12-2014

The Influence of Supportive Nursing Leadership in Staff Nurse Retention

Theresa L. Dawson

Grand Valley State University

Follow this and additional works at: http://scholarworks.gvsu.edu/dissertations

Part of the Nursing Commons

Recommended Citation

This Dissertation is brought to you for free and open access by the Graduate Research and Creative Practice at ScholarWorks@GVSU. It has been accepted for inclusion in Doctoral Dissertations by an authorized administrator of ScholarWorks@GVSU. For more information, please contact scholarworks@gvsu.edu.
The Influence of Supportive Nursing Leadership

In Staff Nurse Retention

Theresa Lea Dawson

A Dissertation Submitted to the Graduate Faculty of

GRAND VALLEY STATE UNIVERSITY

In

Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF NURSING PRACTICE

Kirkhof College of Nursing

December 2014
Acknowledgment

I would like to acknowledge Dr. Patricia Schafer, Committee Chair, for her continued belief in my abilities to be successful on this journey. I appreciate the guidance and scholarship that Dr. Jean Barry provided over the last year as my project began to unveil. I would also like to thank Dr. A.J. Jones for his continued mentorship and patience during my clinical immersion, allowing me to grow both professionally and personally.

I would be remiss without acknowledging my peers Marie Vanderkooi, Linda Buck and Sylvia Simons who endured this journey with me, providing support and the encouragement when I needed it the most. And last, but certainly not least, a special thank you to my friends and family who never wavered in their support for me achieving my educational dream.
Abstract

Based on the increasing need to retain healthcare’s greatest assets, work environments must provide positive relationships and RN empowerment in an effort to improve staff nurse retention. A variety of factors can influence a registered nurse’s intent to stay, however supportive nursing leadership is thought to have the greatest impact on improving work environments resulting in greater job satisfaction. The purpose of this organizational assessment was to determine the current culture of supportive nursing leadership, RN perceptions of supervisory support, and themes that appeared to require nursing leadership development intervention. Based on these findings a series of leadership development workshops were conducted with those managers and directors who directly supervised RNs.

Thirty four registered nurses participated in the assessment of supervisory support and practice environment measurements. The Supportive Supervisory Scale (SSS) was used to measure perceived nursing leadership behaviors. Descriptive statistics revealed areas of weakness to be those of relationship-building and shared decision-making. The Brisbane Practice Environment Measure (B-PEM) was used to measure nurse perceptions of their work environment. The areas identified that needed most improvement were “feeling valued” and “professional development”. The organizational assessment along with both surveys supported the need for nursing leadership development in relationship-building skills and empowering nurses. The results of these assessments informed the development of an organization specific leadership development intervention.

Leadership development workshops were conducted as a pilot intervention and instruction provided to the nursing care directors and managers on the identified topics as
a part of this project. Self-efficacy evaluation pre and post intervention was conducted to evaluate the confidence of the managers and directors in providing supportive leadership behaviors. Sustainability of these skills will be dependent on continued organizational mentoring and growth of the participants of the workshops. The desired outcome of staff nurse retention will need to be evaluated by the site in the future to determine if leadership development has been successful.
# Table of Contents

List of Tables .................................................................................................................. 8

List of Figures .................................................................................................................. 9

List of Appendices .......................................................................................................... 10

Chapter

1 INTRODUCTION ......................................................................................................... 11
   Statement of the Problem .......................................................................................... 11
   Purpose and Significance of the Scholarly Project ................................................ 16

2 LITERATURE REVIEW ............................................................................................... 18
   Situation ..................................................................................................................... 19
   Work Environment ................................................................................................. 19
   Leadership Characteristics .................................................................................... 22
   Supportive Leadership and Nurse Retention ......................................................... 26
   Summary .................................................................................................................. 30

3 CONCEPTUAL FRAMEWORK .................................................................................... 32
   The Planned Behavior Theory ............................................................................. 32
   Donabedian’s Structure, Process, Outcome Framework ....................................... 33
   Summary .................................................................................................................. 37

4 PLANS AND METHODS ............................................................................................. 38
   Phase 1: Organizational Assessment .................................................................... 39
   Transformational Factors ..................................................................................... 40
   Mission ................................................................................................................... 40
   Leadership .............................................................................................................. 41
   Organizational Culture ......................................................................................... 41
   Transactional Factors ............................................................................................ 42
   Structure ................................................................................................................ 42
   Systems ................................................................................................................... 42
   Work Unit Climate ............................................................................................... 44
   Individual Needs and Values ............................................................................... 44
   Motivation ............................................................................................................... 45
   Summary of Organizational Assessment ............................................................... 46
   Phase 2: Development of Project Implementation Plan-Methods
   Identification .......................................................................................................... 46
   Design ...................................................................................................................... 47
   Instruments ............................................................................................................ 48
   Procedure ............................................................................................................... 49
   Implementation ....................................................................................................... 50
Program Content and Delivery ................................................................. 50
Data Analysis and Evaluation................................................................. 51

5 RESULTS ............................................................................................. 53
  Staff Nurse Participants ......................................................................... 53
  Demographics ......................................................................................... 54
  Staff Nurse Perception of Supervisory Support ....................................... 56
  Staff Nurse Perception of Work Environment ....................................... 57
  Leadership Development Workshops ...................................................... 59
    Leadership Development Workshop One ............................................. 60
    Leadership Development Workshop Two ........................................... 61
    Leadership Development Workshop Three ......................................... 62
    Leadership Development Workshop Four ......................................... 63
  Summary .................................................................................................. 64

6 DISCUSSION ......................................................................................... 66
  Conceptual Framework ........................................................................... 67
  Effectiveness, Feasibility and Sustainability .......................................... 68
  Facilitators and Barriers ......................................................................... 70
  Limitations .............................................................................................. 71
  Implications of the Doctor of Nursing Practice (DNP) Graduate ............ 71
  Recommendations .................................................................................. 73
  Conclusion and Summary ...................................................................... 75

APPENDICES ............................................................................................. 77

REFERENCES ........................................................................................... 96
List of Tables

TABLE
1  Years of Experience in Nursing and Employment at the Center by Group…55
2  Nurse Respondents’ Age and Years of Experience as an RN…………55
3  Nurse Respondents’ Age and Length of Employment………………….56
4  Perceptions of RN Practice Environment by Subscale………………..58
List of Figures

FIGURE

1    Donabedian’s SPO Implementation Model Application to Project…………37
List of Appendices

APPENDIX

A  Synthesis Table ........................................................................................................ 78
B  Evaluation Table ........................................................................................................ 79
C  Self-Efficacy Tool ..................................................................................................... 82
D  Supervisory Support Scale ........................................................................................ 83
E  Brisbane Practice Environment Measure .................................................................. 84
F  Permission to Use Instruments .................................................................................. 85
G  Cover Letter ................................................................................................................ 87
H  Demographic Information Survey .............................................................................. 88
I  Supervisory Support Scale Results ............................................................................. 89
J  Leadership Workshop Outline and Modules ............................................................... 90
K  Self-Reflection Results on Behavioral Change ............................................................ 95
CHAPTER 1
INTRODUCTION

Statement of the Problem

As the nursing shortage continues to accelerate, concerns over the need to retain nurses becomes more imminent. It is predicted that by the year 2020, the growing number of people with chronic disease who will require health care, in addition to the increase in life expectancy of the general population, will create a nursing shortage that will be at a critical point. “In 2010, the United States Department of Labor Statistics projected a twenty two percent increase in the demand for Registered Nurses by 2018,” (Cottingham, DiBartolo, Battistoni, & Brown, 2011, p. 250). Due to the recent economic depression, there is a false sense that the nursing shortage is not extreme. With a majority of practicing nurses being over the age of 50 years (Cottingham, et al., 2011), an examination of the replacement factor for nurses concluded that the predicted increase of those who will be in need of care will outpace the supply of new nurses graduating from nursing programs. This inequality of supply and demand could touch those citizens requiring health care in the future.

The magnitude of this potential nursing shortage could be devastating to the health care delivery system as registered nurses are the primary care givers in most environments. This exemplifies the importance of retaining quality staff nurses rather than losing them to controllable forces such as job dissatisfaction. Cowden and Cummings (2012) proposed that this “global nursing shortage and high nursing turnover rate demands evidence-based retention strategies” (p.1). This is the challenge set forth for consideration.
At a time when fiscal responsibility is expected in health care, organizations can no longer afford the costs associated with continued orientation of new employees. It is estimated that it costs an organization approximately $47,000 to replace each staff nurse and potentially $85,000 to replace a specialty care nurse lost through turnover (Cottingham et al., 2011). Duffield, Roche, Blay & Stasa (2010) pointed out that the savings that an organization can realize from staff nurse retention could be allocated to educate future nurse leaders in mentorship and other leadership skills. It is imperative that the profession of nursing take this issue under its own control to assure that the future public and community health needs are met.

When examining the many variables that cause nurses to leave their positions, one must consider the influences that nursing leadership may contribute to staff nurse retention. The Institute of Medicine (IOM), in conjunction with the National Academy of Sciences and the Robert Wood Johnson Foundation, published a compelling report in 2011 on *The Future of Nursing* whereby messages for the advancement of health care for the future were delivered. One of the key messages was that collaboration with other health professionals in the redesign of health care should include nurses as full partners in planning and implementation (IOM, 2011). The report articulated the importance of strong and effective leadership to transform health care in a manner where common vision and goals flow among all team members, without regard to position. It is believed that a positive work environment will result in increased nurse retention, adding stability to the workforce.

Nurse leaders have the potential to make an impact on this phenomenon. Kleinman (2004) stated, “effective leadership styles among nurse managers have been associated
with staff nurse job satisfaction and retention” (p.4). Nurse leadership is often misunderstood to be a positional characteristic rather than an acquired skill. Nurses may be placed in positions of influence without the necessary knowledge base or skills in order to be successful. It is imperative that nurses who have the potential to lead others have the skills to enact their roles in a supportive manner. Creating a work environment that is supportive, positive and takes into consideration the individual needs of the staff nurse is paramount in retaining quality nursing staff.

The complex nature of most healthcare systems requires an evidence-based approach to leadership (Burns, 2001). Leaders must understand the principles of complexity science in order to survive the disorder that often occurs on a daily basis. Burns (2001) pointed out, leaders must learn “to focus less on prediction and control and more on fostering relationships and creating conditions in which complex adaptive systems can evolve to produce creative outcomes” (p. 474). Dissemination of knowledge in supportive leadership behaviors to future nurse leaders is important in order to transform work cultures into a supportive environment.

The need for more information and education on the effects of supportive leadership is required for future nurse leaders in order to develop a change in behavior. Knowledge translation is required, taking best practice evidence from the literature and transforming it into action through communication and education. Many theories may be appropriate in supporting leadership qualities, ranging from social theories of networking where a nurse leader may be seen as the link of influence to a larger group, to theories of supportive (congruent, transformational) leadership. As Graham, et al., (2006) explained,
it is necessary to think about the process of knowledge creation in order for those receiving it to understand its application.

It is proposed that knowledge translation through leadership education utilizing the supportive supervisory framework described by McGilton, Profetto-McGrath, & Robinson (2013) can be used to introduce and reinforce supportive leadership behaviors that, when employed, can assist in the retention of staff nurses. The implementation of these leadership characteristics of mentorship, positive relationship building, presence, and administrative and clinical competence are the core of the framework. Since interpersonal processes and change are often difficult, human response and meaning must be considered. Dissemination of information in the form of education with the ultimate goal of application of this knowledge by future nurse leaders is crucial. To assist in the educational process, translation of knowledge will be required to fit the environment in which the change is to occur.

Leadership behaviors and the perceptions of them are qualitative in nature. Interactions that occur in healthcare environments which may affect job satisfaction for staff nurses involve personal meaning and values of individuals. Grace and Powers (2009) used the human responses domain to summarize the importance of studying this interaction through qualitative evidence. This inspired a search of the literature that consisted primarily of qualitative or descriptive research assessing nurse leadership and staff nurse job satisfaction.

While reviewing the literature, positive (supportive) leadership behaviors were assumed to be synonymous with collaborative, transformative, servant, mentoring, and relationship-centered approaches. Job satisfaction was thought to be related to
collaboration, trust and praise resulting in increased staff nurse retention. The inclusion strategy used was to identify as many qualitative or correlational descriptive studies as possible on the subject of nurse leadership and staff retention, including nurses and unlicensed personnel, and job satisfaction.

Many of the concepts that emerged from the literature review regarding leadership behaviors that improved staff nurse job satisfaction and retention mentioned positive relationship building and mentoring. Other concepts included recognition of staff nurses, collaboration, and caring. Synthesis of the literature reviewed revealed a positive correlation between positive leadership and increased job satisfaction and an inverse relationship between negative leadership behaviors and job satisfaction. Other literature reviewed captured the humanist opinions through interviewing and hermeneutic interpretation methods, considered as support for themes of effective leadership styles.

McGilton (2010) conducted a secondary analysis in order to determine the reliability and validity of a supportive supervisory survey. Positive relationships were identified as a core element of effective leadership. The tool that was being tested, Supportive Supervisory Scale (SSS), was found to be reliable for measuring effective nursing leadership with factor loading >.40 on one factor. During the assessment of the tool, the survey done reflected a positive relationship between effective leadership and job satisfaction leading to staff retention.

This limited literature review supports the intervention of nurse development in supportive leadership behaviors resulting in increased staff nurse retention. It is evident that more research on supportive leadership and its effects on staff nurse retention are needed, especially in the areas of human response and meaning.
Purpose and Significance of the Scholarly Project

The purpose of this scholarly project was to determine present levels of staff nurse job satisfaction and perception of supervisory support at a community-based health center in order to guide a leadership development intervention. Following the literature review and pre-intervention surveys, the Donebedian Model of Structure, Process Outcome (1966) was used to implement and evaluate a pilot of supportive leadership education and training of all nursing leaders within the organization. The process was guided by the nurse leader development framework outlined by Herrin & Spears (2007) that includes leader assessment, development programs and individual coaching. The actual educational intervention consisted of concepts taken from McGilton et al. (2013) with the theory of planned behavior as formulated by Ajzen (1991) as the basis for modifying leadership behaviors.

The selected site, a large, Federally Qualified Health Center (FQHC) in the Midwest, was assisted in developing an educational intervention to instill and practice supportive leadership strategies in their particular organizational culture. This process included the key constituents in order to assure buy in and support. Lukas, et al., (2007) stated, “although leadership strategies began at the top of the organization, improvement was greater when middle and frontline managers were committed” (p. 315). The influence of all leaders within the organization must be examined and methods of relationship-building assessed. Intention to stay in an organization is influenced not only by an increased knowledge base through education and empowerment, but through many affective determinants that often are not considered (Cowden & Cummings, 2012). Recognition, empowerment, teamwork, and praise are all related to staff nurse job
satisfaction. The more extensively leaders within an organization understand the influences that cause job dissatisfaction, the better the chances of them learning ways in which to improve the relationships that result in trust and greater nurse retention.

The potential outcome of this educational intervention could result in increased job satisfaction leading to improved retention of registered nurses in the organization. The success of the intervention could then be measured by a follow up assessment of supportive supervisory practices within the organization after a period of approximately one year. Potential fiscal impact to the organization as a result of increased nurse retention could be included in the evaluation of the intervention.
CHAPTER 2
LITERATURE REVIEW

The underlying purpose of this project is to determine the influence of supportive leadership on staff nurse retention. The literature review was conducted to determine the variables that affect staff nurse intent to stay and to uncover what is known about positive leadership behaviors related to staff nurse retention. In addition, an effort to identify tools to measure leadership behaviors and staff nurse job satisfaction was completed. Finally, a summary of the conclusions and implications for this project are presented.

A systematic search of the literature was conducted in CINAHL, MedLine and Google Scholar databases. The screening process for the traditional databases included peer-reviewed journals. Key words utilized to search the practice problem were: supportive leadership, servant leadership, positive leadership, transformational leadership, nurse retention, work environment, nurse manager, nurse turnover, leader, registered nurse (RN) job satisfaction, relationship-centered care and organizational culture. Leadership studies on case management, team work and evidence-based practice implementation were excluded as the project focus was on nursing leaders with direct staff nurse supervisory responsibilities. Initial results yielded 247 articles for review. In refining the search, supportive nursing leadership AND staff nurse retention were used and was limited to the English language; however, the search was not limited to the United States or years of publication. The final yield after the refined search included ten articles for review.
Situation

The United States Department of Labor Statistics predicts that by the year 2020, more than 1.2 million additional RN’s will be needed to work a variety of health care settings (Rosseter, 2012) in order to meet the demand that will exist. “One of the essential causes of the current nursing shortage in the United States is the dissatisfaction of nursing with the work environment” (Erenstein & McCaffrey, 2007, p.303). Many nursing organizations have also emphasized that the looming nursing shortage is not about numbers only, but of retention of experienced nurses to care for the higher acuity patients who will emerge with changes in health care (Upenieks, 2005). It behooves health care organizations to examine environmental factors and leadership characteristics that can assist in retaining staff nurses in the current workforce. The purpose of this literature review is to identify leadership characteristics that affect staff nurse retention and increase RN job satisfaction. The findings are organized in subgroups of work environment, leadership characteristics and supportive leadership AND nurse retention.

Work Environment

The influence of work environment on staff nurse retention is supported in the literature. Lavoie-Tremblay, et al. (2010) utilized a correlational descriptive design to compare work climate perceptions and intentions to quit among three generations of nurses. Chi-square analysis demonstrated a significant proportion of generation Y nurses (p<.01) were looking to quit, three times more than the generation X and Baby Boomers. Due to the outcome variables having inter-correlations, MANOVA was used to further explore the findings. The study found significance with intention to quit and work climate, Wilk’s lambda = .864, p<.001. This study looked at job challenge and absence
of conflict and the differences between generations, and reinforced the need to recognize
the differences between generations as it relates to work climate.

Duffield, Roche, Blay, & Stasa (2010) performed a secondary analysis of two larger
studies in which leadership was measured by the work environment. The purpose of the
study was to determine the impact of leadership characteristics of nursing managers, as
perceived by staff nurses, on staff satisfaction and retention. The assumption was that a
positive work environment, created by a nurse leader who displays visibility,
accessibility, recognition and support, will assist in the increasing job satisfaction and
therefore nurse retention. Nurse, patient and environmental data were collected for seven
consecutive days on 94 randomly selected medical/surgical units in 21 public hospitals
across two states of Australia between 2004-2006. All staff nurses on these units were to
complete a 49-item survey which identified organizational attributes that are associated
with good patient outcomes. There were also open-ended questions about job
satisfaction, nursing profession satisfaction and intention to leave their present position.
Data regarding retention at these 21 hospitals were not available to the author. The
specific area of interest was leadership and consisted of a 12 item instrument with a
Cronbach’s alpha of .80. After surveys that had missing data were removed, the final
sample size was n = 1559.

Descriptive statistics were used for work classification and status (full versus part time
employment). Seventy-eight percent were registered nurses including educators, 24.8 %
were LPN’s, and 2.4% were patient care assistants. More than half (51.7%) were
employed full time with the remainder working part time (< 38 hours/week) or casual.
Satisfaction with their jobs was conveyed by 67.1% of the respondents, and 72.8% of
them were satisfied being a nurse. Less than one third had any intentions of leaving their current position.

The secondary analysis supported the correlation between positive work environment measured through leadership and staff nurse retention. Limitation of this study was that it was performed in Australia where health care delivery is different than the United States; therefore, the findings cannot be generalized to all countries and health care systems.

In an effort to determine the effect of healthcare work environments on nurse retention, Erenstein & McCaffrey (2007) conducted a literature review to examine the factors that create unhealthy environments leading to poor nurse retention. All the studies utilized either self-report surveys or interviews with nurses. The results identified common themes of job stress, excessive demands, poor staffing, physical demands and lack of respect as reasons for job dissatisfaction. The authors concluded that the studies demonstrated how healthy work environments can positively influence nurse retention. Specifically, nurse participants valued autonomy and empowerment that was promoted by nursing leadership.

The impact of a positive work environment has been well documented in health care literature since the early 1980’s. In the United States, as Magnet-designated hospitals consistently reported higher nurse retention rates, the recommendations for changes in work place environments allowing for increased autonomy, decision-making, participatory leadership and recognition were encouraged. Upenicks (2005) summarized the prevention strategy for Magnet hospitals as a call for a change in leadership approaches to include participatory practices and positive communication.
Based on two studies, one literature review and one expert opinion on the effect of work environment on job satisfaction, the literature demonstrated a positive correlation between supportive work environments and increased nurse job satisfaction and retention. The variables that create a supportive work environment consistently were identified as clear nursing philosophy, leaders with ability and experience, praise and recognition, involvement in decision making, adequate resources and good relationships with colleagues.

**Leadership Characteristics**

As work environment is important in nurse retention, it is also helpful to examine the characteristics of nursing leaders that may have a positive effect on retaining these assets. Strengths of leaders can be judged by their abilities to think critically. Zori, Nosek, & Musil (2010) explored the connection between a nurse manager’s ability to think critically and perceptions of staff nurses of the practice environment. The authors felt that transformational leaders are thought to be capable of influencing others through their critical thinking abilities; therefore, being able to link critical thinking to effective nurse management may be helpful in preparing new leaders.

A descriptive study design to place nurse managers in categories of either weak or strong in critical thinking was used. This was achieved by using the California Critical Thinking Disposition Inventory (CCTDI) which consisted of 75 items grouped into seven subscales: truth-seeking, open-mindedness, analyticity, systematicity, critical thinking self-confidence, inquisitiveness, and critical thinking maturity. Reliability of the tool was reported a Cronbach’s alpha ranging between .60 to .78 on subscales and .90 overall. A 6-point likert scale was used on the questionnaire.
The practice environment was measured by the Practice Environment Scale (PES) to examine nurse job satisfaction. The tool consisted of 31 items grouped in five subscales that measured “nursing participation in hospital affairs, nursing foundations for quality care; nurse manager ability; leadership and support of nurses; staffing and resource adequacy; and collegial nurse-physician relations” (Zori, 2010, p. 307). The setting was in a 490-bed voluntary, non-profit, tertiary hospital in the northeastern United States. The inclusion criterion for the nurse manager sample was that they had to have been a nurse manager for at least 6 months in their current position. They were required to be able to read and write in English in order to interpret the questions. The final convenience sample consisted of 12 nurse manager participants from different units of the hospital. The inclusion criteria for the staff RNs were that they had to be full or part-time for at least 6 months and worked on a unit of a participating nurse manager. They also were required to speak and read English. In order to achieve a medium effect size, 128 RNs needed to participate. Random sampling was done resulting in a final sample for this group of 132.

The CCTDI scales descriptive statistics revealed significance between nurse managers’ CCTDI scores for open-mindedness, analyticity, and critical thinking confidence and systematicity when compared with respective RN scores in all subscales. This supports that a positive relationship between strong critical thinking abilities in nurse managers and RN’s perception of the practice environment. The limitations of the study were that it cannot be generalized as this was only conducted in one medical center and the nurse managers volunteered to participate leading to a limited sample size and possible bias in the sample. Since the units in which each nurse manager varied to a large
extent, it is not known if the type of unit may have affected the results as there was no analysis done to explore unit variation.

The social context of leadership was described by Akerjordet & Severinsson (2008) as emotional intelligence that is highlighted by self-awareness, positive empowerment and the ability to support change. In their literature review conducted of international studies between 1997 and 2007, there were eighteen articles that explored emotional intelligence and its link to nursing leadership. They found both theoretical and empirical studies to review with increasing numbers of publications after 2000 as the issue of emotional intelligence became an area of interest for study. Each author independently reviewed the full texts. They concluded that the review revealed “emotional intelligence was associated with positive empowerment processes as well as positive organizational outcomes” (p. 565). The skills of considering feelings, understanding mindfulness and using reflection as leaders appears to have a positive outlook for the future.

Leadership style is often referenced when considering behaviors of health care leaders. Azarre & Gross (2011) conducted a study to “explore the nature of leadership styles used by nurse managers, and describe staff nurses’ perceptions of leadership styles” (p. 672). The premise was that effective leadership is associated with staff nurse job satisfaction resulting in increased retention rates. As a secondary aim, the study was attempting to determine if other outcomes such as quality, safety, and effective delivery of care were related to leadership styles presented.

Using ethnographic research methods, a questionnaire was used to collect two types of data, demographic information and open-ended semi-structured questions. The tool used to collect data was peer-reviewed. The questionnaire was used to guide interview
questions in a face-to-face manner and the interviews were tape-recorded. Follow up questions were allowed if the respondent’s answers needed clarification or expression of feelings. Since in ethnographic inquiry human behavior and feelings are important data, a tool needs to be flexible in order to obtain as much information as possible regarding the research questions of interest. No specific number of questions was utilized, 15-20 minutes were allowed for the interview. This was considered to be appropriate for the exploratory/descriptive nature of the study. Field notes were also made to capture any significant verbalization for analysis.

The sample was taken from nursing units of two hospitals in Ghana with staff nurses from both hospitals and all three shifts interviewed. Quota sampling was used to obtain 20 staff nurses who would represent the general nursing population. Criteria for sampling were that the staff nurse had to have practiced for at least one year and be on duty at the time of the research.

Hermeneutic analysis was used to reveal four themes of leadership style: non-consultative, abusive/hostile, disempowered and knee-jerk leadership. Many narrative examples were provided in the article. The findings suggested that there was a sense by staff nurses that nursing managers were just a figure-head with no actual authority. There was a feeling of mistrust among staff nurses resulting in dissatisfaction. The organizational culture in Ghana’s health system is considered to be bureaucratic in nature and may explain why nurse managers feel they need to control the environment. There were only 5% of the staff nurses who had been employed for 10 years or more, perhaps reflecting a lack of satisfaction in the workforce.
Limitations consisted of the inability to generalize to health systems universally as this was conducted in a very specific region and culture. The findings are “suggestive not conclusive” (p. 680) making further research in this area necessary. In addition, the author stated in the conclusion that nursing leaders need to be selected for their ability to lead, not based on seniority.

According to Melnek & Fineout-Overholt’s (2011) critical appraisal of qualitative evidence, the study by Azaare, et al. demonstrates credibility and trustworthiness. The sampling process used nurses from two different hospitals using convenience methods. Saturation was thought to have been reached after 10 interviews at each hospital. The sample represented a typical hospital setting in Ghana. Data triangulation was done with observation, field notes and tape recordings. The data were collected by the authors only, no other peers were utilized. After the data were analyzed, it was shared with the informants for verification. This supports the transferability of the study. Dependability and confirmability were not possible due to lack of replication of a similar study for comparison at this time.

**Supportive Leadership and Nurse Retention**

Supportive leadership, as described by McGilton (2010), focuses on the development of positive relationships in an attempt to improve job satisfaction for nurses, laying the foundation for the future of nursing in a complex health care environment. Complexity theory reinforces the need for inter-relatedness and relationship building in an effort to face today’s changing health care needs (Burns, 2001). Development and testing of the SSS found that the core element in supportive supervision was that of the ability of leaders to maintain positive relationships (McGilton, 2010).
Many of the concepts that emerged from the literature review regarding supportive leadership characteristics mentioned positive relationship building and mentoring. Other concepts included recognition of staff nurses, collaboration, and caring. Kleinman (2004) utilized a prospective correlation design to assess staff nurse perceptions of nurse leadership that contribute most to nurse retention using a self-report tool. The findings revealed that active management through visibility was the only specific leadership behavior significantly correlated with staff nurse turnover.

In a study by Bott, Boyle, Hanson, Tauton & Woods (1997), leadership behaviors were found to be determining factors in staff nurse retention. The purpose of the study was to test a paradigm developed by the investigator attempting to link nurse manager leadership and hospital staff nurse retention. The paradigm, Organizational Dynamics Paradigm of Nurse Retention, incorporated models of anticipated turnover of staff nurses. Specifically, nurse manager characteristics were looked at regarding the effects on nurse retention “through work characteristics, job stress, job satisfaction, commitment, and intent to stay” (p. 205). The theory used to develop the paradigm was that of Leavitt’s (1958) model of behavior within organizations. The Organizational Dynamics Paradigm proposed that four sets of predictor variables determine retention of staff RNs. These consisted of: manager characteristics (leadership style), organizational characteristics (practice autonomy), work characteristics (communication), and nurse characteristics (education, other opportunities).

This correlational research consisted of simultaneous data collection on predictor variables (manager characteristics, organizational characteristics, work characteristics and nurse characteristics) as well as intervening variables (job satisfaction,
administration, enjoyment, commitment, intent to stay). Retention, the outcome variable, was monitored for 6 months following data collection. The tools used three indicators to measure retention: turnover, unit separation and retention. Manager characteristics were measured with five concepts: reward, coercive, legitimate, referent and expert. Influence of the nurse manager on environmental characteristics was measured by work activities such as influence over assignments, decisions related to personnel and resource allocation, and coordination of work (Bott, et al., 1997). Factor analysis reduced this to two factors of influence (personnel resources and work activities). Job satisfaction was determined to be represented by enjoyment as a measure of satisfaction. Finally, unit structure and nurse characteristics were incorporated as correlates. Work environment was found to be correlated with retention. “The manager’s leadership behavior was more important for unit separation (move to another work area) than turnover; job satisfaction predicted unit separation but not turnover; and, commitment predicted turnover, not unit separation” (p. 214). Bott et al., (1997) concluded that nurse turnover underestimates issues of staff dissatisfaction requiring leadership behaviors as the primary intervention to improve retention.

McCloughen, O’Brien, & Jackson (2011) used hermeneutic phenomenology to investigate the theory of mentorship as a mode of being. This method uses interviews, recording and transcription of the conversations that are evaluated for themes until the meanings are free of contradictions. There were three themes that emerged; imagination, journey and mode of being. This translates into the thought that mentorship was an extension of the person, a way of behaving, not something that is taught, themes that are relevant to leadership principles.
The study used a purposive sample selection which lends credibility for descriptive phenomenology to assure that the participants had experience in mentorship, leadership and held peer recognition as a nurse leader. This lived experience is crucial to the design. Transcripts were utilized by the interviewer to assure consistency in presentation. Themes emerged through extensive review of recorded interviews. The results described the existence of lived experiences in mentorship and the belief that it is an inherent attitude, not a learned skill.

Nurses’ intention to stay related to leadership behaviors was further studied by Cowden, Cummings & Profetto-McGrath (2011). A systematic review of the literature examining the relationship between managers’ leadership practices and staff nurses’ intent to stay revealed support for a relationship between “transformational leadership, supportive work environments and staff nurses’ intentions to remain in their current positions” (p. 461). Review of twenty three research articles revealed the common theme of relational effects of supervision. They concluded that the influence of all leaders within the organization must be examined and methods of relationship building assessed. Intention to stay in an organization is influenced not only by an increased knowledge base through education and empowerment, but through many affective determinants that often are not considered correlated with intent to stay.

Based on four studies and one systematic review on the relationship between nursing leadership and staff nurse retention, the literature demonstrated a positive correlation between these concepts. The behaviors that were commonly found to describe supportive nursing leadership were positive relationship-building skills, caring, mentoring and collaboration with colleagues.
Summary

Demonstrating presence and providing mentorship are characteristics believed to be a part of effective leadership. This requires the ability of the nurse leader to balance responsibility, yet recognize and support those who are caring for the patients. Building positive relationships is crucial in developing the trust that is necessary to earn respect as a leader. If staff nurses believe they are valued, they are more likely to be satisfied with their position.

Synthesis of the literature review demonstrated a correlation between positive leadership and increased job satisfaction and an inverse relationship between negative leadership behaviors and job satisfaction (Appendix A). The qualitative literature captured human responses through interviewing and hermeneutic interpretation methods and was considered as support for themes of effective leadership styles described in the quantitative studies.

There is a significant amount of support for continued investigation into the effects of supportive leadership on retention of staff nurses that contribute to the proposed project. Melnyk & Fineout-Overholt (2011) use a hierarchy of evidence from high level (level 1) evidence consisting of systematic review or meta-analysis of randomly controlled trials to the lowest level of evidence (level VII) consisting of expert opinion. Overall the strength of evidence found in this literature review demonstrated various levels from higher level exploratory and predictive correlational studies to lower level expert opinion that express ideas and concepts. Evidence was provided in the form of systematic reviews of the literature (level V) that examined the relationship between leadership practices and staff nurses’ intent to stay in their positions and transformational leadership effects on nurse
satisfaction and retention. A meta-synthesis (level V) of qualitative research done on supportive leadership behaviors provided evidence that supports the proposed project. Qualitative studies using interviewing and hermeneutics phenomenology techniques that revealed consistent themes of leadership behaviors that resulted in job satisfaction provided level VI evidence. The lower level (level VII) of evidence consisted of expert opinions and commonly cited recommendations for further study. Therefore, through critical appraisal of these 10 articles (Appendix B), one can conclude that supportive supervisory behaviors and nurse job satisfaction resulting in retention are highly correlated.
CHAPTER 3

CONCEPTUAL FRAMEWORK

The purpose of the evidence-based project was to determine the baseline levels of job satisfaction and perceived supervisory support among nurses in a community-based health center (Center) followed by educational strategies that may facilitate development of supportive leadership behaviors among clinical directors and managers resulting in improved staff nurse retention. Using the premise that these eventual behavioral changes would require intention to do so, Ajzen’s (1991) Theory of Planned Behavior (TPB) was used as a theoretical framework for the planned educational intervention strategies. Translation of evidence into the practice environment was guided by Donabedian’s model.

The Theory of Planned Behavior

According to the Theory of Planned Behavior developed by Ajzen (1991), “an individual’s intention to perform a given behavior is the strongest predictor of actual behavior” (p. 181). Ajzen (1991) proposed that this intention is based on three factors: (1) attitudes (2) benefit or social expectations (subjective norms) and (3) perceived control that allows a readiness to change. If intention for behavioral change is linked to attitude, expectations to perform and sense of control, then planned change strategies must address these elements of cognitive determination. The general thought is that a favorable attitude together with a greater perceived amount of control and acceptance by those who are important to them, the more likely the individual’s intention will be to change behaviors.

In addressing the issue of leadership development through planned behavior change, attitudes were evaluated by assessments of current beliefs towards supportive
The self-evaluation of behaviors performed by leaders helped determine if supportive leadership is meaningful to them. Perceived self-efficacy (Bandura, 1977) evaluation was conducted prior to the educational intervention and was used to help in determining the belief of the participants that they can actually perform the behaviors of supportive leadership (Appendix C). Assessing the leadership expectations of those who report to them provides for feedback (subjective norm) identifying the need for behavior change. Providing education to increase the leaders’ cognitive knowledge base, and developing interventions that utilize individual reflection on leadership skills will support perceived control over enacting the desired behavior. Educational material was developed to address each of the elements of the theory of attitudes and intention through the use of self-reflection and inquiry in an effort to support the development of future leaders within the organization. Post self-efficacy was measured to determine if the educational intervention was helpful in influencing the likelihood of behavioral change.

**Donabedian’s Structure, Process, Outcome Framework**

To understand the leadership readiness and organizational structures in place to assure successful implementation of such an intervention, an appreciation of the context of the organization was explored. Donabedian’s (1966) framework of structure, process, outcome (SPO) was utilized in this project to assess the organizational structures affecting leadership practices and the processes that influence the outcome of staff nurse retention. Identification of potential barriers for behavioral change that exist consisted of a difference of perceived control and the subjective norm within the organizational culture. This required additional thought on implementation climate, intended interventions and readiness for change.
Donabedian’s model (1993) originally offered a framework for medical care quality. It is used to assist in system-wide strategies to evaluate process effectiveness, resource utilization and a better understanding of institutional behaviors in order to achieve desired outcomes. As with many implementation frameworks, the use of evidence and involvement of concerned stakeholders are the keys to success. As an implementation model, the SPO framework does not dictate theories by which the process (intervention) element must be presented. This allows for the creativity and very specific approaches informed by the TPB utilized in this project in regard to education strategies.

The Donabedian (1966) model was chosen because it utilizes a blend of organizational assessment and structure analysis in addition to the consideration of social aspects that may affect meeting the desired outcomes. It is Donabedian’s belief that “structure, process and outcomes are not independent of one another. The appropriate structure will promote good processes, which in turn yield good outcomes” (Harrington, 2010, p. 47). The model allows for specific measurement of any of the variables and for identification of causal relationships in structure, process or outcomes. The SPO models flexibility in application to all types of organizational structure and processes as well as its inclusion of the social aspects affecting organizations aligned very well with the supportive leadership project. As nursing leadership is an important element of structure and the ensuing work environment, using Donabedian’s model to assist in implementing change in an organization to strengthen leadership skills as an avenue to support staff nurses will ultimately achieve better nurse retention and job satisfaction.

In reference to the model, Donabedian’s (1966) conceptualization of Structure refers to the organization in which the intervention or change is to occur and the variables that
affect processes within the organization. It includes administrative structure, culture or environment, policy and procedures, resources that are allotted, and the qualifications of those who are employed within the organization. Variables in the project describing structure include both staff factors and system factors. Structural staff factors examine staff age, years of experience, self-esteem (value), and staff empowerment. System factors were considered to be staff nurse retention rates, current nursing leadership support, organizational culture and structure, and staffing models being utilized. These structural elements were obtained through organizational assessment. This first step is crucial for sustainability of any change implemented. The desired outcomes of the project, increased staff nurse retention and empowerment, should be identified from the onset in order that measurement of success can be done at the conclusion.

Process evaluation as created by Donabedian (1966) refers to assessment of the current state of the variables of interest, activities occurring within the organization, development of a planned intervention to attain the desired outcomes and provide feedback for future outcome measurement. The process variables of the project included current staff nurses’ perception of supervisory support and work environment and an organizational assessment that was guided by The Causal Model (Burke & Litwin, 1992). These assessment findings laid the foundation for the leadership education development. The process then included the key stakeholders in the review of the linkage between the assessment findings and development of the intervention in order to assure buy in and support. The executive leadership provided feedback on the proposed intervention with the overall goal being to instill and practice supportive leadership strategies in their organizational culture.
The intervention of leadership education using the Theory of Planned Behavior (Azjen, 1991) was introduced to reinforce supportive leadership behaviors such as positive relationship building, mentorship, and empowerment of staff nurses. The need to link intentions with actual behavioral change through future measurement was introduced for future leadership evaluation. In order to assure sustainability, seasoned and knowledgeable mentors need to embrace the theories presented and uphold the underlying structural changes that were recommended.

Potential facilitators and barriers such as the overall philosophy of the organization and the amount of support from key people in administration were determined. Without support at the administrative level, processes may be jeopardized due to constraints that are placed on the project intervention. Barriers to the project might also include the lack of internal mentors, lack of skill or knowledge in evidence-based practice change, or a general lack of value for evidence by the organization. These barriers must be addressed before moving forward with the process of leadership education.

Theoretically, if leadership development is successful by changing the structures and processes in which support and relationship building occur, the project outcome of increased staff nurse job satisfaction and empowerment can lead to increased retention of qualified nurses. This third and final element (outcomes) of Donabedian’s model provides the premise for evaluation. An overview of the SPO implementation application to the proposed project is depicted in Figure 1.

Staff nurse retention and improved working relationships lead to increased job satisfaction leading to positive effects on overall patient outcomes (Laschinger, Read, Wilk, & Finegan, 2014). Fiscal improvements should also be realized as replacement
factors for nurses are eliminated. Outcome measurement should include a linkage to quality attributes described by Donabedian (1993) such as: increased staff nurse retention, and job satisfaction that reflect success of supervisory support efforts, and display of supportive leadership behaviors.

Figure 1. Donabedian’s SPO implementation model application to project

**Summary**

The success of any intervention relies on the ability to evaluate relationships among variables. Given the complexity of health care organizations, system’s performance evaluation using a model of interdependence is imperative (Handler, Issel & Turnock, 2001). The integrated structure-process-outcome framework provided by Donabedian (1966) offers an excellent approach to provide this evaluation.
CHAPTER 4

PLANS AND METHODS

The purpose of this chapter is to describe the project, methodology and its design. The area of interest in this project is to determine the influence of supportive leadership behaviors on staff nurse retention in a well-established Federally Qualified Health Center (Center) in a Midwestern state. The Center is designated as federally qualified through the Department of Health and Human Services and is located in an urban area. Historically the Center served the uninsured, under-insured and Medicaid population in the county area; the Center recently expanded to serve those who are commercially insured as well. The Center currently employs 270 people equating to an estimated 230 full time equivalents (FTEs). Registered nurses (RNs) constitute 35 FTE’s of the Center’s budget.

The Chief Executive Officer (CEO) and President is a doctorally prepared nurse who has been with the organization for 25 years. Designated time was spent with the CEO who served as a preceptor for this student offering the opportunities for exposure to executive level management operations and personnel. Interest in the topic of increased nurse retention was articulated and current levels were assessed using formative evaluation.

The chapter is organized in phases guided by Donabedian’s (1966) framework for implementation of structure, process and outcomes (SPO). During Phase 1, an organizational assessment was completed (structure and process) utilizing Burke & Litwin’s (1992) Causal Model. The assessment was utilized to gain knowledge of the organizational structures and processes that influence nursing retention and to distinguish
the baseline, justification, barriers or facilitators, and readiness for evidence-based change. The planned intervention of leadership development and future evaluation of the project (outcome) was based on an understanding of the organization, recognition of key stakeholders, and identification of barriers and champions prior to making recommendations. A culture of inquiry at all levels in the organization is essential for the intervention. Phase 2 consisted of determining the appropriate methods of inquiry and plans for implementation of the project guided by the findings from the organizational assessment and the conceptual models chosen to guide the project. Phase 3 consists of outcome evaluation and analysis of the RN retention rates, job satisfaction and empowerment perceptions by the organization in the future.

**Phase 1: Organizational Assessment**

The organizational assessment occurred during the months of January through May, 2014. The Causal Model by Burke & Litwin (1992) proposed that organizational performance is affected by causal linkages described as transformational and transactional factors. Specifically, the causal model states:

Transformational change occurs as a response to the external environment and directly affects organizational mission and strategy, the organization’s leadership, and culture. In turn, the transactional factors are affected such as structure, systems, management practices and climate. These transformational and transactional factors together affect motivation, which, in turn, affects performance (Burke & Litwin, 1992, p. 523).
Factors range from system level variables (such as mission, strategy, structure, leadership, culture) to group level (climate) and individual level variables (motivation, job fit, values) and their effects on each other.

The assessment information was gathered utilizing observation in clinical areas, interviews with key administrative staff, review of organizational documents, attendance at organizational meetings, and review of policy and procedures. As the area of interest for the project was staff nurse retention as it relates to work environment and leadership behaviors, the transformational factors of mission, leadership, organizational culture, and the transactional factors of structure, systems, work unit climate and individual needs and values were utilized to guide the planned assessment and intervention.

Transformational Factors

Mission. The mission statement for the Center states, “At the Center, we provide quality health care with the belief that all individuals have the right to considerate service at all times with recognition of their personal dignity” (Mission Statement, 1998). The Vision Statement lists three primary areas of importance: trusted by patients to meet their needs, a valued partner in the community, and creators of positive change (Vision Statement, 2012). These are further delineated by value statements (not all inclusive) that emphasize that the patient always ‘comes first’, services are continuously evaluated to meet community needs, staff take pride in their work, and are good stewards of limited resources, that teamwork is central to their work and intentional ‘fun’ is incorporated into the environment.

While the organizational belief of being patient-centered was observed to be clear and apparent in daily operations across all disciplines, the concept of teamwork appeared to
vary at different levels within the Center. The executive management team was very cohesive and supportive of each other, whereas the frontline staff teamwork was observed to be unorganized at times, lacking clear role delineation and trust between staff members and leaders. Patient–centeredness was evident through observations of employees keeping the patients’ needs as priority in their interactions; however employees did not appear to be committed to others in their work environment and were averse to making decisions without supervisor approval.

**Leadership.** The organizational structure was hierarchical and the executive leadership team guided the direction of the organization. The Chief Operating Officer (COO) was responsible for all operations. All of the operational directors and managers reported directly to the COO; little opportunity for autonomy at the mid-management level and below was observed. Permission from the COO was necessary for routine operational decision-making regarding patients, families, equipment needs or processes within departments. The structural arrangement allowed little room for employee input in policies and practices.

**Organizational culture.** The Center culture appeared to be different at various levels of the organization. For the patients they serve, respect and patience was expected whereas the employees often were not shown the same. The executive management culture was collegial in nature, always seeking feedback and respectful of each other’s opinion. The same was not evident at the manager and director levels who were not allowed autonomy in decision making for routine operational changes. These behaviors trickled down to the staff members. The valuing of patients was demonstrated through active listening to their concerns, displaying respect and meeting their needs. This was
found to be consistent and a shared practice throughout the organization. If the culture of an organization sets the tone for the “social system” within, the values and beliefs may be appropriate; however, the behaviors that are modeled by some of the executive leaders did not emulate the intent of these values.

**Transactional Factors**

**Structure.** The organizational structure of the Center reflected the culture and decision-making authority described previously. The structure was vertical in nature with the primary authority spread among four individuals. The CEO is a doctorally prepared nurse and described himself as filling the role of Chief Nurse. Communication and authority was hierarchical in nature to the point that decisions at the unit level could not be made without the approval of a manager who must then inform executive management members. Communication of decisions made by the executive team was presented at the “all staff meetings” held monthly by the CEO.

These restrictive structural factors were represented in the policies and procedures of the organization such as chosen membership of committee participation by the executive management team. Without the decision-making authority at the clinical level, there were a multitude of layers of positions that ultimately reported to the COO in order that control was maintained. It is interesting to note that at the clinical level, the structure is very much the opposite as medical assistants, licensed practical nurses and registered nurses all dressed the same and job duties were without clear delineation of roles.

**Systems.** Most of the policies and procedures had been developed by executive management with very little input from staff members. Committees that may have been formed for policy development were ‘chosen’ by executive level management. Language
regarding administrative function referred to the right to change methods of clinical operations with no reference to employee participation in the process. This did not allow for empowered decision-making or participation by employees. Rather than the policies and procedures being a guide for organizational behavior, they were specific and directive rules.

The human resource decisions and performance appraisals were all carried out at the mid-management level with approval for salary recommendations received from the COO. The managers and directors were given little opportunity to mentor new staff as their roles were controlled by the COO. The mean attrition rate was difficult to ascertain as attrition was operationally defined as those RNs who had left voluntarily or, terminated after the 90-day probation period. No one who left during the 90-day probation period was calculated into attrition figures. Also, RNs and medical assistant departure was reported together making it necessary to create a separate process to determine actual RN attrition. The estimated attrition for RNs was over 10% in 2013.

Budgetary decisions were made via the middle managers/directors with recommendations taken to executive management team and finalized by the CFO. Tight control of the budget appeared to be related to the FQHC status and regulations that are associated with this designation.

Reward systems were demonstrated by the CEO, who provided some events that are “fun or celebratory”. Rewards were in the form of gift cards, group recognition for a good suggestion and encouragement of self-development by offering tuition reimbursement. There were no non-financial rewards such as internal advancement or educational recognition of achievement (such as RN to BSN) in the organization.
Registered nurses were not identified internally as a professional group working to their fullest scope of practice potentially resulting in role confusion, and a perceived lack of a sense of value.

**Work unit climate.** The employees of the Center demonstrated a desire to do a good job as was verbalized by them; however, there was a certain amount of ambivalence that was evident in their interactions with their supervisors that suggested fear of retribution if they neglected to inform or favoritism for those who reported variances from expectations. Trust did not appear to be the underlying premise of relationships between employees and their immediate supervisors. These undertones existed throughout the organization, not solely within a specific unit.

The future for potential leadership growth will be influenced by the strength and knowledge of leadership principles of the front line managers and directors. As Bolman & Deal (2008) reported, “managers frequently learn that getting ahead is a matter of personal credibility which comes from doing what is socially and politically correct” (p. 208). This leadership credibility founded in trust had not been observed to be a trait of the front line leadership team.

**Individual needs and values.** There was a diverse employee group at the Center both ethnically and experientially. Although the values of most individuals seemed to reflect the organization’s values in regard to quality care of patients, there were some employees who were willing to sacrifice relationships with co-workers in order to be recognized by their supervisors. For example, this was observed when an employee reported co-workers whom they believed were not following procedures regarding lab entry to their
supervisor without knowing all the details of the situation. This division of trust could result in a lack of initiative and self-actualization.

Provider productivity was of concern operationally; however, building teams of providers and clinical staff who complement the experience and knowledge of other team members had not been accomplished optimally. Often clinical staff were temporarily reassigned from one area to another in order to maximize patient flow interfering with team building and job satisfaction within groups. This could create a subsequent shortage of personnel resources in another area, perpetuating the problem of loss of efficiency and lending to inconsistencies in practice among assigned teams and errors in procedures (e.g. lab orders not being placed in the EHR). Team cohesion was not apparent in all areas beyond the executive management group management group due to the lack of consistent clinical assignment (care teams), empowerment of staff, clear delineation of roles or manager/director support.

**Motivation.** Motivation at the Center varied between the executive management team and the clinical staff. The executive management team’s motivation for placing a priority on productivity is financially driven as they are reimbursed on a patient encounter system. This was reflected in the continuous measurement of monthly encounters that was displayed for all staff members to see providing a measure by which providers are evaluated on an annual basis. Recently, provider report cards were developed and displayed in a shared site to stimulate a sense of transparency for performance among providers.

Executive management members’ motivation to meet financial and operational goals (break even budget and operational effectiveness) was reflected in their behaviors of
power and authority. The need for tight financial control was understood by most in the organization in order that they can remain fiscally solvent and continue to offer services to their clients. Clinical staff members did not always speak of a sense of value or empowerment as their motivation for working at the Center; it is primarily the mission of serving the community and hours of operation that they found appealing.

**Summary of Organizational Assessment**

The Center had a well-defined mission, vision and values that spoke very clearly to the community they serve. Assessment of the many factors in The Causal Model (Burke & Litwin, 1992), led to the organizational diagnosis of: lack of clear role delineation and RN empowerment. This is evidenced by no formal shared governance processes at the Center, limited RN empowerment at the clinical level, and roles of clinical staff that often overlapped resulting in inconsistencies and confusion. Management practices and the vertical organizational structure provided further evidence that RN empowerment was not valued at this time. These practices and organizing structure ultimately affected organizational and individual performance. The assessments served to raise awareness of the need for cultural change and nursing leadership development. Improved supportive behaviors at the clinical director and manager level in an effort to create positive work environment and retain registered nurses is the focus of this scholarly project.

**Phase 2: Development of Project Implementation Plan-Methods Identification**

For the purpose of the project, the long term goal is an improvement of registered nurse retention and increased job satisfaction through improved work environment. The short term goals were to provide the Center with an assessment of current perceptions, and to develop and implement leadership education based on this information. The
literature supported the notion that supportive supervisory behaviors and positive work environment will help reach this goal. As the structure of the Center has been assessed for current status, Donabedian’s (1966) model suggested the determination of current perceptions of leadership and job satisfaction. In order to assure that progress is made at a system-wide level, the culture and readiness for the proposed project must be understood. There must be a desire or vision for culture change supported by executive management in order for success. This evaluation must take into account the mission and values identified in the organizational assessment as well as the commitment for utilization of evidence-based initiatives leading to leadership development. The proposed changes that positively affect staff nurse retention rates are intended to be the measurement of outcome. Demographic information were measured to determine if relationships among these variables existed that may need to be addressed, however some staff factors were purposely excluded in order to maintain anonymity.

**Design**

This project used a survey methodology that included two assessments: one to determine participants’ current perceptions of supervisory support, and a second assessment that determined perceptions of work environment. After review of the literature, two instruments were found that would provide the means for assessing these variables.

The participants consisted of all registered nurses currently employed at the Center with the exception of nurses working in advanced practice roles (Nurse Practitioners and/or Certified Midwives) and administrative roles. The assessments provided
information on the participants’ perceptions of the leadership behaviors and work environment that currently existed in the organization.

**Instruments**

The data collection tools used for this project were the Supervisory Support Scale (SSS) developed by McGilton (2010) and the Brisbane Practice Environment Measure (B-PEM) created by Flint, Farrugia, Courtney, & Webster (2010). Permission was obtained to use the assessment tools from both of the original authors.

The SSS developed by McGilton (2010) is based on the conceptual definition of supportive supervision and consists of a 15-item self-report scale of perceived supervisory attributes of dependability, empathy, and nurturing relationships. The response selections include never, seldom, occasionally, often, or always and uses a summated rating scale out of a possible 75 points (Appendix D). Although there were no official embedded sub scores, the fifteen items on the scale are meant to define traits of dependability, empathy, and relationship-building capacity.

McGilton (2010) determined the SSS to be valid for measuring effective nursing leadership with principal component analysis and primary item-factor loading of at least .50 with .20 between items. Construct validity was positively correlated with the professional supportive domain of Chou’s Nursing Job Satisfaction Scale (2002) at r=.475, p < .003. The SSS was negatively correlated with lack of support from the supervisor domain of the Expanded Nurse Stress Scale with r = -.30, p < .003 (French et al., 2000). Reliability of this tool had also been established. The internal consistency demonstrated item correlations were positive, in the .30 to .70 range, with the scales coefficient alpha reported to be .94. Test-retest coefficient of the SSS was .71.
The B-PEM developed by Flint et al. (2010) was developed to measure practice environment in an effort to facilitate greater job satisfaction and retention. The tool consists of a 33-item self-report scale focusing on 5 themes: feeling safe, feeling valued, getting things done, opportunities for professional development and being flexible. The range for responses is never, rarely, sometimes, frequently and always. Subscales can be utilized for identification of specific interventions that may be needed (Appendix E).

Flint, et al. (2009) utilized principal component factor analysis with a factor loading of at least .40, eigenvalues greater than 1, and percentage of total variance explained by each factor as acceptable to determine construct validity. “This yielded a four-factor solution with eigenvalues greater than 1 that explained 52.53% of the variance” (p. 78). Internal consistency was measured using Cronbach’s alpha; the coefficient was 0.94.

In order to fit the Center environment, minor modifications were made to both surveys. In the SSS reference to residents was altered to patients, and the B-PEM use of roster was changed to assignment. Permission to utilize both instruments was received by the authors via email communication (Appendix F).

**Procedure**

As it was determined the proposed project did not fit the definition of research, approval was received from Grand Valley State University to proceed without submission to the Human Research Review Committee. The Center did not require institutional review as the project was determined to be quality improvement in nature, therefore data collection ensued. A current list of all registered nurses (n=34) meeting the inclusion criteria employed at the Center was obtained from the Human Resources department. The survey packet consisted of a general letter of explanation, a
demographic questionnaire (Appendix G) and the two survey instruments. Return of the survey served as implied consent. An explanatory email was sent to all registered nurses about the pending assessment. The survey packets were distributed by the Doctor of Nursing Practice student during a period of one week. No personal identifiers were a part of the data collection process with all completed questionnaires being placed in a sealed envelope after completion. The sealed envelopes were placed in a locked collection box at a specified central location, collected on a weekly basis by the doctoral student and placed in a secured location. The collection period consisted of 10 business days.

**Implementation**

The primary reason for the assessment surveys was to determine the perceptions of current work environment and supervisory support among all registered nurses at the Center. Once this was determined, targeted leadership development through educational interventions was developed related to themes from the survey feedback. The constructs of Theory of Planned Behavior (Ajzen, 1991) guided the intervention with the health care team leaders of directors and managers assisting in their self-assessment of behavioral change and intention. A customizable implementation plan of intervention that best fit within the organizational structure was developed for the future in collaboration with the directors and managers of the institution. Suggested tools for evaluation were provided to the Center’s CEO at the completion of the project.

**Program Content and Delivery**

According to Ajzen (1991), “a central factor in the theory of planned behavior is the individual’s intention to perform a given behavior. Intentions are assumed to capture the motivational factors that influence behavior…..” (p. 181). Therefore, the focus of the
program content was informational and self-reflective; the content also provided coaching in order that mutual motivational factors could be explored.

The planned program of leadership development aimed at strengthening supportive behaviors was offered in a series of 4 weekly workshops conducted by the doctoral student. The target audience consisted of clinical directors and managers who have staff RNs reporting to them. The workshops were intended to increase the knowledge of supportive leadership behaviors through didactic presentations of these leadership concepts. The sessions were each an hour and 30 minutes in length, concluding with self-reflective exercises related to presented material. This reflection assisted in individual assessment of motivational factors affecting behavioral intentions and perceptions of behavioral control. At the conclusion of the educational series, a comprehensive self-reflection was requested and submitted to the doctoral student for evaluation. Self-efficacy evaluation prior to and at the conclusion of the series was done to ascertain the confidence of the participants in their ability to display supportive leadership behaviors. To assist in sustainability of supportive leadership behaviors, development of a plan to continue to support and mentor the clinical leaders for future growth was discussed in groups of RN leaders and with executive management.

**Data Analysis and Evaluation**

Data analysis from the RN surveys (SSS and B-PEM) was completed utilizing SPSS software. Descriptive statistics from both surveys were used in order to identify themes for planned educational intervention. Evaluation of the usefulness of the educational intervention for the participants was measured by the percent difference between self-reported pre and post self-efficacy assessment of behavioral intention.
Long term outcome evaluation of the project will be measured by three indicators: increased staff nurse retention at the Center; increased job satisfaction by the RNs and increased supportive leadership behaviors by nursing leaders as perceived by nursing staff. This analysis could occur by the Center after the completion of the project by repeating the Supportive Supervisory Scale and the B-PEM at a designated time in the future to evaluate the effectiveness of the educational intervention. Staff nurse retention can be measured using the existing methods of the Center with separation of attrition by employee category (RN, LPN, and MA). Work environment perceptions can be assessed using the B-PEM tool observing for any improvement in both indicators. The assessment tool (self-efficacy evaluation) that examines individual attitudes of perceived behavioral control based on The Theory of Planned Behavior will be provided by the doctoral student to the organization and can be utilized for future leadership development courses offered by the Center.
CHAPTER 5

RESULTS

The results of this project are organized and reported in this chapter in three sections. The first is a description of the participants in the assessment portion of the project including a summary of demographics. The second section presents descriptive statistics of the results of perceived staff nurse work environments and supervisory support, and the third section summarizes the leadership development workshops developed as a result of the assessment findings. These workshops were provided to the directors and managers of the Center.

Staff Nurse Participants

The Supervisory Support Scale (SSS) and Brisbane Practice Environment Measure (B-PEM) were distributed to all staff RN’s (n=34) and 27 surveys were returned, a 79% response rate. One survey set submitted was removed because of multiple missing data points. Two surveys had one missing data point, while one had two missing data responses. The remaining surveys were complete. All items completed on the surveys were included in the descriptive analysis of the survey. A total of 26 surveys (B-PEM and SSS) were included in reporting the findings of this project to assist in the leadership development quality improvement project.

The surveys were accompanied by a cover letter (Appendix H), brief demographic questionnaire and a blank return envelope. Demographic information was minimal to protect the anonymity of individuals participating in the survey process and included ranges of age, length of employment, and number of years as a registered nurse. The participants were given ten business days to complete the surveys. A locked collection...
box was placed in the employee break room for return of the surveys and assurance of confidentiality. The surveys were collected by the doctoral student and individual data were entered with no identifiers utilized. Descriptive statistics were run on the demographics and current RN perceptions of work environment and supervisory support. The B-PEM survey results were further separated into four general subscales (factors) of perception of work environment to identify specific areas for development.

**Demographics**

The ages of 25 respondents were obtained with a higher percentage of RNs being 50 years of age or older (48%). One demographic survey was not completed accounting for the discrepancy in total number of respondents versus demographic statistics. The range of ages and percentages found were 18-29 years 16% (n=4); 30-39 years 12% (n=3); 40-49 years 24% (n=6); 50-59 years 28% (n=7) and 60 years and older 20% (n=5).

When comparing the age of respondents with the years of nursing experience and length of employment, it was noted after survey distribution that the experiential and employment range on the demographic survey was overlapping. Therefore the third and fourth selections were combined to reflect experience and employment as 4 years and above. The years of experience and years of employment at the center were analyzed using descriptive statistics. The findings reflected that 44% (n=11) of RNs had 4 or more years of nursing experience, while 80% (n=20) had 4 or more years of employment at the clinic (see Table 1).
Table 1

*Years of Experience in Nursing and Employment at the Center by Group*

<table>
<thead>
<tr>
<th>Years in ranges</th>
<th>N = 25</th>
<th>N = 25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>1-3 years</td>
<td>8</td>
<td>32%</td>
</tr>
<tr>
<td>4 years and &gt;</td>
<td>11</td>
<td>44%</td>
</tr>
</tbody>
</table>

While 48% (n=12) of the RNs 50 years and above had been nurses for 4 or more years (see Table 2), when experience and longevity at the Center were compared with the age groups described earlier, 36% (n=9) of the RN’s who were 50 years and above had been employed at the Center for 4 or more years (see Table 3).

Table 2

*Nurse Respondents Age and Years of Experience as an RN*

<table>
<thead>
<tr>
<th>Age</th>
<th>Years of Experience as an RN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;1 yr.</td>
</tr>
<tr>
<td>18-29</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>1</td>
</tr>
<tr>
<td>40-49</td>
<td>0</td>
</tr>
<tr>
<td>50-59</td>
<td>0</td>
</tr>
<tr>
<td>60 and above</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 3

Nurse Respondents Age and Length of Employment at Center

<table>
<thead>
<tr>
<th>Age</th>
<th>Length of Employment at the Center</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 1 yr.</td>
</tr>
<tr>
<td>18-29</td>
<td>2</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
</tr>
<tr>
<td>50-59</td>
<td>0</td>
</tr>
<tr>
<td>60 and above</td>
<td>1</td>
</tr>
</tbody>
</table>

Older, experienced nurses are more inclined to stay in their current jobs at the Center, implying that retention efforts should be focused on the younger, less experienced nurses. Educational level was not considered as there are very few baccalaureate prepared nurses who are employed at the community-based health center thus inquiring may have jeopardized the anonymity of employed RNs. Educational degree may have provided additional information for consideration regarding experience and longevity.

Staff Nurse Perception of Supervisory Support

The SSS is a relational tool to measure supervisory support of nursing staff (McGilton, 2010). The 15 items identify supervisor attributes and behaviors. The directions were to check the box that reflects your relationship with your supervisor on a 5-point scale (never, seldom, occasionally, and always). Cronbach’s alpha was used by McGilton to measure the reliability on the SSS survey. The Cronbach’s alpha was 0.94, suggesting high internal consistency among the items on the survey.
In order to ascertain where supportive leadership development was needed at the Center, a frequency distribution of the responses from the Center was done on each item using the 5-point scale. When responses by the participants were ambiguous on the survey, a coin was used to determine whether the higher or lower score would be recorded. Heads was recorded as the higher score and tails was recorded as the lower. If there was one obvious value (frequently) in between recorded scores (sometimes and always), this value was used. The results were graphically displayed by total responses for each question by category (always, often, occasionally, seldom, or never). The findings revealed that although there appeared to be recognition by the supervisors of RN ability to perform work and clear expectations of what was expected of them, items that were correlated with relationships and shared decision-making scored lower (Appendix I). The findings supported the need for education in supervisory relationship building and strategies for RN empowerment.

**Staff Nurse Perception of Work Environment**

The B-PEM questions fall into four categories or subscales: “getting things done” (item numbers 16, 18, 21 through 25, 28, 29 and 32); “flexibility of management support” (item numbers 1, 5, 9, 13, 14, 20, 30 and 31); “feeling valued” (item numbers 3, 4, 7, 8, 10, 12, 19, and 26); and “professional development” (item numbers 2, 6, 11, 15, 27, and 33) (Flint, et al., 2010). Item number 17 was deleted during confirmatory factor analysis by the author. The directions given to the participants were to check the box that reflects their current perceptions of their practice environment on a 5 point scale (never, seldom, occasionally, and always).
A scale of 10 as a minimum score and 50 as a maximum score was used for frequency analysis by using a sum of 10 items from factor one. Factor 2 and 3 consisted of 8 items therefore the scale of 8 as a minimum and 40 as a maximum score was used. Factor 4 consisted of 6 items where a minimum of 6 and maximum of 30 was used as the scale. Some surveys had missing data points in which response item was skipped during data entry accounting for the discrepancy of sample sizes. The mean score of factors related to “getting things done” was 34.83, (SD= 4.48, range 26-41). The mean score of factors related to “flexibility of management support” was 30.61 (SD= 5.40, range 20-38). The mean score related to “feeling valued” was 26.0 (SD = 2.00, range 23-31), and the mean score of “professional development” factors was 20.78 (SD=4.50, range 9-27) (see Table 4). Cronbach’s alpha was used by Flint, et al. (2010) to measure the reliability for the B-PEM survey. The Cronbach’s alpha for the overall B-PEM was 0.94, suggesting high internal consistency among the items on the survey.

Table 4

*Perceptions of RN Practice Environment by Subscale*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Things Done</td>
<td>24</td>
<td>34.8</td>
<td>4.48</td>
<td>26.0</td>
<td>41.0</td>
</tr>
<tr>
<td>Flexibility of Management Support</td>
<td>23</td>
<td>30.6</td>
<td>5.40</td>
<td>20.0</td>
<td>38.0</td>
</tr>
<tr>
<td>Feeling Valued</td>
<td>24</td>
<td>26.0</td>
<td>2.00</td>
<td>23.0</td>
<td>31.0</td>
</tr>
<tr>
<td>Professional Development</td>
<td>23</td>
<td>20.8</td>
<td>4.50</td>
<td>9.0</td>
<td>27.0</td>
</tr>
</tbody>
</table>
The results suggested that the practice environment allows for the appropriate amount of clinical resources, including right skill mix and workload reflected in questions related to “getting things done”, although the mean scores fall in the middle of the scale overall. The same is true of the subscale of “flexibility of management support” implying that there could be improved flexibility in scheduling, assignments, and readiness of managers to assist in daily work. The areas that appear to need the most improvement are “feeling valued” and “professional development” which both speak to RN empowerment, relationship building, individual recognition and equity in staff development. These results mirror the findings of the SSS and were used to help guide the design of content for the leadership development workshops.

**Leadership Development Workshops**

Four leadership workshops were planned to assist in the development of supportive leadership behaviors at the community-based health center. Objectives and activities were determined based on the findings from the supervisory support and practice environment surveys. Key concepts from the Theory of Planned Behavior used to inform this plan were inclusion of encouragement of attitudes that influence behavioral change, understanding socially approved behaviors and finally having a sense of control over these behavioral changes. Arrangements were made with the CEO to allow for 3 Directors and 3 Managers who have staff RNs reporting to them to attend the four planned leadership sessions. A classroom was made available with Mondays from 1000-1130 designated as meeting times. The workshops began on September 29, 2014 and concluded on October 20, 2014.
A total of 6 participants attended all workshops. The workshops consisted of didactic presentation, group discussion, guided group work and self-reflection. Research publications supporting the subject matter to be discussed were given to the participants prior to each session. Assessment of self-efficacy (participants’ confidence) of supportive leadership behaviors was completed prior to the intervention and at the conclusion of the four part leadership development. The self-efficacy tool was developed by the doctoral student using the 5 themes utilized in the leadership intervention to determine participants’ confidence levels in mentoring, building relationships, appropriate use of empowerment and control and creating a positive environment.

**Leadership Development Workshop One**

At the first session, a review of the project with the objective of influencing staff nurse retention through supportive leadership was presented. General introductions of each member of the group included a brief history of leadership experience. Among the group, educational preparation ranged from a director with no formal college education to a director with a Master’s degree in Management. All three directors are non-nurses, while the three managers are nurses. Only one of the nurse managers has completed a BSN. Length of employment of the entire group at the community-based health clinic ranged from 18 months to 19 years.

The role of the doctoral student as a facilitator of the workshop was described with modules and planned outline provided for the four sessions (Appendix J). A pre-workshop self-efficacy evaluation regarding leadership behaviors was done prior to the content of the first workshop. A review of the literature that supports a relationship between leadership behaviors and staff nurse retention followed. Methods used for the
organizational assessment and survey assessment of perceived supervisory support and work environment were reviewed. The descriptive results of the survey assessments for the community-based health center were provided to the group in addition to the RN turnover rates for the past year. It was explained that these findings helped guide topics of leadership development for the workshops.

Following a review of the assessment findings, general leadership styles, frames and behaviors were presented. A self-assessment of leadership frames using a tool developed by Bolman & Deal (2008) was carried out to provide reflection on personal leadership styles or approaches. Group discussion ensued with facilitation by the doctoral student. At the conclusion of the workshop, a self-reflection journal entry was made by each participant to allow for evaluation of their attitudes toward supportive leadership behaviors described in the workshop following the concepts of Ajzen’s Theory of Planned Behavior (1991).

**Leadership Development Workshop Two**

The second workshop focused on the effective use of inter-professional teams. A review of the values, mission and vision of the organization was done to lay the groundwork for team focus on a shared purpose. The doctoral student facilitated group discussion regarding roles within teams, mentoring opportunities, and relationship building. The concepts of person-centeredness, front line engagement, relentless focus, transparency and boundarilessness as described by the Institute for Healthcare Improvement (IHI) (2013) were used as elements of effective team building. Participants were guided through an exercise on moving from volume-based care to value-based care following the recommendations from the IHI. They were asked to reflect on how inter-
professional teams could move the organization in the direction of value-based care. This discussion was followed by the viewing of a short video-clip of David Kelley (2012) who spoke about creative innovation and its relationship to team member’s self-efficacy and confidence in being creative. Discussion ensued regarding the connection between effective teams, self-efficacy and a transformation to value-based organizational culture.

At the conclusion of the workshop, a self-reflection journal entry was made by each participant to allow for evaluation of their beliefs on how others may perceive the behaviors toward inter-professional teams.

**Leadership Development Workshop Three**

The objectives for workshop three were to introduce concepts of empowerment, shared governance and clear role delineation. Literature on scope of practice, workplace empowerment of nurses and polarity thinking were provided for participant review prior to the session. Discussions regarding scope of practice as it relates to the licensed practical nurse role was very sensitive and caused some anxiety among members. This was thought to be related to current role ambiguity and lack of clarity related to role delineation. Relationships between RN empowerment and retention that was supported in the literature were discussed as a group.

The concept of polarity thinking (Wesorick, 2014) was introduced by the doctoral student facilitator. Introductory examples of managing polarities through mapping were provided for purposes of evoking thought. Group exercises facilitated by the doctoral student were done to further understand the use of this method of thinking. Individual participants were then given a blank polarity map and asked to consider “empowerment versus control”. This activity required continuous reinforcement by the facilitator as
none of the participants had previous experience with the concept. The group members shared their responses with discussion on how to apply these strategies for managing polarities in inter-professional teams. At the conclusion of the workshop, a self-reflection journal entry was made by each participant to allow for evaluation on their perceived behavioral control and their ability to perform the behavior.

**Leadership Development Workshop Four**

The final workshop presented concepts of transparency in nursing leadership and the behaviors that promote it. Transparency as it relates to supportive leadership and quality patient outcomes were discussed as a group. All participants shared their thoughts and discussions they have had with their teams regarding outcome goals. For example, the family practice/internal medicine team is going to work on patient outcomes related to reduction of HgA1c levels for their diabetic patients. The importance of the use of transparency during this process regarding budgetary resources and team role clarification were discussed. The doctoral student facilitator provided time for a review of concepts from all leadership workshops and addressed questions or concerns. The facilitator provided an opportunity for feedback on the workshops and suggestions for improvement. The participants were asked at this time to write a journal reflection on their attitudes, beliefs and perceived control of supportive supervisory behaviors. This journal was submitted to the facilitator without any personal identifiers. These data were used to identify themes of participants ‘confidence in behavioral change.

At the conclusion of the workshop series, the same five question self-efficacy evaluation was done to assess the participants’ confidence of their ability to perform supportive leadership behaviors. Ajzen (1991) believed self-efficacy and perceived
behavioral control are conceptually related supporting the use of this form of evaluation for leadership development effectiveness. The pre and post self-efficacy percentage change difference was 7% which was not significant. Based on the positive comments received from the participants regarding the usefulness of the leadership workshop content, it is suggested that the pre-intervention self-efficacy scores were inflated due to a lack of understanding of what they did not know regarding these leadership behaviors. A written summary of the informal feedback for improvement of the workshops and participant self-efficacy was provided to the organization by the facilitator.

The self-reflective journals of the six participants completed at the conclusion of the workshops revealed an overall positive perception of supportive leadership behaviors by the participants. Specific comments regarding attitudes, perceived normative acceptance and beliefs of the ability to practice these behaviors were positive (Appendix K).

Summary

The assessment of the organization and staff nurses’ perception of supervisory support and work environment provided the structural context on which the educational intervention was based. The results from the 26 RN respondents were presented to the group of 6 directors and managers. The process of leadership development workshops provided a venue for potential planned behavioral change through self-assessment of attitudes, beliefs and control over supportive leadership behaviors. Review of current literature on the relationship between supportive leadership and staff nurse retention was included to provide the foundation for change. Outcomes were measured at the conclusion of the workshops through pre and post self-efficacy evaluation and self-reflection journal entries. Supportive leadership behavioral change and improved work
environments has the potential to improve RN retention at this community-based health center.
CHAPTER 6
DISCUSSION

The focus of this scholarly project was to determine levels of staff nurse job satisfaction and perception of supervisory support at a community-based health center that would assist in the formulation of the concepts for nurse leadership development. A detailed organizational assessment and staff nurse survey results provided an understanding of the existing culture and nursing leadership behavior. These assessment findings substantiated the need for nursing leadership development specifically in the areas of relationship building and registered nurse (RN) empowerment strategies. While some disagree, a preponderance of the literature supported the influence that positive nursing relationships and empowering work environments had on RN retention and improved patient outcomes (Laschinger, et al., 2014). Both qualitative and quantitative data supported the need for continued study of this phenomenon; however, no inference can be made that using nursing leadership development to improve supervisory behaviors alone will facilitate nurse retention leading to improved quality of care.

This chapter reveals the recommendations for nursing leadership development at the community-based health center guided by the Structure, Process, and Outcome framework of Donabedian (1966). The organizational assessment and RN surveys were used to inform the interventional strategy of leadership development and ways in which to measure outcomes immediately. Through self-efficacy evaluation and analysis of reflective journals, suggested outcome measures were formulated for the future. Effectiveness and sustainability of the leadership development education will be discussed along with potential fiscal measures that may help substantiate continuance of
the program. Implications for future roles of nurses, educated as Doctors of Nursing Practice, in health care environment changes are summarized. Finally, facilitators, barriers and limitations of the project, and recommendations for the future are presented.

**Conceptual Framework**

Donabedian’s (1966) model of structure, process and outcome was used as the implementation framework for this project. His model provided a method with which to assess current organizational conditions, perceived nursing leadership behaviors and work environments (*structure*). This led to concepts to be used in the leadership development intervention provided to the directors and managers at the community-based health center (*process*).

For this project a series of leadership development workshops was proposed and implemented. The identified areas of perceived nursing leadership behaviors that could be improved upon (RN empowerment and relationship-building) were the focus of the intervention content. Objectives and literature to support the workshop intention was provided to all participants. Prior to implementation of the leadership development, organizational support, including physical and material resources, was obtained from the executive team to support the intervention. In addition, a commitment from the CEO was given in the form of organizational transformation that would allow for future leadership development at the Center. This significant beginning cultural shift has inspired a sense of excitement and inquiry among all levels of nursing staff at the Center.

The *outcomes* of the nursing leadership development workshops were measured utilizing self-reflection and self-efficacy evaluation post intervention. This evaluation can be used by the Center as a tool in the future to assess clinical leaders’ confidence in
their leadership behaviors. Outcomes of effective leadership behavioral change can be further measured by continual methods of monitoring RN turnover rates, patient outcome and budgetary impact of staff nurse retention.

**Effectiveness, Feasibility, and Sustainability**

Effectiveness of the leadership development intervention can be measured over time through examination of RN retention rates, continued self-reflective evaluations and job satisfaction among staff RNs. Ultimately, the building of positive relationships among the team through supportive supervision will assist in leading to improved patient outcomes that can be monitored on a continual basis, however it must be remembered that these behaviors alone cannot sustain the change. Organizational transformation includes many facets, supportive leadership being only one variable in its success.

The tools that were utilized to measure the pre-intervention perceptions of supervisory support and work environment by RN staff members in this project can continue to be useful for evaluation by the community-based health center in regards to continued leadership development and success. It is suggested that with changes in leadership behaviors, leader effectiveness is translated into positive relations with professional nurses resulting in increased retention and quality (Herrin & Spears, 2007). The leadership development series was provided to the Center for future use, however its continued success will be reliant on coaching, mentoring and the importance placed on nursing leadership and its influence in the work environment. Registered nurses are the key to outcome-based practice making positive work environments of paramount importance.
The feasibility of health care team leaders continuing to place emphasis on the behaviors presented during the educational series will depend on their personal attitudes and perceived control of these behaviors. The Theory of Planned Behavior (Ajzen, 1991), guided the intervention process with self-reflection on the concepts of attitudes, expected norms and perceived control of supportive leadership behaviors. While an immediate assessment of planned behavioral change was positive, sustainability of these practices will need to be the focus of the organization.

In addition to continued leadership education on a regular basis, it is recommended that organizational support is provided in the form of expected leader characteristics embedded in job descriptions for nursing managers and directors and that behavioral expectations are evident in performance evaluation. Adequate resources and leadership must continue with clear goals articulated. Ultimately, champions should be identified to advocate for the continuation of the program. Within the Center structure, the nurse managers are the most likely candidates to lead the charge. They must be able to articulate the cost-benefit of continued leadership development that has the potential to improve RN retention and patient outcomes, both of which offset the actual costs of the education provided. As self-efficacy of nursing leaders to enact supportive supervision continues to strengthen, RN empowerment should continue until a true shared-governance model is created.

Finally, sustainability of supportive leadership behaviors is imperative as it relates to the ever-changing health care environment. As reimbursement for primary care shifts from encounter-based systems to patient outcome incentives, both internal and external pressure will be placed on organizations to review fiscal and operational effectiveness. It
is imperative that the Center’s nursing leaders are knowledgeable about value-based care in order to move the organization in this direction.

**Facilitators and Barriers**

Implementation of evidence-based strategies for educational intervention required an examination of the facilitators and barriers that existed. For this project, the facilitators were identified as the desire of the RN staff to become empowered in their work and the mission of the clinic to serve the community compassionately and responsibly. These goals were mutually supportive and lead to examination of ways in which to achieve them simultaneously.

What initially was thought to be a barrier for leadership development success later exposed itself as a facilitator for change. The executive management structure and culture at the origin of the project was vertical in nature, not allowing for RN empowerment and growth. This was assumed to be a barrier at the onset. However at the conclusion of the RN survey process and communication of those findings with the executive team, major organizational transformation was made in support of interdisciplinary teams and decision-making. The transformation included development of the designated teams, redefining of roles and scope of practice, daily huddles to improve communication, and development of a councilor structure of responsibility, a Council of Advisors. The decision by the CEO to empower teams to make decisions in the best interest of their patients became a facilitator for the leadership development project. The teams were put into place prior to the intervention, thus those in attendance had new energy and permission to lead others. The leadership development sessions supported the new direction in which the organization was intending to grow.
The potential barriers for the future may include continued organizational commitment and priority given to nursing leadership development, appropriate selection of a future Chief Nursing Officer, trust in allowing true empowerment, and skill levels of those currently in nursing leadership positions.

**Limitations**

The SSS questionnaire, although a reliable tool, has been utilized primarily in long term care settings. Utilization of the tool in assessing supervisory support in the primary care setting had not been done; therefore generalizability to other settings cannot be made. With this limitation in mind, the SSS could certainly be used for comparative purposes of RN perceptions following leadership development within the organization.

Another limitation of this project was the small sample size of RNs participating in the survey assessment. There were 34 RNs employed by the Center at the time of the assessment, with 26 respondents. Even though the response rate was 79% allowing for sufficient descriptive analyses for the designed leadership development project, the small sample does not allow for further defined inferences. This evidence-based project was intended to describe human experiences and perceptions in an effort to change leadership behaviors at this Center based on feedback, thus for this purpose, the sample size was not a limiting factor.

**Implications for the Doctor of Nursing Practice (DNP) Graduate**

Leaders in nursing practice prepared with a Doctor of Nursing Practice degree are skilled in translation of evidence-based knowledge into practice. Executive leadership that is required in today’s health-care environment involves dissemination of this knowledge in the form of change theory and implementation practices, both of which are
included in the core of DNP preparation. Several of the Essentials of Doctoral Education for Advanced Nursing Practice (American Association of Colleges of Nursing, 2006) informed the work of this project. Essential I (Scientific Underpinnings for Practice) requires the doctoral student to be able to analyze data in order to formulate the methods in which to implement behavioral change projects. This was done through review of the literature and subsequent survey evaluation of staff RNs in this project. Essential II (Organizational and Systems Leadership for Quality Improvement and Systems Thinking) was the basis for the organizational assessment. Having the ability to evaluate systems and use advanced communication skills were paramount in conveying the needed organizational changes to the CEO. Provision of the evidence by the doctoral student that supported the needed change was the catalyst for substantiating the recommendations. The overall intent of the project to improve work environment and increase staff nurse retention uses this essential as its foundation. Determination of the significance of survey results that led to planned educational intervention addresses the Clinical Scholarship and Analytical Methods for Evidence-Based Practice (DNP Essential III). Through development of the benchmarks of which to measure leadership behavioral change and the moral courage to enter into difficult conversations, the doctoral student was able to support the efforts for system-wide cultural shift. The importance of Interprofessional Collaboration for Improving Patient and Population Health (DNP Essential VI) and systems leadership are key in the transformation of nursing leadership behaviors, specifically in the primary care arena. This knowledge provided the basis for the planned intervention of leadership development in this specific project.
Facilitation of leadership education requires knowledge of appropriate theories or frameworks to help guide the process and the moral courage to address politically charged situations. Implementation science is at the center of doctoral education for nursing practice requiring the student leader to articulate suggested plans for sustainability. The role requires maturity in communication and negotiation skills necessary for building networks for the future of the nursing profession.

Dissemination of knowledge is the responsibility of DNP graduates in order to lead to improved population and national health (DNP Essential VII). As a part of this project, survey results were shared with the executive management team, nursing managers and team directors, and staff nurses who participated. The leadership development workshop material will be given to the organization for future use as well. Future dissemination plans include presentation of a poster at a professional nursing conference and ultimately publication of the quality improvement project.

**Recommendations**

When reviewing the results of the self-efficacy evaluation pre-intervention, the reported levels of confidence were surprisingly high for a mixture of directors and managers with varying levels of education and experience. All of the participants of the leadership development, both nurses and non-nurses, felt strongly that they were confident in their abilities to build relationships, positive team relationships and create a positive work environment. Only two participants felt they did not have confidence with control versus empowerment and mentoring behaviors. During the workshops, the discussions of the group did not support advanced leadership understanding, thus the findings of the pre-evaluation are questioned. Consideration should be given to
development of a self-efficacy scale with ranges of responses as subscales or a more specific tool that measures self-perception of leadership qualities.

True assessment of the growth in leadership behaviors should be studied through repeated RN assessment of perceived supervisory support and work environment at regular intervals. Utilizing the same instruments used in this project would provide good comparison data on changes or trends in these perceptions. These results should be shared with the managers and directors as feedback is critical to continual supportive behavior actions. If the premise of the intervention is to improve processes resulting in the desired outcomes of increased staff nurse retention and job satisfaction, continuous monitoring of these outcomes should be sustained and supported by the organization. It is proposed that supportive leadership behaviors will result in cost effectiveness, positive work environments and overall improved quality of care delivery (Laschinger, et al. 2014). Additional leadership development workshops should be held with a consistent facilitator to assure continuity of the program. Interventions should continue to target RN empowerment, role definition and relationship building as these are the areas of greatest identified need. Ajzen (1991) suggested that unless the expected consequences of behavior change are realized, in this case improved RN empowerment and work environment, the behaviors will revert to what they were prior to the intervention. This premise supports the need for continued assessment and education.

While the teaching delivery mode for the facilitated development workshops was interactive and face-to-face in nature, it could be argued that enhancement of these methods could be provided through online modules or other means of education. Examination of the age of learners and preferred learning styles should be considered
prior to the planning of future educational workshops to identify the method of content delivery that would be most effective.

The organization may want to consider reorganizing to include an experienced chief nursing officer rather than a replacement of the COO in order to provide continued guidance of leadership development at the director and manager levels for all nursing teams. Mentoring of future leaders through daily presence can lead to a transformation of the nursing culture to one of empowerment and shared governance. While the CEO is a nurse and very knowledgeable, that role can then be focused on leading the vision of the Center and maintaining the appropriate community and political networks necessary for sustainability.

**Conclusions and Summary**

The RNs surveyed in this project were primarily (>50%) forty years of age or older. The data also suggested that they have more nursing experience and have been employed the longest at the clinic. As nurses decide to retire, and younger nurses replace these RNs, a better understanding of generational differences will be necessary for successful leadership practices. “The recruitment and retention of younger nurses should focus on the opportunity of providing life balance” (Zurmehly, Martin, & Fitzpatrick, 2009, p. 329). A need for increased flexibility in staffing patterns to allow younger nurses more time with family and concentration on employee wellness programs appears to be indicated.

Since relationship building and RN empowerment were found to be the areas in which perceived improvement is necessary, it is recommended that involving nurses in decision-making, providing flexibility in their schedules, and building genuine rapport between
staff nurses and managers become part of the nursing leadership culture. Lavoie-Tremblay, et al., (2010) stated, “if generational-specific retention strategies are developed, these should focus on three areas identified to have intergenerational differences: challenges, absence of conflict, and warmth” (p. 414). Improving the work environment has the potential to retain nurses of all generations.

The current literature suggested a positive relationship between supportive supervision and staff nurse retention. Very little has been written about these concepts as they relate to primary care clinics. The results of this evidence-based project suggest that the linkage between these two concepts is very similar in a primary care setting as has been found in acute and long-term care settings, and focused leadership development may provide an avenue for retaining healthcare’s greatest assets, registered professional nurses.
## Appendix A

### Synthesis Table

<table>
<thead>
<tr>
<th>Studies</th>
<th>Design</th>
<th>Sample</th>
<th>Tool for Measurement</th>
<th>Results comparing PL, JS, SR, NgL, I2S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ajerjordet, (2008)</td>
<td>SA CDD HP SYSR EDD-E</td>
<td>SN UNP NL</td>
<td>N/A</td>
<td>EIL = ↑JS</td>
</tr>
<tr>
<td>Azaare, (2011)</td>
<td>X</td>
<td>x</td>
<td>CRT</td>
<td>NgL = ↓JS</td>
</tr>
<tr>
<td>Bott, (1997)</td>
<td>X</td>
<td>x</td>
<td>X</td>
<td>HAMS</td>
</tr>
<tr>
<td>Cowden, (2012)</td>
<td>X</td>
<td>x</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Duffield, (2010)</td>
<td>x</td>
<td>x</td>
<td>NWI-R</td>
<td>PL = ↑JS</td>
</tr>
<tr>
<td>Kleinman, (2004)</td>
<td>X</td>
<td>x</td>
<td>MLQ</td>
<td>PL = ↑JS #SR</td>
</tr>
<tr>
<td>Lavoie-Tremblay, (2010)</td>
<td>X</td>
<td>x</td>
<td>CRISO-PCQ</td>
<td>NgL = ↓SR</td>
</tr>
<tr>
<td>McCloughen, (2011)</td>
<td>x</td>
<td>x</td>
<td>CRT</td>
<td>n/a</td>
</tr>
<tr>
<td>Zori, (2010)</td>
<td>x</td>
<td>X</td>
<td>CTDI, PES, NWI</td>
<td>PL = ↑JS</td>
</tr>
</tbody>
</table>

**Assumptions:**
- Positive Leadership = collaborative, transformational, servant, transactional, mentor, supportive, relationship-centered.
- Job Satisfaction = collaborative, trusting, praise
- Positive morale = reduced staff nurse turnover

**Observations:**
- All the tools used were able to measure leadership styles and perceptions of staff nurses with the exception of the McCloughen article which used CRT as a method of data collection and systematic reviews.
- There was a pattern of positive leadership being associated with job satisfaction and the inverse of negative leadership styles with decreased job satisfaction and staff nurse retention in all studies but one (McCloughen).
- The McCloughen article measured only NL perceptions and was very philosophical in nature. Good information for examining the concept of innate mentoring abilities of future leaders.
- The relationship between positive leadership and job satisfaction in the McGilton study is only applicable to unlicensed personnel.
- Intent to stay was influenced by positive leadership that led to improved work environments.

*Key:* CTDI, California Critical Thinking Disposition Inventory; CDD, Correlational Descriptive Design; CL, committed leadership; CRISO-PCQ, French version of Psychological Climate Questionnaire; CRT, Conversation, recording, transcribe; EDD-E, Exploratory Descriptive Design-Ethnography; EIL, emotionally intelligent leader; HAMS, Hinshaw & Atwood Multiple Scales; HP, Hermeneutic Phenomenology; I2S, intent to stay; JS, Job Satisfaction; MLQ, Multifactor Leadership Questionnaire; NgL, Negative Leadership; NL, Nursing Leader; NWI, Nursing Work Index; NWI-R, Nursing Work Index-Revised; PES, Practice Environment Scale; PL, Positive Leadership; SA, Secondary Analysis; SN, Staff Nurse; SNM, Staff Nurse Morale; SR, Staff Retention; SSS, Supportive Supervisory Scale; SYSR, Systematic Review; UNP, Unlicensed Nursing Personnel.
## Appendix B

### Evaluation Table

<table>
<thead>
<tr>
<th>Citation</th>
<th>Conceptual Framework</th>
<th>Design/Method</th>
<th>Sample/Setting</th>
<th>Major Variables Studied and Their Definitions</th>
<th>Measurement</th>
<th>Data Analysis</th>
<th>Findings</th>
<th>Appraisal: Worth to Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akerjordet, &amp; Severinsson (2008)</td>
<td>EI</td>
<td>SYSR</td>
<td>9 TH 9 E</td>
<td>DV=EI leadership IV=SN/WB, SN/PD</td>
<td>N/A</td>
<td>QA,IR</td>
<td>EI=TL</td>
<td>Level V: EI leadership skills are important in creating a supportive environment.</td>
</tr>
<tr>
<td>Bott, Boyle, Hansen, Taunton, &amp; Woods (1997)</td>
<td>ODPNR</td>
<td>CDD</td>
<td>95 MNM 1171 SN</td>
<td>PV=MC, WC, NC ITV=JS,AD,EN,CMT,I2S</td>
<td>HAMS</td>
<td>FA, MR, DRA</td>
<td>CDD =MC (r=.16-.39, p=&lt;.05), JS (r=.18-.24,p&lt;.05), WE (r=.15, p=.05), DRA=US )F=4.88, P&lt;.05), TO (F=4.39, p&lt;.05)</td>
<td>Level II: ODPNR assists in explaining variables of managers and intent to stay. Manager leadership behaviors target for intervention. Commitment predicted turnover.</td>
</tr>
<tr>
<td>Cowden, &amp; Cummings (2012)</td>
<td>CMI2S, DNI2RE</td>
<td>SYSR</td>
<td>22 TH</td>
<td>DV=I2S IV= OC, JS, LP, WE, INC, CD</td>
<td>N/A</td>
<td>QA,IR</td>
<td>CMI2S = PI2S</td>
<td>Level V: Guide to promotion of leadership practices supportive of I2S.</td>
</tr>
<tr>
<td>Lavoie-Tremblay, M., Paquet, Duchesne, Santo, Gavrancic,</td>
<td>PC, SR</td>
<td>CDD</td>
<td>UAHW PCQ n=1324</td>
<td>DV #1= I2Q DV #2 =WCP IV= GenY,GenX, BB</td>
<td>CRISO-PCQ, single question regarding</td>
<td>DA, MANOVA, Chi-square, ANOVA</td>
<td>Chi square = Gen Y (p&lt;.01) I2Q. MANOVA=</td>
<td>Level II: Reinforces importance of recognizing</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Methodology</td>
<td>Sample</td>
<td>DV</td>
<td>IV</td>
<td>CRT</td>
<td>Findings</td>
<td>Level</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------</td>
<td>--------</td>
<td>----</td>
<td>----</td>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Courcy, &amp; Gagnon (2010)</td>
<td></td>
<td></td>
<td>I2Q.</td>
<td></td>
<td></td>
<td>Wilks Lambda = .864, and p&lt;.001 I2Q, WCP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ANOVA= p&lt;.001, I2Q, JC. MANOVA Wilks Lambda= .95, p&lt;.001, WCP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>generation differencesWCP. Small ES.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kleinman, (2004)</td>
<td>MLB, CMSNR</td>
<td>CDD</td>
<td>CH, SN, NM SN= 79, 10=NМ</td>
<td>DV=SN turnover IV= PMLB</td>
<td>MLQ.</td>
<td>DA,CDD, PC,ANOVA CDD=( r=.26, p=.03),AM, PC= (r=-.4, p&lt;.01),MV. ANOVA =AM (F= 3.3, p=.01).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Level II :MLQ potential for cause and effect relationship, ES small</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McCloughen, O’Brien, &amp; Jackson, (2011).</td>
<td>None</td>
<td>HP</td>
<td>NL n=13 (10 women, 3 men).</td>
<td>N/A</td>
<td>CRT</td>
<td>Themes, HI until free of contradictions 3 themes emerged: imagination, journey and mode of being.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Level IV: philosophical in nature, mentoring innate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duffield, Roche, Blay, &amp; Stasa (2010).</td>
<td>None</td>
<td>SA</td>
<td>PH, SN n=1559.</td>
<td>DV: SSR IV: PLC</td>
<td>NWI-R</td>
<td>DA, LRA Mean leadership item = 2.8 (SD 0.48) LRA = p&lt;.01 praise and recognition, clear philosophy of nursing with OR 1.47, 1.40 &amp; .83 respectively, NM good leader I2L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Level II: job satisfaction and leadership praise.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azaare &amp; Gross, (2011).</td>
<td>None</td>
<td>EDD-E</td>
<td>SN, Ghana hospital.</td>
<td>DV: SN job satisfaction and retention. IV: SN perception of leadership styles.</td>
<td>CRT</td>
<td>IA, CA, HP Analysis done until no new information emerged into HP = thematic analysis. Four themes emerged: non-consultative leadership,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Level II: HP has potential for identifying themes in leadership.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zori, Nosek, &amp; Musil (2010)</td>
<td>None</td>
<td>DS</td>
<td>12 NM 132 SN Non-profit tertiary hospital</td>
<td>DV: Critical thinking IV: SN perception of practice environment</td>
<td>CCTDI PES NWI</td>
<td>DA T-test</td>
<td>T-test = differences between NM CCTDI scores (p&lt;.001)OM, AN and CT</td>
<td>Level II: + correlation between strong critical thinking abilities in NM and RN perception of PE.</td>
</tr>
</tbody>
</table>

---

**Key:** AD, administration; AM, active management; AN, analyticity; BB, baby boomers; CA, Comparative Analysis; CD, career development; CCTDI, California Critical Thinking Disposition Inventory; CDD, Correlational Descriptive Design; CH, community hospital; CMII2S, Conceptual Model of Intent to Stay; CMSNR, Causal Model of Staff Nurse Retention; CMT, commitment; CRISCO-PCQ, French version Psychological Climate Questionnaire; CRT, conversation, recording, transcribe; CT, critical thinking; DA, descriptive analysis; DCS, descriptive comparative study; DNII2RE, determinants of nurse intent to remain employed; DRA, discriminate analysis; DS, descriptive study; DV, dependent variable; E, empirical; EDD-E, exploratory descriptive design-ethnography; EI, emotional intelligence; EN, enjoyment; ES, effect size; FA, factor analysis; FL, factor loading; GenX, generation X; GenY, generation Y; HAMS, Hinshaw & Atwood Multiple Scales; HI, Hermeneutic interpretation; HP, Hermeneutic Phenomenology; IA, inductive analysis; I2L, intent to leave; I2Q, intent to quit; IES, intent to stay; INC, individual nurse characteristics; IR, independent review; IST, individual supervisory traits; ITV, intervening variable; IV, independent variable; JC, job challenge; LP, leader practices; LRA, logistic regression analysis; LTCF, long term care facility; MC, manager characteristics; MLB, Model of Leadership Behavior; MLQ, Multifactor Leadership Questionnaire; MNM, middle nurse manager; MR, multiple regression; MV, manager visibility; NC, nurse characteristics; ND, normal distribution; NL, nursing leader; NM, nursing manager; NWI, Nursing Work Index; NWI-R, Nursing Work Index-Revised; OC, organizational commitment; ODPRN, Organizational Dynamics Paradigm of Nurse Retention; OM, open-mindedness; OR, oblique rotation; PC, Pearson correlation; PCQ, Psychological Climate Questionnaire; PD, professional development; PES, Practice Environment Scale; PH, public hospital; PLE2S, predictor of intent to stay; PLC, perceived leadership characteristics; PMLB, perceived manager leadership behavior; PrC, principle component; PsC, psychological climate; PV, predictor variables; QA, quality assessment; RL, resonant leadership; RT, relationship theory; SA, secondary analysis; SN, staff nurse; SR, situational referents; SS&R, staff satisfaction and retention; SSS, Supportive Supervisory Scale; SYSR, systematic review; TH, theoretical; TL, transformational leadership; TO, turnover; UAHW, University affiliated hospital workers; UNP, unlicensed nursing personnel; US, unit separation; WB, well-being; WC, work characteristics; WCP, work climate perceptions, WE, work environment.
Appendix C

Self-Efficacy Evaluation Tool

The purpose of this survey is to understand your personal opinions about being a supportive leader in your current position as a result of this development series.

Please check the box that corresponds to your own view for each of the items.

In my current position, I am confident I can:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>provide supportive leadership through mentoring others.</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>build positive individual relationships.</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>build positive team relationships.</td>
<td>☐</td>
</tr>
<tr>
<td>4.</td>
<td>differentiate between appropriate use of control and empowerment.</td>
<td>☐</td>
</tr>
<tr>
<td>5.</td>
<td>create a positive work environment.</td>
<td>☐</td>
</tr>
</tbody>
</table>

Thank you for your participation.
Appendix D

Supervisory Support Scale

Below are 15 statements that relate to how you feel about your supervisor. Please check the box that reflects your relationship with your supervisor. Please be as honest as you can. Your answers are confidential and will not be shared with others you work with. If you work with more than one supervisor, please answer these questions in relation to the supervisor that you work with most often.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Occasionally</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>My supervisor recognizes my ability to deliver quality care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>My supervisor tries to meet my needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>My supervisor knows me well enough to know when I have concerns about patient care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>My supervisor tries to understand my point of view when I speak to them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>My supervisor tries to meet my needs in such ways as informing me of what is expected of me when working with my patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I can rely on my supervisor when I ask for help, for example, if things are not going well between myself and my co-workers or between myself and patients and/or their families.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>My supervisor keeps me informed of any major changes in the work environment or organization.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>My supervisor keeps me informed of any decisions that were made in regards to my patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>My supervisor strikes a balance between clients/families’ concerns and mine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My supervisor encourages me even in difficult situations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>My supervisor makes a point of expressing appreciation when I do a good job.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>My supervisor respects me as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>My supervisor makes time to listen to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>My supervisor recognizes my strengths and areas for development.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Brisbane Practice Environment Measure
Below are 33 statements that relate to how you feel about your work environment. Please check the box that reflects your current perceptions. Please be as honest as you can. Your answers are confidential and will not be shared with others you work with.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel supported by my clinical manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Performance and appraisal is completed in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In this area staff get away with bad behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel respected in the way people speak to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I am able to change my assignment if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. There is time for staff development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. It is difficult to influence change in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. There is a great team spirit in my work area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. My clinical manager is responsive to emergent leave Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I am treated as an individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. There is equity in staff development opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My skills are acknowledged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I participate in assignment development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. My clinical manager is approachable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Off line time is offered for professional Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I am thrown in at the deep end</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The workload is overwhelming in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I have access to the information I need to do my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I feel intimidated when working in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. There is equity in assignment in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I am acknowledged when I put in extra effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. The skill mix is about right in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. In this area, material resources are adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I am asked to operate outside my scope of practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. There is a high level of expertise I can access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I feel just like a number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. There is support for professional development in my area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Continuity of care is considered in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I enjoy coming to work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Our assignment complies with regulations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. My clinical manager is ready to help out in the clinical area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Staff workloads are equal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Opportunities for advancement are available in this organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F

Permission to Use Instruments

Theresa Dawson

From:   Anndrea Flint <Anndrea.Flint@health.qld.gov.au>
Sent:   Tuesday, May 06, 2014 2:49 AM
To:     Theresa Dawson
Subject: RE: Request for tool utilization
Attachments: BPEM.doc; Psychometric Analysis of the B-PERM.pdf; Brisbane Practice Environment Measure.pdf

Hi Theresa

Sure I have attached the two articles published about the tool and have given you a copy of the whole tool. In the factor analysis a few of the questions were deleted. You will notice the difference in the two papers.

Hope this helps

Regards,

Anndrea

Anndrea Flint
Clinical Nurse Consultant
Special Care Nursery
DECT: 36473974
OFFICE: 36460565
Email: Anndrea.Flint@health.qld.gov.au

From: Theresa Dawson [mailto:dawsonth@millercoll.edu]
Sent: Friday, 2 May 2014 12:51 AM
To: Anndrea Flint
Subject: Request for tool utilization

Good morning Ms. Flint,

My name is Theresa Dawson, a current DNP student at Grand Valley State University in Grand Rapids, MI. I am currently getting ready to complete my dissertation on “The Influence of Supportive Leadership on Staff Nurse Retention”. I have utilized your research in my study of this very important topic, therefore I am requesting your permission to use the Brisbane Practice Environment Measure as a tool for my project. I have been very impressed with the data produced to date. If you find it appropriate for me to utilize your tool for study, would you be willing to send me a clean copy of the tool for my use?

Thank you for your consideration. Nursing leadership is my passion and I hope to continue to make an impact on the future of our nursing leaders.
Respectfully,

Theresa Dawson, RN, MSN, CCRN
Dear Theresa,

You are more than welcome to use the scale I developed. Good luck with your dissertation.

Kathy

From: Theresa Dawson [mailto@dawson@millercollage.edu]  
Sent: Thursday, May 01, 2014 10:49 AM  
To: McGillon, Kathy  
Subject: Request for tool utilization

Good morning Dr. McGillon,

My name is Theresa Dawson, a current DNP student at Grand Valley State University in Grand Rapids, MI. I am currently getting ready to complete my dissertation on "The Influence of Supportive Leadership on Staff Nurse Retention". I have utilized your research in my study of this very important topic, therefore I am requesting your permission to use the Supportive Supervisory Scale as a tool for my project. I have been very impressed with the data produced to date. If you find it appropriate for me to utilize your tool for study, would you be willing to send me a clean copy of the tool for my use?

Thank you for your consideration. Nursing leadership is my passion and I hope to continue to make an impact on the future of our nursing leaders. Respectfully,

Theresa Dawson, RN, MSN, CCRN  
Dean/ School of Nursing  
Miller College  
Director/Nursing Education  
Kellogg Community College

This e-mail may contain confidential and/or privileged information for the sole use of the intended recipient. Any review or distribution by anyone other than the person for whom it was originally intended is strictly prohibited. If you have received this e-mail in error, please contact the sender and delete all copies. Opinions, conclusions or other information contained in this e-mail may not be that of the organization.
Appendix G

Cover Letter

TITLE: The Influence of Supportive Leadership in Staff Nurse Retention

INVESTIGATOR: Theresa Dawson, MSN, RN, DNP Student

DATE: 9/3/14

Consent to participate in a survey.

Dear Registered Nurse:

I invite you, the Registered Nurses who are employed at the clinic, to participate in a survey of RN work environment and supervisory support. Your participation in the survey is voluntary.

The purpose of this project is to determine the influence of supportive leadership on staff nurse retention. Therefore, I am interested in learning about your current level of job satisfaction and perception of supervisory support at the place of your employment.

In order to learn about the current perceptions, I will ask you to complete two surveys: The Supportive Supervisory Scale (SSS) and the Brisbane Practice Environment Measure (B-PEM). Each of these surveys will be administered at the same time. The completion of both surveys should take approximately 15-20 minutes of your time.

There are no anticipated risks to you related to participating in these surveys. If you choose not to participate in this project there will be no negative consequences on your employment at the clinic The anticipated benefits are that we can learn more about the influence of supportive leadership behaviors and staff nurse retention.

At any point in time if you wish to stop participating in the project you may stop completing the survey. All data will be analyzed and reported in a manner that maintains your anonymity.

Should you have any questions about this project, you may contact me by calling 269-924-2756. If you have any questions about your rights as a participant you may contact the Office of the Human Research Review Committee at Grand Valley State University, 616 331-3197.

Your willingness to participate in this project will be indicated by your completion of the surveys.

The completed forms will remain confidential. Only the investigator, Theresa Dawson, will have access to them. The forms will be stored in a secure file at the Kirkhof College of Nursing until the project has been completed. After that they will be destroyed.

When you have finished reading this letter and making the decision whether to participate or not please place the surveys (completed if you are participating; blank if you are not) into the envelope provided, seal it and return it to the secure survey collection box. I will pick these up every 3 days for timely analysis. Please have all surveys returned by 9/5/14.

Thank you for considering participating in this project.

Sincerely,

Theresa Dawson
Appendix H

Demographic Information Survey

By completing and submitting these surveys, you are consenting to participate in this study. Thank you for your time.

RN Work Environment/Supervision Survey

Demographic Information

(Please check appropriate boxes)

AGE

☐ 18-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60 and above

LENGTH OF EMPLOYMENT AT CURRENT EMPLOYER

☐ Less than one year
☐ 1-3 years
☐ 4-6 years
☐ 5 years or more

NUMBER OF YEARS AS A REGISTERED NURSE

☐ Less than one year
☐ 1-3 years
☐ 4-6 years
☐ 5 years or more
Appendix I
Supervisory Support Scale Results (Total number of responses by question)

- My supervisor recognizes my strengths and areas for development
- My supervisor makes time to listen to me
- My supervisor respects me as a person
- My supervisor makes a point of expressing appreciation when I do a good job
- My supervisor encourages me even in difficult situations
- My supervisor strikes a balance between clients/families concerns and mine
- My supervisor keeps me informed of any decisions that were made in regards to my patients
- I can rely on my supervisor to be open to any remarks I may make
- My supervisor keeps me informed of any major changes in the work environment or organization
- I can rely on my supervisor when I ask for help
- My supervisor tries to meet my needs in such ways as informing me of what is expected of me when working with my patients
- My supervisor tries to understand my point of view when I speak
- My supervisor knows me well enough to know when I have concerns about patient care
- My supervisor tries to meet my needs
- My supervisor recognizes my ability to deliver quality care
Appendix J

Leadership Workshop Outline and Modules

Outline

Day 1:

- Introductions/background in leadership
- Pre-intervention self-efficacy evaluation
- Relationship between leadership behaviors and retention
- Results of Center’s surveys/current retention rates
- General leadership terms
- Frames of leadership/self-assessment
- Discussion of results
- Self-reflection

Day 2:

- Values/Mission of the organization
- Inter-professional team building
- Mentoring
- Work environment (respect/relationships)
- Discussion
- Self-reflection

Day 3:

- Empowerment
- Shared governance
- Scope of practice/Role delineation
- Polarity thinking/Empowerment versus Control
- Polarity mapping
- Self-reflection

Day 4:

- Transparency in leadership
- Presence
- Administrative and clinical competence
- Effective leadership/quality outcomes
- Review/sharing/reflective journal on all three concepts of TPB theory
- Self-efficacy survey
Module Objectives:

1. Understand the relationship between leadership and staff nurse retention.
2. Examine the current perceptions of nursing leadership at Center.
3. Identify various leadership styles.
4. Introspect on personal leadership styles.

Readings:

Module 2
Attributes of Supportive Leadership
October 6, 2014

Module Objectives:

1. Identify characteristics of inter-professional teams.

2. Apply strategies to incorporate supportive leadership behaviors.

3. Introspect on personal leadership behaviors.

Readings:


Module Objectives:

1. Identify the relationship between staff nurse retention and empowerment.
2. Apply strategies of managing polarities in an inter-professional team.
3. Introspect on personal leadership styles appropriate to addressing polarities.

Readings:

Module 4
Effective Leadership/Quality Outcomes
October 20, 2014

Module Objectives:

1. Understand concepts of transparency and presence related to leadership behaviors.
2. Identify the relationship between effective leadership and quality outcomes.
3. Evaluate self-efficacy post-intervention related to leadership behaviors.

Readings:

### Appendix K

#### Self-reflection Results on Behavioral Change

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Normative Acceptance</th>
<th>Beliefs of Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well worth the invested time</td>
<td>People have been longing for it</td>
<td>I feel I have the ability to make the changes</td>
</tr>
<tr>
<td>Individuals are capable of making good decisions</td>
<td>Will be received with open arms</td>
<td>Treading carefully</td>
</tr>
<tr>
<td>Fosters teamwork</td>
<td>Will feel a sense of equality</td>
<td>I feel responsible to support my team on a daily basis</td>
</tr>
<tr>
<td>Teams have good ideas</td>
<td>Cannot come across as the fad of the month</td>
<td>I have learned from the workshops and believe I can implement change</td>
</tr>
<tr>
<td>Feel excited to be more supportive</td>
<td>Teams will feel a sense of relief</td>
<td>I believe I can display team involvement</td>
</tr>
<tr>
<td>Can provide growth to the team</td>
<td>Most want this type of management style</td>
<td>I have been working more closely with staff</td>
</tr>
</tbody>
</table>
References


Harrington, L. (2010). From talking the talk to walking the walk: The role of nurse leaders in nursing research. *Nurse Leader, 46*-49. doi: 10.1016/j.mnl.2009.08.004


Rosseter, R. (2012, September 18). AACN and community college leaders join together to support academic progression [Electronic mailing list message]. Retrieved


