Cronbach's alpha ranges from 0.69–0.96</li> </ul>  |

APPENDIX E. IRB AND INSTITUTIONAL APPROVALS



**INDIANA UNIVERSITY**  
OFFICE OF RESEARCH ADMINISTRATION

Date: June 22, 2010

To: Dr. Patricia Ebright  
Adult Health Nursing  
NU

From: Regina Weber  
Research Compliance Administration, IUPUI  
UN 618

Subject: IUPUI/Clarian Institutional Review Committee - Exempt Review of  
Human Study

Study Number: EX1006-31B

Study Title: Staff Nurse Perceptions of Nurse Manager Behaviors That Influence Job  
Satisfaction

Your application for approval of the study named above has been accepted as meeting the criteria of exempt research as described by Federal Regulations [45 CFR 46.101(b), paragraph 2]. A copy of the acceptance is enclosed for your file.

Although a continuing review is not required for an exempt study, prior approval must be obtained before change(s) to the originally approved study can be initiated. When you have completed your study, please inform our office in writing.

If the research is conducted at or funded by the VA, research may not be initiated until approval is received from the VA Research and Development Committee.

Please contact the Office of Health Care Billing and HIPAA Programs at 317-278-4891 for information regarding a Data Use Agreement, if applicable.

Enclosures:  Copy of acceptance

Phone: 317-274-8289 • Fax: 317-274-5932 • Email: [irbexp@iupui.edu](mailto:irbexp@iupui.edu) • Website: <http://research.iupui.edu>

June 15, 2010

Dear Chief Nursing Officer,

I am a PhD student at the Indiana University School of Nursing requesting permission to recruit registered nurse (RN) subjects for my research study at your facility. I am interested in learning about the influence of nurse manager behaviors on job satisfaction. The RN interviews will be conducted in two facilities with a targeted sample of 15 to 40 nurses in focus groups of 5 to 8 each.

The goal of the study is to explore the perceptions of registered nurse staff members regarding nurse manager behaviors that influence their job satisfaction. Information gained from this study will be used to determine if measures currently available accurately represent nurse manager behaviors in today's health care environment that affect job satisfaction.

Participants will be recruited through distribution of a flyer through email, during staff meetings, and/or through an announcement in the newsletter at your facility. The focus group interviews are entirely voluntary and will not take place during working hours. Institutional Review Board approval will be obtained before the study is initiated. The individuals and organizations that participate in the study will not be identified in any way, even if the results of the study are published.

Please find copies of the flyer, demographic data sheet, and summary of the proposal attached for your review. If you agree to provide permission for contact of your staff nurses for this study, pending IRB review and approval by \_\_\_\_\_, please sign and date the form below and fax it to me at the School of Nursing, \_\_\_\_\_. Do not hesitate to call or write me if you have any questions or concerns regarding the study.

I do hope you will agree to participate. Thank you in advance for your consideration.

Sincerely,

Rebecca Feather PhD, MSN, RN, NE-BC  
Indiana University School of Nursing, PhD graduate student

Email: \_\_\_\_\_

.....  
I have no objections to the recruitment and participation of registered nurses employed at my facility in the study, "Staff Nurse Perceptions of Nurse Manager Behaviors that Influence Job Satisfaction" pending IRB review and approval by IUPUI IRB and \_\_\_\_\_ Hospital IRB.

\_\_\_\_\_  
Name and Position

\_\_\_\_\_  
Name of Facility

*Hospital*

*6-11-10*  
Date



June 15, 2010

Dear Chief Nursing Officer,

I am a PhD student at the Indiana University School of Nursing requesting permission to recruit registered nurse (RN) subjects for my research study at your facility. I am interested in learning about the influence of nurse manager behaviors on job satisfaction. The RN interviews will be conducted in two facilities with a targeted sample of 15 to 40 nurses in focus groups of 5 to 8 each.

The goal of the study is to explore the perceptions of registered nurse staff members regarding nurse manager behaviors that influence their job satisfaction. Information gained from this study will be used to determine if measures currently available accurately represent nurse manager behaviors in today's health care environment that affect job satisfaction.

Participants will be recruited through distribution of a flyer through email, during staff meetings, and/or through an announcement in the newsletter at your facility. The focus group interviews are entirely voluntary and will not take place during working hours. Institutional Review Board approval will be obtained before the study is initiated. The individuals and organizations that participate in the study will not be identified in any way, even if the results of the study are published.

Please find copies of the flyer, demographic data sheet, and summary of the proposal attached. If you agree to provide permission for contact of your staff nurses for this study, please sign and date the form below and fax it to me at the School of Nursing. Do not hesitate to call or write me if you have any questions or concerns regarding the study.

I do hope you will agree to participate! Thank you in advance for your consideration.

Sincerely,

Rebecca Feather PhDc, MSN, RN, NE-BC  
Indiana University School of Nursing, PhD graduate student

.....  
I have no objections to the recruitment and participation of registered nurses employed at my facility in the study, "Staff Nurse Perceptions of Nurse Manager Behaviors that Influence Job Satisfaction" pending IRB review and approval by IUPUI IRB and Columbus Regional Hospital IRB.

\_\_\_\_\_  
Name and Position

\_\_\_\_\_  
Name of Facility

Hospital

6.17.10

Date

## APPENDIX F. STAFF NURSE FOCUS GROUP DEMOGRAPHIC QUESTIONNAIRE

Please answer each question by filling in the blank. It is important to this study that each question is answered completely. Your answers will remain confidential and will not be seen by anyone except the researchers.

1. Age: \_\_\_\_\_
2. Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male
3. Race: \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Non Hispanic or Latino  
\_\_\_\_\_ American Indian or Alaska Native  
\_\_\_\_\_ Asian  
\_\_\_\_\_ Black or African American  
\_\_\_\_\_ Native Hawaiian or other Pacific Islander  
\_\_\_\_\_ White  
\_\_\_\_\_ Other or unknown: Please specify \_\_\_\_\_
4. Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed
5. Highest Degree as a Registered Nurse:  
\_\_\_\_\_ Diploma \_\_\_\_\_ ASN \_\_\_\_\_ BSN \_\_\_\_\_ MSN \_\_\_\_\_ Doctoral
6. How long have you practiced as a nurse: \_\_\_\_\_ Years \_\_\_\_\_ Months
7. Name of Primary Department:  
\_\_\_\_\_ Medical/Surgical \_\_\_\_\_ Psych \_\_\_\_\_ Critical Care \_\_\_\_\_ Surgical Services  
\_\_\_\_\_ Neurology \_\_\_\_\_ Maternal/Child Health \_\_\_\_\_ Emergency \_\_\_\_\_  
Orthopedics \_\_\_\_\_ PCU \_\_\_\_\_ Cardiovascular Services \_\_\_\_\_ Oncology \_\_\_\_\_ Rehab  
Other: \_\_\_\_\_
8. Certification in your specialty: \_\_\_\_\_ Yes \_\_\_\_\_ No

9. What shift length do you work: \_\_\_\_ 6-hour \_\_\_\_ 8-hour \_\_\_\_ 12-hour  
\_\_\_\_ Other: Please specify \_\_\_\_\_

10. Specify the usual shift times that you work:  
\_\_\_\_ (AM/PM) to \_\_\_\_ (AM/PM)

11. How long have you been employed on your current unit:  
\_\_\_\_ Years \_\_\_\_ Months

12. How long have you been employed under current manager:  
\_\_\_\_ Years \_\_\_\_ Months

13. How long have you been employed at your current hospital:  
\_\_\_\_ Years \_\_\_\_ Months

## APPENDIX G. INFORMED CONSENT

### **IUPUI and CLARIAN INFORMED CONSENT STATEMENT FOR**

#### **Staff Nurse Perceptions of Nurse Manager Behaviors that Influence Job Satisfaction**

You are invited to participate in a research study of staff nurse perceptions of nurse manager behaviors that influence job satisfaction. You were selected as a possible subject because you are a registered staff nurse at a community based hospital in southern Indiana. We ask that you read this form and ask any questions you may have before agreeing to be in the study. The study is being conducted by Rebecca Feather, a PhD candidate with the Indiana University School of Nursing.

#### **STUDY PURPOSE**

The purpose of this study is to describe registered nurse perceptions of nurse manager behaviors which most influence registered nurse job satisfaction.

#### **NUMBER OF PEOPLE TAKING PART IN THE STUDY:**

If you agree to participate, you will be one of 24 to 40 registered nurse participants who will be participating in this research.

#### **PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things: Participate in a focus group with 4 to 7 other registered nurses. You will be asked to complete a demographic questionnaire and respond to questions as part of a group discussion. Participation is voluntary and you may withdraw from the study at any time prior to or during the focus group.

#### **RISKS OF TAKING PART IN THE STUDY:**

While on the study, the risks are: Completing the demographic questionnaire and being uncomfortable answering the focus group questions, and risk of loss of confidentiality

Measures that will be employed to minimize the risks listed above are:

While completing the demographic questionnaire, you can tell the researcher that you feel uncomfortable or do not care to answer a particular question. Participants will be asked not to speak with each other or quote the others outside the focus groups. The possibility of loss of confidentiality will be addressed by assigning a number to each participant. The master list of participants with code numbers will be kept in a locked file and made only available to the Principal Investigator and co-investigators. The master participant list, focus group transcripts and audio recordings will be de-identified and kept separate from data following completion of the study. Dissemination of the findings will be identified only as group data. The computer used to store the data is protected with both software and hardware firewalls and is password protected. All data access will be limited to the principal investigator and co-investigators for study purposes only. Audiotapes will be destroyed at the earliest possible time following completion of the study and dissemination of the findings.

## **BENEFITS OF TAKING PART IN THE STUDY:**

The benefits to participation that are reasonable to expect are those received as professional registered nurses for contributing to the body of knowledge involving staff job satisfaction in relation to nurse manager behaviors. This study has the potential to benefit the recruitment and retention of highly qualified registered nurses.

## **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and in databases in which results may be stored. The master participant list, focus group transcripts and audio recordings will be de-identified and kept separate from data following completion of the study. Dissemination of the findings will be identified only as group data. The computer used to store the data is protected with both software and hardware firewalls and is password protected. All data access will be limited to the principal investigator and co-investigators for study purposes only. Audiotapes will be destroyed at the earliest possible time following completion of the study and dissemination of the findings.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the IUPUI/Clarian Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA) [for FDA-regulated research and research involving positron-emission scanning], the National Cancer Institute (NCI) [for research funded or supported by NCI], the National Institutes of Health (NIH) [for research funded or supported by NIH], etc., who may need to access your medical and/or research records.

## **COSTS**

There are no costs to you for taking part in this study.

## **PAYMENT**

You will receive payment for taking part in this study. A \$20 gift card will be provided to the participants who have completed the focus groups.

## **FINANCIAL INTEREST DISCLOSURE**

There is no financial benefit to any individual or organization for participation in this study.

## **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study or a research-related injury, contact the researcher **Rebecca Feather** at [redacted]. If you cannot reach the researcher during regular business hours (i.e. 8:00AM-5:00PM), please call the IUPUI/Clarian Research Compliance Administration office at (317) 278-3458 or (800) 696-2949.

In the event of an emergency, you may contact **Rebecca Feather** at [redacted].

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IUPUI/Clarian Research Compliance Administration office at (317) 278-3458 or (800) 696-2949.

**VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. However, the \$20 gift card will be provided only upon completion of the entire focus group. Your decision whether or not to participate in this study will not affect your current or future relations with your current employer.

**SUBJECT'S CONSENT**

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

**Subject's Printed Name:** \_\_\_\_\_

**Subject's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(must be dated by the subject)

**Printed Name of Person Obtaining Consent:** \_\_\_\_\_

**Signature of Person Obtaining Consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ATTENTION ALL REGISTERED NURSES!!!**

**ALL REGISTERED NURSES ARE INVITED TO PARTICIPATE IN A RESEARCH STUDY UTILIZING FOCUS GROUP SESSIONS THAT WILL BE CONDUCTED BY BECKY FEATHER, A PhD CANDIDATE WITH THE INDIANA UNIVERSITY SCHOOL OF NURSING.**

- ◆ The goal of the study is to explore the perceptions of registered nurses regarding their job satisfaction. Participation is voluntary and the identity of the participants will be kept totally confidential.
- ◆ The focus group interviews will not take place during working hours, but will be held at the facility when possible. Participants will receive a \$20 gift card upon completion of the focus group in appreciation of their time.
- ◆ The dates and times of the focus groups will be determined based upon the availability of eligible participants.

**Please contact Becky Feather by email at \_\_\_\_\_  
or by phone at \_\_\_\_\_ if you are interested in  
participating.**



## **ATTENTION ALL REGISTERED NURSES!!!**

### **FOCUS GROUPS: STAFF NURSE PERCEPTIONS OF JOB SATISFACTION**

**ALL REGISTERED NURSES ARE INVITED TO PARTICIPATE IN A RESEARCH STUDY UTILIZING FOCUS GROUP SESSIONS THAT WILL BE CONDUCTED BY BECKY FEATHER, A PhD CANDIDATE WITH THE INDIANA UNIVERSITY SCHOOL OF NURSING.**

- ◆ The goal of the study is to explore the perceptions of registered staff nurse members regarding their job satisfaction. Information gained from the study will be used to determine if surveys currently available accurately represent staff nurse perceptions of nurse manager behaviors that influence job satisfaction in today's health care environment.
- ◆ Participation is voluntary and the identity of the participants will be kept totally confidential. The individuals and organizations that participate in the study will not be identified in any way, even if the results of the study are published.
- ◆ The focus group interviews will not take place during working hours, but will be held at the facility when possible. Participants will receive a \$20 gift card upon completion of the focus group in appreciation of their time.
- ◆ The dates and times of the focus groups will be determined based upon the availability of eligible participants. Each focus group will include 5-8 RN staff nurses.

Please contact Becky Feather by email at [beckyfeather@iu.edu](mailto:beckyfeather@iu.edu) if you are interested in participating.

or by phone at [317.497.1234](tel:3174971234)



## APPENDIX J. FOCUS GROUP THEMES

| Themes of Manager Behaviors Supportive of RNS—Present or Absent | As Defined in the Focus Group Discussions  | Number of Focus Groups In Which Theme Occurred |
|---|--|--|
| <b>Communication</b>  | The manager directly speaks with the staff & openly shares information.                                      | 3  |
| • Consistency   | The manager does what he/she says he/she is going to do.   | 4  |
| • Fear  | Anticipation of repercussions for speaking up.   | 3  |
| • Listening   | Demonstrated by appropriate verbal and non-verbal responses.   | 4  |
| • Trust   | Privacy is protected, valued through actions & commitment of the manager for betterment of the staff & unit. | 3  |
| <b>Respect</b>  | The manager shows employee he/she is valued as an individual.  | 3  |
| • Fairness  | The manager treats everyone the same.  | 4  |
| • Recognizing   | The manager acknowledges good work and contributions of individual staff.                                    | 5  |
| <b>Feeling Cared For</b>  | The manager provides needed resources for staff's needs and patient/family care.                             | 4  |
| • Advocate  | The manager goes to bat or represents the staff and resolves conflict.                                       | 3  |
| • Flexibility   | The manager is able to bend based upon the needs of the individual or the unit.                              | 3  |
| • Lack of breaks/meals  | No time for personal needs to be met (breaks and food).  | 3  |
| • Staffing  | The perception of adequate caregivers for workers (the number of and experience levels of caregivers).       | 5  |
| • Visibility  | The manager is seen by staff on the unit; is frequently present on the unit.                                 | 5  |

APPENDIX K. PRESENCE OF DATA IN THE PES, MLQ, NMSS, CAT-ADMIN

TOOLS

|  | PES | MLQ | NMSS | CAT-admin |
|--|-----|-----|------|-----------|
| <b>Manager Behaviors Supportive of RNS-Present or Absent</b>           |     |     | X    | X         |
| • Communication  |     | X   | X    | X         |
| • Respect  | X   |     | X    | X         |
| • Feeling cared for  | X   | X   | X    | X         |
| <b>RNs Perceived Disconnect of Work Issues from the Manager's Role</b> |     |     |      | X         |

APPENDIX L. COMPARISON OF DATA TO THE NMSS AND CAT-ADMIN

| Feather Data (themes)   | NMSS Role Behaviors   | CAT-Admin Items  |
|---|---|--|
| <b>Communication</b>  |   |  |
| <ul style="list-style-type: none"> <li>Consistency</li> </ul> | <p>The nurse manager of our unit promotes staff cohesiveness and is a positive force in getting us to work together.</p>          | <p>Checks on me frequently.<br/>           Fails to keep his/her promises to me.<br/>           Makes me wait a long time for an appointment when I need help.<br/>           Treats me kindly.<br/>           Uses management terms I don't understand.<br/>           Fails to keep his/her promises to me.</p>  |
| <ul style="list-style-type: none"> <li>Fear</li> </ul>        | <p>Our nurse manager is accessible, approachable, and safe.</p>   | <p>Discourages me from asking questions.<br/>           Limits or interferes with my routine practices.<br/>           Helps me understand my feelings.<br/>           Helps me cope with the stress of my work.<br/>           Does not want to talk to me.<br/>           Acts as if he/she disapproves of me.<br/>           Seems annoyed if I speak my true feelings.</p> |
| <ul style="list-style-type: none"> <li>Listening</li> </ul>   | <p>Our nurse manager fosters sound decision making by asking for the "best practice" evidence that we are using.</p>              | <p>Pays attention to me when I am talking.<br/>           Looks me in the eye when he/she talks to me.<br/>           Answers my questions.<br/>           Listens to me.</p>  |
| <ul style="list-style-type: none"> <li>Trust</li> </ul>       | <p>Our nurse manager "lives" the values of the organization regarding patient care. He or she "walks the talk."</p>               | <p>Helps me with all of my work problems.<br/>           Helps me deal with negative feelings.<br/>           Responds honestly to my questions.<br/>           Respects my need for confidentiality.</p>  |
| <b>Respect</b>  |   |  |
| <ul style="list-style-type: none"> <li>Fairness</li> </ul>    | <p>Our nurse manager is diplomatic, fair, and honest in resolving conflicts between nurses, physicians, or other departments.</p> | <p>Helps me explore alternative ways of dealing with my work.<br/>           Helps me find solutions regarding my problems.<br/>           Accepts me as I am.</p>   |
| <ul style="list-style-type: none"> <li>Recognizing</li> </ul> | <p>Our nurse manager cites specific examples, both positive and negative, when he or she provides us with feedback.</p>           | <p>Knows what is important to me.<br/>           Refuses to tell me aspects about my work when I ask.<br/>           Asks me how my work is going.<br/>           Respects me.<br/>           Uses my name when he/she talks to me.<br/>           Ignores me.</p>   |

Table continues

| <b>Respect</b>   |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>Fairness</li> </ul>             | <p>Our nurse manager is diplomatic, fair, and honest in resolving conflicts between nurses, physicians, or other departments.</p>   | <p>Helps me explore alternative ways of dealing with my work.</p> <p>Helps me find solutions regarding my problems.</p> <p>Accepts me as I am.</p>  |
| <ul style="list-style-type: none"> <li>Recognizing</li> </ul>          | <p>Our nurse manager cites specific examples, both positive and negative, when he or she provides us with feedback.</p>   | <p>Knows what is important to me.</p> <p>Refuses to tell me aspects about my work when I ask.</p> <p>Asks me how my work is going.</p> <p>Respects me.</p> <p>Uses my name when he/she talks to me.</p> <p>Ignores me.</p>  |
| <b>Feeling Cared For</b>   |   |   |
| <ul style="list-style-type: none"> <li>Advocate</li> </ul>             | <p>Our nurse manager represents the position and interests of our unit and the staff to other departments and to administration; he or she “watches our back.”</p> <p>If we need resources such as equipment or supplies, our nurse manager can make it happen.</p> | <p>Helps me set career goals that I am able to accomplish.</p>  |
| <ul style="list-style-type: none"> <li>Flexibility</li> </ul>          | <p>Our nurse manager makes it possible for us to attend continuing education, outside courses, and/or degree completion programs.</p>   |   |
| <ul style="list-style-type: none"> <li>Lack of breaks/meals</li> </ul> |   | <p>Doesn't care whether I get a break.</p>  |
| <ul style="list-style-type: none"> <li>Staffing</li> </ul>             | <p>Our nurse manager on our unit sees to it that we have adequate numbers of competent staff to get the job done.</p>   |   |
| <ul style="list-style-type: none"> <li>Visibility</li> </ul>           | <p>Our nurse manager is accessible, approachable, and safe.</p>   | <p>Spends time with me.</p> <p>Checks on me frequently.</p> <p>Is available to me.</p>  |
| <b>Disconnect of Work Issues</b>                                       |   |   |
|  |   | <p>Helps me explore alternative ways of dealing with my work problems.</p> <p>Helps me cope with the stress of my work.</p> <p>Helps me with all of my work problem/s, not just part/s of them.</p> <p>Refuses to tell me aspects about my work when I ask.</p> <p>Asks me how I think my work is going.</p> <p>Uses management terms I don't understand.</p> |

## REFERENCES

- Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing, 32*(3), 536–543.
- Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., . . . Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43–53.
- Aiken, L., Clarke, S., Sloane, D., Sochalski, J., & Silber, J. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987–1993.
- Aiken, L., & Patrician, P. (2000). Measuring organizational traits of hospitals: The revised Nursing Work Index. *Nursing Research, 49*(3), 146–153.
- Aiken, L., & Sloane, D. (1997a). Effects of organizational innovations in AIDS care on burnout among urban hospital nurses. *Work and Occupations, 24*(4), 453–477.
- Aiken, L., & Sloane, D. (1997b). Effects of specializations and client differentiation on the status of nurses: The case of AIDS. *Journal of Health and Social Behavior, 38*(3), 203–222.
- Allen, D., & Vitale-Nolen, R. (2005). Patient care delivery model improves nurse job satisfaction. *The Journal of Continuing Education in Nursing, 36*(6), 277–282.
- American Association of Colleges of Nursing. (2002). Hallmarks of the professional nursing practice environment. *Journal of Professional Nursing, 18*(5), 295–304.
- American Nurses Association. (2007). *Nursing's legislative and regulatory initiatives for the 110th Congress*. Retrieved from <http://www.nursingworld.org>

- American Nurses Association. (2008). *ANA's health system reform agenda* (Issue Brief). Retrieved from <http://www.nursingworld.org>
- American Nurses Association. (2009). *NDNQI® RN Survey* (Data Variables). Retrieved from <http://ana.confex.com/ana/NDNQIRNSurveyDataListNovember2009.pdf>
- American Organization of Nurse Executives. (2000). *Testimony of the American Organization of Nurse Executives before the Work Environment for Nurses and Patient Safety Committee of the Institute of Medicine*. Retrieved from <http://www.aone.org/>
- Andrews, D., & Dziegielewska, S. (2005). The nurse manager: Job satisfaction, the nursing shortage and retention. *Journal of Nursing Management, 13*(4), 286–295.
- Antonakis, J., Avolio, B., & Sivasubramaniam, N. (2003). Context and leadership: An examination of the nine-factor full-range leadership theory using the Multifactor Leadership Questionnaire. *The Leadership Quarterly, 14*(3), 261–295.
- Avolio, B., Bass, B., & Jung, D. (1999). Re-examining the components of transformational and transactional leadership using the Multifactor Leadership Questionnaire. *Journal of Occupational and Organizational Psychology, 72*(4), 441–462.
- Bass, B. M., & Avolio, B. J. (2004). *Multifactor Leadership Questionnaire. Manual and Sampler Set* (3rd ed.). Retrieved from <http://mindgarden.com>
- Bass, M. (1985). *Leadership and performance beyond expectations*. New York, NY: Free Press.
- Best, M., & Thurston, N. (2004). Measuring nurse job satisfaction. *Journal of Nursing Administration, 34*(6), 283–290.

- Bono, J., Foldes, H., Vinson, G., & Muros, J. (2007). Workplace emotions: The role of supervision and leadership. *Journal of Applied Psychology, 92*(5), 1357–1367.
- Boyle, D., Bott, M., Hansen, H., Woods, C., & Taunton, R. (1999). Manager's leadership and critical care nurses' intent to stay. *American Journal of Critical Care, 8*(6), 361–371.
- Buerhaus, P. (2008). Current and future state of the US nursing workforce. *Journal of the American Medical Association, 300*(20), 2422–2424.
- Buerhaus, P., Auerbach, D., & Staiger, D. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs, 29*(4), w657–w668.
- Burns, N., & Grove, S. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence* (6th ed.). St. Louis, MO: Sanders Elsevier.
- Ceria, C. D. (1992). *Testing Brooke's causal model of absenteeism on nurses* (Unpublished doctoral dissertation). Virginia Commonwealth University, Richmond, VA.
- Congdon, J. (2003). Qualitative data generation. In K. Oman, M. Krugman, & R. Fink (Eds.), *Nursing research secrets* (pp. 179–185). Philadelphia, PA: Hanley & Belfus.
- Cronin, S., & Becherer, D. (1999). Recognition of staff nurse job performance and achievements: Staff and manager perceptions. *Journal of Nursing Administration, 29*(1), 26–31.

- Cummings, G., Olson, K., Hayduk, L., Bakker, D., Fitch, M., Green, E., . . . Conlon, M. (2008). The relationship between nursing leadership and nurses' job satisfaction in Canadian oncology work environments. *Journal of Nursing Management, 16*(5), 508–518.
- Dictionary.com. (n.d.). Retrieved from <http://dictionary.reference.com>
- DiMeglio, K., Padula, C., Piatek, C., Korber, S., Barrett, A., Ducharme, M., . . . Corry, K. (2005). Group cohesion and nurse satisfaction. *Journal of Nursing Administration, 35*(3), 110–120.
- Duffy, J. (2009). Caring Assessment Tools and the CAT-admin. In A. Graubard & J. Rosen (Eds.), *Assessing and measuring caring in nursing health sciences* (2nd ed., pp. 131–147). New York, NY: Springer.
- Dunham, W. (2009, March 8). *U.S. healthcare system pinched by nursing shortage*. Retrieved from <http://www.reuters.com/>
- Ekvall, G., & Arvonen, J. (1991). Change centered leadership. An extension of the two dimensional model. *Scandinavian Journal of Management, 7*(1), 17–26.
- Ekvall, G., & Arvonen, J. (1994). Leadership profiles, situation and effectiveness. *Creativity and Innovation Management, 3*(3), 139–161.
- Fletcher, C. (2001). Hospital RNs' job satisfactions and dissatisfactions. *Journal of Nursing Administration, 31*(6), 324–331.
- Force, M. (2005). The relationship between effective nurse managers and nursing retention. *Journal of Nursing Administration, 35*(7/8), 336–341.



- Herrin, D., & Spears, P. (2007). Using nurse leader development to improve nurse retention and patient outcomes. *Nursing Administration Quarterly*, 31(3), 231–243.
- Hersey, P., & Blanchard, K. (1977). *Management and organizational behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Herzberg, F. (1968/2002). One more time: How do you motivate employees? *Best of Harvard Business Review, On Point* (Product Number 388X). Boston, MA: Harvard Business.
- Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- Huseman, R. (2009). The importance of positive culture in hospitals. *The Journal of Nursing Administration*, 39(2), 60–63.
- Hutchinson, M., & Mattice, S. (2000). Attract and retain RNs. *Modern Healthcare*, 30(5), 22.
- Institute of Medicine of the National Academies. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Retrieved from <http://www.iom.edu>
- Irvine, D., & Evans, M. (1995). Job satisfaction and turnover among nurses: Integrating research findings across studies. *Nursing Research*, 44(4), 246–253.
- Kanste, O., Miettunen, J., & Kyngas, H. (2006). Psychometric properties of the Multifactor Leadership Questionnaire. *Journal of Advanced Nursing*, 57(2), 201–212.

- Kelly, L., & Joel, L. (1999). *Dimensions of professional nursing* (8th ed.).  
New York, NY: McGraw Hill.
- Kimball, B., O'Neil, E., & Health Workforce Solutions. (2002). *Health care's human crisis: The American nursing shortage*. Retrieved from <http://www.rwjf.org>
- Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *British Medical Journal*, *311*(7000), 299–302.
- Kleinman, C. (2004a). Leadership: A key strategy in staff nurse retention. *The Journal of Continuing Education in Nursing*, *35*(3), 128–132.
- Kleinman, C. (2004b). The relationship between managerial leadership behaviors and staff nurse retention. *Hospital Topics: Research and Perspectives on Healthcare*, *82*(4), 2–9.
- Kramer, M., & Hafner, L. (1989). Shared values—Impact on staff nurse job-satisfaction and perceived productivity. *Nursing Research*, *38*(3), 172–177.
- Kramer, M., Maguire, P., Schmalenberg, C., Brewer, B., Burke, R., Chmielewski, L., . . . Waldo, M. (2007). Nurse manager support. What is it? Structures and practices that promote it. *Nursing Administration Quarterly*, *31*(4), 325–340.
- Kramer, M., & Schmalenberg, C. (2004). Development and evaluation of Essentials of Magnetism tool. *Journal of Nursing Administration*, *34*(7/8), 365–378.
- Kramer, M., Schmalenberg, C., Maguire, P., Brewer, B., Burke, R., Chmielewski, L., . . . Waldo M. (2009). Walk the talk: Promoting control of nursing practice and a patient-centered culture. *Critical Care Nurse*, *29*(3), 77–93.

- Krueger, R. (1998). *Questions analysts must face. Analyzing & reporting focus group results*. Thousand Oaks, CA: Sage.
- Lageson, C. (2004). Quality focus of the first line nurse manager and relationship to unit outcomes. *Journal of Nursing Care Quality, 19*(4), 336–342.
- Lake, E. (2002). Development of the Practice Environment Scale of the Nursing Work Index. *Research in Nursing and Health, 25*(3), 176–188.
- Lake, E. (2007). The nursing practice environment. Measurement and evidence. *Medical Care Research and Review, 64*(2), 104–122.
- Lake, E., & Friese, C. (2006). Variations in nursing practice environments. *Nursing Research, 55*(1), 1–9.
- Lance, C. (1991). Evaluation of a structural model relating job satisfaction, organizational commitment and precursors to voluntary turnover. *Multivariate Behavioral Research, 26*(1), 13–162.
- Larrabee, J., Janney, M., Ostrow, C., Withrow, M., Hobbs, G., & Burant, C. (2003). Predicting registered nurse job satisfaction and intent to leave. *Journal of Nursing Administration, 33*(5), 271–283.
- Laschinger, H., & Leiter, M. (2006). The impact of nursing work environments on patient safety outcomes. *Journal of Nursing Administration, 35*(5), 259–267.
- Laschinger, H. K. S. (2004). Hospital nurses perceptions of respect and organizational justice. *Journal of Nursing Administration, 34*(7/8), 354–364.
- Lederman, L. (1990). Assessing educational effectiveness: The focus group interview as a technique for data collection. *Communication Education, 39*(2), 117–127.

- Leiter, M., & Laschinger, H. (2006). Relationships of work and practice environment to professional burnout. *Nursing Research*, 55(2), 137–146.
- Loke, J. (2001). Leadership behaviors: Effects on job satisfaction, productivity and organizational commitment. *Journal of Nursing Management*, 9(4), 191–204.
- Ma, C., Samuels, M., & Alexander, J. (2003). Factors that influence nurses' job satisfaction. *Journal of Nursing Administration*, 33(5), 293–299.
- Manojlovich, M. (2005). Linking the practice environment to nurses' job satisfaction through nurse/physician communication. *The Journal of Nursing Scholarship*, 37(4), 367–373.
- Manojlovich, M., & Laschinger, H. (2007). The nursing worklife model: Extending and refining a new theory. *Journal of Nursing Management*, 15(3), 256–263.
- McGillis-Hall, L., & Doran, D. (2007). Nurses' perceptions of hospital work environments. *Journal of Nursing Management*, 15(3), 264–273.
- McGuire, E., & Kennerly, S. (2006). Nurse managers as transformational and transactional leaders. *Nursing Economics*, 24(4), 179–185.
- McGuire, M., Houser, J., Jarrar, T., Moy, M., & Wall, J. (2003). Retention: It's all about respect. *Health Care Manager*, 22(1), 38–44.
- McNeese-Smith, D. (1997). The influences of manager behavior on nurses' job satisfaction, productivity, and commitment. *Journal of Nursing Administration*, 27(9), 47–55.
- Montalvo, I. (2007). The National Data Base of Nursing Quality Indicators. *The Online Journal of Issues in Nursing*, 12(3). Retrieved from <http://www.nursingworld.org>

- Morgan, D. (1998). Why should you use focus groups? In M. Flemming & D. Alexsen (Eds.), *The Focus Group Guidebook: Focus Group Kit 1* (pp. 9–16), Thousand Oaks, CA: Sage.
- Morrison, R., Jones, L., & Fuller, B. (1997). The relation between leadership style and empowerment on job satisfaction of nurses. *Journal of Nursing Administration*, 27(5), 27–34.
- Nassar-McMillan, S. C., & Borders, L. D. (2002, March). Use of focus groups in survey item development. *The Qualitative Report*, 7(1). Retrieved from <http://www.nova.edu/ssss/QR>
- Mueller, C., & McCloskey, J. (1990). Nurses' job satisfaction: A proposed measure. *Nursing Research*, 39(12), 113–117.
- Ngo, D. (2009, January 5). Job Descriptive Index [Web log post]. Retrieved from <http://www.humanresources.hrvinet.com/job-descriptive-index-jdi/>
- Person, C. (2001). Shared commitment. *Creative Healthcare News*, 1(3), 2.
- Porter, I., & Steers, R. (1973). Organizational work and personal factors in employee turnover and absenteeism. *Psychological Bulletin*, 80(2), 151–176.
- Porter-O'Grady, T. (2003). A different age for leadership, part 1. *Journal of Nursing Administration*, 33(2), 105–110.
- Price J., & Mueller, C. (1986). *Handbook of organizational measurement*. Cambridge, MA: Ballinger.
- Riley, J., Rolband, D., James, D., & Norton, H. (2009). Clinical ladder. Nurses' perceptions and satisfiers. *The Journal of Nursing Administration*, 39(4), 182–188.

- Rother, J., & Lavizzo-Mourey, R. (2009). Addressing the nursing workforce: A critical element for health reform. *Health Affairs*, 28(4), 2620–2624.
- Saane, N., Sluiter, J., Verbeek, J., & Frings-Dresen, M. (2003). Reliability and validity of instruments measuring job satisfaction—A systematic review. *Occupational Medicine*, 53(3), 191–200.
- Samad, S., & Alam, S. (2005). Unraveling the organizational commitment and job performance relationship: Exploring the moderating effect of job satisfaction. *The Business Review, Cambridge*, 4(2), pp. 79–84.
- Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, 18(4), 371–375.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340.
- Schmalenberg, C., & Kramer, M. (2008). Essentials of a productive nurse work environment. *Nursing Research*, 57(1), 2–13.
- Schmalenberg, C., & Kramer, M. (2009). Nurse manager support: How do staff nurses define it? *Critical Care Nurse*, 29(4), 61–69.
- Sellgren, S., Ekvall, G., & Tomson, G. (2006). Leadership styles in nursing management: Preferred and perceived. *Journal of Nursing Management*, 14(5), 348–355.
- Sellgren, S., Ekvall, G., & Tomson, G. (2008). Leadership behavior of nurse managers in relation to job satisfaction and work climate. *Journal of Nursing Management*, 16(5), 578–587.

- Severinsson, E., & Kamaker, D. (1999). Clinical nursing supervision in the workplace – Effects on moral stress and job satisfaction. *Journal of Nursing Management, 7*(2), 82–91.
- Shader, K., Broome, M., Broome, C., West, M., & Nash, M. (2001). Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center. *Journal of Nursing Administration, 31*(4), 210–216.
- Shirey, M., Ebright, P., & McDaniel, A. (2008). Sleepless in America. Nurse managers cope with stress and complexity. *The Journal of Nursing Administration, 38*(3), 125–131.
- Shobbrook, P., & Fenton, K. (2002). A strategy for improving nurse retention and recruitment levels. *Professional Nursing, 17*(9), 534–536.
- Shortell, S., & Kaluzny, A. (2000). Motivating people. *Health care management* (4th ed.). Albany, NY: Thomson Learning.
- Slater, P., & McCormack, B. (2007). An exploration of the factor structure of the Nursing Work Index. *Worldviews on Evidence-Based Nursing, 4*(1), 30–39.
- Spector, P. (1997). *The nature of job satisfaction. Job satisfaction. Application, assessment, causes, and consequences*. Thousand Oaks, CA: Sage.
- Stamps, P. (1997). *Nurses and work satisfaction: An index for measurement* (2nd ed.). Chicago, IL: Health Administration Press.
- Strachota, E., Normandin, P., O'Brien, N., Clary, M., & Krukow, B. (2003). Reasons registered nurses leave or change employment status. *Journal of Nursing Administration, 33*(2), 111–117.

- Sullivan, E., & Decker, P. (2009). Thinking critically, making decisions, solving problems. In M. Connor (Ed.), *Effective leadership and management in nursing* (pp. 117–118), Upper Saddle River, NJ: Pearson Education.
- Sullivan-Havens, D., & Aiken, L. (1999). Shaping systems to promote desired outcomes: The Magnet hospital. *Journal of Nursing Administration*, 29(2), 14–19.
- Taunton, R., Boyle, D., Woods, C., Hansen, H., & Bott, M. (1997). Manager leadership and retention of hospital staff nurses. *Western Journal of Nursing Research*, 19(2), 205–226.
- United States Department of Labor, Bureau of Labor Statistics. (2008). Registered nurses. *Occupational outlook handbook* (2008–2009 ed.). Retrieved from <http://www.bls.gov>
- United States Department of Labor, Bureau of Labor Statistics. (2010). Registered nurses. *Occupational outlook handbook* (2010–2011 ed.). Retrieved from <http://www.bls.gov>
- Upenieks, V. (2003). The interrelationship of organizational characteristics of Magnet hospitals, nursing leadership, and nursing job satisfaction. *Health Care Manager*, 22(2), 83–98.
- Vandenberghe, C., Stordeur, S., & D'hoore, W. (2002). Transactional and transformational leadership in nursing: Structural validity and substantive relationships. *European Journal of Psychological Assessment*, 18(1), 16–29.
- Watson, J. (2009). *Assessing and measuring caring in nursing health sciences* (2nd ed.). New York, NY: Springer.



- Weiss, D. J., Dawis, R. V., England, G. W., & Lofquist, L. H. (1967). *Manual for the Minnesota Satisfaction Questionnaire*. Minneapolis: University of Minnesota, Work Adjustment Project Industrial Relations Center.
- Whitley, M., & Putzier, D. (1994). Measuring nurses' satisfaction with the quality of their work and work environment. *Journal of Nursing Care Quality*, 8(3), 43–51.
- Wilson, B., Squires, M., Widger, K., Cranley, L., & Tourangeau, A. (2008). Job satisfaction among a multigenerational nursing workforce. *Journal of Nursing Management*, 16(6), 716–723.
- Zangaro, G., & Soeken, K. (2005). Meta-analysis of the reliability and validity of Part B of the Index of Work Satisfaction across studies. *Journal of Nursing Measurement*, 13(1), 7–22.
- Zurmehly, J. (2008). The relationship of educational preparation, autonomy, and critical thinking to nursing job satisfaction. *The Journal of Continuing Education in Nursing*, 39(10), 453–460.

## CURRICULUM VITAE

**NAME:** Feather, Rebecca A.

### **EDUCATION:**

#### Undergraduate:

|                                      |              |      |
|--------------------------------------|--------------|------|
| Ball State University, Muncie, IN    | AA, Business | 1985 |
| Indiana University, Indianapolis, IN | BS, Nursing  | 1993 |

#### Graduate:

|                                      |                            |      |
|--------------------------------------|----------------------------|------|
| Indiana University, Indianapolis, IN | MS, Nursing Administration | 2004 |
| Indiana University, Indianapolis, IN | PhD                        | 2011 |

### **ACADEMIC APPOINTMENTS:**

|   |  |              |
|---|--|--------------|
| Ivy Tech Community College, Bloomington, IN           |  |              |
| Adjunct Faculty                                       |  | 1997–2000    |
| Faculty/Assistant Professor                           |  | 1999–2002    |
| Indiana University School of Nursing, Bloomington, IN |  |              |
| Faculty/Clinical Lecturer                             |  | 2004–Present |

### **CLINICAL APPOINTMENTS:**

|  |  |              |
|--|--|--------------|
| First Health Care, Bloomington, IN                           |  |              |
| Acute Care and Occupational Health RN                        |  | 1995–1997    |
| Bloomington Hospital, Bloomington IN                         |  |              |
| Progressive Care – Critical Care Step-Down Unit nurse intern |  | 1992–1993    |
| Emergency Department RN                                      |  | 1993–1994    |
| PACU charge nurse/RN   |  | 1994–2007    |
| Cardiopulmonary Rehab RN                                     |  | 1996–2001    |
| Department of Organizational Effectiveness                   |  | 2004–Present |
| Professional and Program Development Specialist–PRN          |  |              |

### **CONSULTATIONS:**

|  |  |      |
|--|--|------|
| Assessment Technologies, Institute, Stilwell, KS                 |  | 2005 |
| Test Item Review/Revision/Development                            |  |      |
| Bloomington Hospital of Orange County, Paoli, IN                 |  | 2005 |
| Customer Loyalty Training/Mandatory Employee Training            |  |      |
| Career Transition Group, Bloomington, IN                         |  | 2005 |
| Consultant on resume, portfolio and career development           |  |      |
| Assessment Technologies, Institute, Stilwell, KS                 |  | 2006 |
| Leadership and Management Content development and chapter review |  |      |

Morgan Hospital & Medical Center, Martinsville, IN 2006  
 Charge Nurse Leadership Delegation, Preceptor/Mentor,  
 Portfolios

Bloomington Hospital, Bloomington, IN 2006–Present  
 Leadership Enhancement and Development Program  
 Development and Instructor–Management;  
 Charge Nurse Classes

**LICENSURE:**

State of Indiana

**CERTIFICATIONS:**

DDI and Customer Service Training Certified Issued: February, 2003  
 Facilitator for Leadership

American Nurses Credentialing Center: Nurse Executive Issued: December, 2009

American Heart Association: CPR Healthcare Provider Current

American Heart Association: Advanced Cardiac Life Support Provider Current

**PROFESSIONAL SOCIETIES:**

- Alpha Sigma Alpha Sorority Alumni Association, member
- American Nurses Association, member
- American Organization of Nurse Executives, member
- Ball State University Alumni Association, member
- Indiana Association of Student Nurses, Board member, Treasurer, 1992–1993
- Indiana State Nurses Association, member
- Indiana University Alumni Association, life member
- National League of Nursing, member
- National Nursing Staff Development Organization, member
- Sigma Theta Tau International, Alpha Chapter, member

**TEACHING ASSIGNMENTS:**

**Indiana University School of Nursing**

| Course   | Term         | No. Students |
|--|--------------|--------------|
| H354 Alterations in Health I (Practicum, 2 cr)   | F04–05       | 10           |
| S481 Nursing Mgmt (Didactic Online, 2 cr)        | SP04–Present | 60           |
| S481 Nursing Mgmt (RN-BSN Didactic Online, 2 cr) | F09          | 6            |
| S482 Nursing Mgmt (Practicum, 3 cr)              | SP04–Present | 20           |
| S482 Nursing Mgmt (RN-BSN Practicum, 3 cr)       | SP09         | 6            |
| S483 Capstone (Practicum, 3 cr)                  | SP04–08      | 12           |
| S484 Research Utilization (Research, 1 cr)       | SP04–08      | 12           |

|   |             |    |
|---|-------------|----|
| S485 Prof. Growth/Empowerment<br>(Didactic Online, 3 cr)        | F04–Present | 60 |
| S485 Prof. Growth/Empowerment<br>(RN-BSN Didactic Online, 3 cr) | Sp09        | 5  |

---

**Ivy Tech Community College**

| Course   | No. Students |
|--|--------------|
| N200 Complex Medical Surgical Nsg. II (ASN Didactic, 3 cr) | 40           |
| N201 Complex Medical Surgical Nsg. II (ASN Clinical, 4 cr) | 10           |
| N105 Medical Surgical Nursing I (LPN Clinical, 2 cr)       | 10           |
| N111 Medical Surgical Nursing II (LPN Clinical, 2 cr)      | 10           |

---

**SERVICE:**

|  |              |
|--|--------------|
| Community Outreach Nursing Program–Ivy Tech nursing students:<br>Developed <i>Healthy Heart</i> program for local elementary schools                         | 2001         |
| Ivy Tech Community College: Developed healthcare-related<br>section of <i>Schools to Careers</i> (continuing education for high<br>school teachers) workshop | 2001         |
| Patient Safety Committee, member   | 2004–2005    |
| Capstone Advisory Committee  |              |
| Online Capstone Preceptor Course Development   | 2004–Present |
| Orient new Capstone Preceptors at various facilities   | 2004–Present |
| Revise/Supervise Capstone preceptor process/ student registration  | 2008–Present |
| Bradford Woods; Clinical Nurse, Edgewood Intermediate School<br>5th Grade Camp (approximately 130 students for three days)                                   | 2005         |
| Richland Bean Blossom School Corporation Community School<br>Nurse Informatics Presentation  | 2005         |
| Indiana University School of Nursing, Graduation Committee, member   | 2005–2006    |
| CCNF BSN Curriculum Committee  | 2004–Present |
| Indiana University School of Nursing, Merit Pay Committee, member  | 2006         |
| ISNA Committee of Approval of Continuing Education,<br>appointed member  | 2006–2007    |
| Bradford Woods; Supervisory Nurse, Edgewood Intermediate School<br>5th Grade Camp (approximately 130 student for three days)                                 | May 2008     |
| Faculty Affairs Committee  | 2009–2010    |
| Clinical Site Scheduling Committee, Bloomington Hospital   | 2009–Present |
| Cub Scout Den meetings presentation on health maintenance and nursing  | 2001–2002    |

### **GRANTS, FELLOWSHIPS, AND AWARDS**

IUPUI Graduate School Dissertation/Thesis Scholarship Award, Fall 2010, \$4,000

IU School of Nursing Graduate Student Nursing Research Scholarship Award, Fall 2010, \$1,260

Indiana Workforce Development Scholarship, PhD Program, 2007–2009

Federal Nursing Faculty Development Loan, 2006–2009

### **PUBLICATIONS/JOURNAL REVIEWS**

Feather, R. (2009). Emotional intelligence in relation to nursing leadership: Does it matter? *Journal of Nursing Management*, 17(3), 376–382.

Feather, R., Reams, P., & Zimmermann, P. (2007). Staff development and performance improvement. In J. Wissmann, A. Knippa, K. Roberts, & D. Prater (Eds.), *Leadership and management. Content mastery series, review module (ver.4.0)*, pp. 79–87. Stilwell, KS: Assessment Technologies Institute.

Reviewer for *Journal of Nursing Management*, 2007–Present.