

2017

The Relationship between Nurse Manager Leadership Style and the Enculturation of Shared Governance

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Walden University

College of Management and Technology

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Anna Keane

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Abstract

The Relationship Between Nurse Manager Leadership Style and Enculturation of Shared
Governance

by

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MA, Seton Hall University, 1994

MSN, Seton Hall University, 1993

BSN, College Misericordia, 1981

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

Walden University

December 2016

Abstract

Shared governance, a participative model of governance, implemented by healthcare organizations for more than 30 years has been associated with empowerment, job satisfaction, and retention of registered nurses. Recent studies document a lack of participation in shared governance by registered nurses; the reason for the change is unknown. The nurse managers' role in this change is unknown. The purpose of this non-experimental, cross-sectional survey design study was to test Bass' theory of transformational leadership that examines the relationship between the leadership style of the manager and the enculturation of shared governance in acute care hospitals in the United States. A random sample of 111 nurse managers, who were members of the American Organization of Nurse Executives, were surveyed on leadership style using the Multi-factor Leadership Questionnaire and unit governance, using the Index of Professional Nursing Governance. Data was analyzed using Pearson's Product Moment Correlation and a statistically significant positive relationship was found between transformational leadership style and shared governance. No relationship was found between other leadership styles and shared governance. There was no relationship between the achievement of a shared governance score on the participation subscale of the Index of Professional Nursing Governance and transformational leadership style. The study contributes to social change through the identification of the manager's use of a transformational leadership style to foster the autonomy and empowerment of nurses to cultivate a positive the work environment using a shared governance model, which results in registered nurse retention and decreased organizational turnover costs.

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Dedication

I dedicate my dissertation work to my beautiful daughters. Follow your dreams where ever they lead; it is only then that you will know your true heart. Continue to dream and your life will be full.

Acknowledgments

The completion of this dissertation would not have been possible without the guidance and support of many people. I would like to thank my family; without your unwavering support and encouragement, I know I could not have completed this journey. To my daughters, I hope my journey has demonstrated to you that you should follow your dreams. I hope you have learned that anything worth having requires hard work and dedication.

To my dissertation team, this work would not have been possible without your continued guidance, support and mentoring. To Dr. L. Lee, thank you for your feedback on how I could improve my study. To Dr. R. De Young, thank you for your patience and ongoing critique of my work. Your guidance helped create synchronicity in my dissertation. Most especially to my committee chair, Dr. Jean Gordon, I could not have completed this process without your never ending support and patience as I worked through all the bumps in the road on my dissertation journey. You helped me navigate my frustrations, set-backs, and the seemingly endless programmatic changes. Dr. Gordon, you have been a wonderful mentor. I cannot find the words to thank you enough.

To Dr. R. Hess, for allowing me to utilize his instrument in my study. I appreciated your support and encouragement in the study of shared governance. To my work family, thank you for your support and for holding me accountable to completing this journey. Each and every day, you encourage me to become a better leader!

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Chapter 1: Introduction to the Study

Maslow's theory of human motivation postulated that some individuals are motivated to achieve self-actualization (Maslow, 1943). This theory, applied to an organization, gave rise to the concept of the knowledge worker, a term coined by Peter Drucker in the 1960s to describe various professionals, including registered nurses. Drucker et al. (2011), stipulated that the knowledge worker is an organizational asset, rather than a liability. As a valuable organizational asset, the knowledge worker must be continually evolved and allowed to perform in networks rather than traditional hierarchical organizations. The work environment and the manager's role in fostering the evolution of the knowledge worker are of significant importance to both the knowledge worker and the organization.

The focus of this study is on the healthcare organization and the registered nurse, as the knowledge worker within the organization. In this study I examined the relationship between the leadership style of the nurse manager and their ability to generate a participative work environment known as shared governance. The development of a participative management leadership style and work environment demonstrates the organizational leadership's value of the employee as a key stakeholder who possesses the knowledge, skills, and abilities necessary to identify and resolve organizational challenges. The demonstration of a democratic or participative leadership style and work environment promotes the empowerment, engagement, job satisfaction, and retention of the knowledge worker (Cheung & Wu, 2014; Pansare & Mohammadi, 2014). When implemented successfully by organizational leaders, a participative

management leadership style and a participative work environment allow businesses to gain a competitive advantage (Pansare & Mohammadi, 2014; Zoghi & Mohr, 2011).

Within the healthcare literature, researchers have demonstrated that both leadership style and shared governance have a positive impact on the professional practice environment of registered nurses in the United States (Lartey, Cummings, & Profetto-McGrath, 2014; Twigg & McCulloch, 2014). When leaders create a positive work environment, registered nurses experience increased job satisfaction and retention (Kutney-Lee, Wu, Sloane, & Aiken, 2013; Numminen et al., 2015). In the current era of healthcare reform and with a significant shortage of registered nurses being projected, understanding the relationship between factors which impact the work environment and foster job satisfaction and retention of employees can lead healthcare organizations to achieve a competitive advantage (Juraschek, Zhang, Ranganathan, & Lin, 2012).

Researchers have identified factors which contribute to a positive, participative work environment for direct care registered nurses (Blake, Leach, Robbins, Pike, & Needleman, 2013; Cowden, Cummings, & Profetto-McGrath, 2011). Researchers have found that empowerment, autonomy, nurse manager leadership, staffing, and collaborative nurse-physician relationships are related to direct care registered nurse retention (Laschinger & Fida, 2014; Twigg & McCulloch, 2014). However, researchers have not examined the interrelationship between nurse manager leadership style and shared governance, which promotes empowerment and autonomy. The primary purpose of this study was to fill that gap in the literature.

In this chapter I provide the introduction to the study and a review of the background, problem statement, purpose, research questions, and hypotheses of the study. An overview of the theoretical framework and the nature of the study are provided. Chapter 1 continues with a definition of terms, the assumptions, scope and delimitations, limitations, and significance of the study. The chapter concludes with a summary and transition into Chapter 2.

Background of the Study

In 1955, industrial psychologist Douglas McGregor took the concept of participative management into the business environment using the mindset of “bottom-up management” (Alden, 2012, p. 1). McGregor found that participative management practices at General Mills emphasized that each employee was a unique individual with separate needs, viewpoints, and desires and wanted to be treated as such by management. The participative manager functioned less as a boss and more as a guide or coach who develops employees while directing them. The purpose of this transformation in management practice was to increase productivity and profits through a more satisfied employee and healthy social structure within the work environment (Alden, 2012).

In the latter part of the 1950s, humanistic, participative management practices spread to various organizations. The inevitability of workplace democracy was acknowledged by the advent of participative management within organizations (Cheung & Wu, 2014). Corporate giants, such as Proctor and Gamble, General Motors, General Electric, and Toyota, found that the use of participative management strategies

significantly improved productivity while enhancing worker satisfaction and the quality of the work environment (Alden, 2012).

Participative management has been in use in both the public and private sectors of business and industry across the world (Pansare & Mohammadi, 2014). It manifests in different forms based on the organization. Some organizations use worker councils, a body or committee formed by an employer among workers, for the discussion of problems of industrial relations. Others use participative management to enhance quality through lean processes and quality circles. Some industries have formed congressional models of participation, which use elected delegates from various segments of the organization for problem resolution (Pansare & Mohammadi, 2014; Zoghi & Mohr, 2011). In the mid-1990s, the concept of participative management experienced resurgence associated with an increase in globalization of the workforce and the continued drive of business organizations to achieve a competitive advantage (Pansare & Mohammadi, 2014).

In academia, participative management arrived in the late 1960s and gained momentum in the 1970s (Dionne et al., 2014; Pansare & Mohammadi, 2014). The concept of participative management in academia became known as shared governance. Scholar practitioners advanced this concept from academia into the nursing practice environment in the late 1970's. Over the next 30 years, the concept of shared governance grew and evolved within the healthcare environment. The implementation of shared governance by organizational leaders has resulted in greater autonomy and empowerment of direct care registered nurses and has led to increased job satisfaction and retention of

the registered nurse workforce (Bamford-Wade & Moss, 2010; Barden, Griffin, Donahue, & Fitzpatrick, 2011; Hutchinson & Jackson, 2013).

The landscape of the United States healthcare environment began to change with the advent of healthcare reform. Registered nurses are the largest percentage of employees working within the hospital. In 2013, the United States Department of Labor, Bureau of Labor Statistics (BLS) reported registered nurses comprised 29.4% of the employees working in hospitals in the United States (BLS, 2014). A deterioration in the registered nurse workforce would create disruption in the delivery of healthcare to the community in which the hospital was established to serve.

In 2008, there were 3,063,162 registered nurses in the United States, with 62.2% employed in hospitals (United States Department of Health and Human Services [USDHHS], 2010). By May of 2013, the BLS reported there were 2,661,890 registered nurses in the United States, with 59.3% employed in hospitals (BLS, 2014). By 2020, the United States is projected to have a shortage of 1,016,900 registered nurses. This shortage is expected to continue through 2030, with all states except Massachusetts and South Dakota, projected to have continued escalation of the shortage. States in the South and Midwest are expected to experience to greatest shortage of registered nurses by 2030 (Juraschek et al., 2012). The projected shortage of registered nurses has the potential to disrupt the delivery of healthcare. The reduction in the registered nurse workforce and the projected shortage of registered nurses in the United States creates the need for healthcare leadership to examine the work environment to ascertain root causes of registered nurse turnover.

In the 2008 National Sample Survey of Registered Nurses (NSSRN), researchers revealed that 11.1% of United States registered nurses were dissatisfied with their job. Three percent of registered nurses left employment in nursing between 2007 and 2008. More than 18% of registered nurses employed in 2007 and remaining employed in 2008 demonstrated a lack of satisfaction with their jobs; 11.6% changed employers, and another 6.5% stayed with the same employer, but changed jobs. In excess of 73% of the nurses who changed employers or jobs reported workplace issues, such as lack of good management and inadequate staffing as the reason for the change in position (USDHHS, 2010). Nurse manager leadership style had an impact on registered nurse retention.

In a longitudinal study on the turnover in the registered nurse workforce, Kovner, Brewer, Fatehi, and Jun (2014), found that 17.5% of newly licensed nurses leave their first job within one year and 33.5% leave within two years. In a retrospective, two-stage panel design study, Kutney-Lee et al. (2013), found that improvements in the work environment were associated with lower rates of nurse burnout, intention of leaving current position, and job dissatisfaction. Twigg and McCullogh (2014) found that empowerment, autonomy, nurse manager ability and leadership, staffing and resource adequacy, and collaborative relationships between the nursing and medical staff were factors which create a positive work environment for registered nurses. Blake et al. (2013), found a positive relationship between communication, collaboration, and effective leadership was key to the development of a healthy work environment and retention of registered nurses.

In this study I examined the relationship between nurse manager leadership style and the enculturation of shared governance. Researchers have identified nurse manager leadership style as one of the factors that contributed to a positive participative work environment (Kovner et al., 2014; Lartey et al., 2014; Twigg & McCulloch, 2014). Autonomy and empowerment are two other factors that contribute to a positive work environment, as both autonomy and empowerment are foundational elements of participative management, known as shared governance (Barden et al., 2011; Hutchinson & Jackson, 2013).

Cowden et al. (2011) conducted a systemic review of the literature which examined the leadership style of the manager and its impact on direct care registered nurse retention. There was a positive relationship between relational leadership practices, such as those seen in transformational leadership, and registered nurse retention. Nurse managers were found to influence the behavioral intentions of nurses and their intent to stay or leave the organization. The retention of registered nurses was also influenced by empowerment, organizational commitment, and desire to stay. Leadership's influence on retention was through empowerment.

Lartey et al. (2014) found, in a systemic review of the literature, that leadership style played a key role in interventions supporting the retention of experienced nurses. Leaders who took an interest in their staff, demonstrated they cared, were approachable, promoted team work, and mentored experienced nurses had lower turnover rates. These supportive behaviors contributed to a positive work environment. This is consistent with the findings of Feather, Ebright, & Bakas (2015) who found that supportive manager

behaviors in the areas of communication, respect, and caring significantly impacted job satisfaction and retention.

Demonstration of these supportive behaviors by leaders align with the four attributes of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Carter, Armenakis, Field, & Mossholder, 2012). Gillet, Fouquereau, Bonnard-Antignac, Mokoukolo, and Colombat (2013), in a cross-sectional study of 343 nurses, found that transformational leaders ensured the quality of work life for nurses which then led to an increase in the nurse's work engagement. These findings are consistent with the work of Jacobs et al. (2013), who found that transformational leadership style had a positive impact on employee well-being.

While leadership style impacts the work environment, fostering empowerment also has the ability to positively impact the work environment. Empowerment is the "perception of being involved and supported, having access to opportunities, resources, and power within an organization" (Twigg & McCulloch, 2014, p. 87). The creation of an empowered work environment occurs through the presence of a shared governance participative structure; using this structure there is open communication from the bedside to leadership (Hastings, Armitage, Mallinson, Jackson, & Suter, 2014). Communication happens as a result of mutual exchange between the direct care registered nurse and nursing leadership. This creates understanding by both parties on the need for resources, support, information, and opportunities necessary to create a positive work environment (Spence-Laschinger, Read, Wilk, & Finegan, 2014).

Another factor that impacts the creation of a positive work environment is autonomy. Professional autonomy relates to the privilege of self-governance (Varjus, Leino-Kilpi, & Suominen, 2011). Autonomy is the ability to make some decisions within the profession of nursing and the right and responsibility to act according to the standards of the profession (Varjus et al., 2011). As the hallmark of professional practice, autonomy is a foundational element of shared governance practice. Through the utilization of a shared governance structure, direct care registered nurses have a professional voice at the organizational table. The structure of shared governance gives nurses at the bedside the autonomy to control aspects of practice which were formerly controlled by management. Within a shared governance structure decisions involving staffing, scheduling, policy, education, and standards of practice and care are made jointly by the direct care registered nurses and the nurse manager (Beglinger, Hauge, Krause, & Ziebarth, 2011).

Shared governance and transformational leadership have been studied in the healthcare literature as separate concepts which researchers have shown influence direct care staff empowerment, satisfaction, and retention. These concepts have not been studied in the healthcare literature relative to their relationship to each other. In this study I examined the relationship of transformational leadership style on the development and evolution of shared governance in the work environment. The findings in this study can be used by organizational leaders to support the empowerment, satisfaction, and retention of the registered nurse workforce.

Problem Statement

Organizational leaders need to understand how to create a satisfying work environment for direct care registered nurses, as a positive work environment is crucial for a stable workforce and avoidance of the high cost of turnover. With a significant shortage of registered nurses predicted by 2020, it will be critical for healthcare organizational leaders to cultivate a satisfying work environment for registered nurses (Jurascheck et al., 2012). Researchers have demonstrated a positive work environment is characterized by autonomy and empowerment of the workforce (Feathers et al., 2015; Hastings et al., 2014; Spence-Laschinger et al., 2014).

Shared governance, a participative decision making model of governance in place in healthcare organizations in the United States for over 30 years, is touted as the foundation of professional practice in nursing (Bina et al., 2014; Johnson et al., 2012). The shared governance model provides a structure which empowers direct care registered nurses to have autonomy over the professional practice environment on their units. Staffing, scheduling, policy, education, standards of practice and care decisions are made in collaboration between the direct care registered nurses and the nurse manager (Beglinger et al., 2011).

The shared governance model is based on the principles of partnership, equity, accountability, and ownership at the point of service (Porter-O'Grady, 2012). The presence of a shared governance structure utilized by direct care registered nurses has been associated with empowerment, job satisfaction, retention of registered nurses, and improved quality of care within the work environment (Bamford-Wade & Moss, 2010;

Barden et al., 2011; Hutchinson & Jackson, 2013). The potential for organizational disruption is significant when considering the erosion of the benefits attributed to shared governance and the projected nursing shortage identified by Jurascheck et al. (2012). It is unknown if this erosion will cause disruption in the work environment or what the impact of a lack of a dynamic shared governance structure may have on direct care registered nurse empowerment, autonomy, and practice of professional nursing.

Researchers, in recent studies, have identified that engaging direct care registered nurses in shared governance has been a challenge. A study of a large Midwestern healthcare network, Scherb, Specht, Loes, and Reed (2011) found that direct care registered nurses were unwilling to be involved in decision making. Graham-Dickerson et al. (2013) found in a study of direct care registered nurses and chief nursing executives at ten Colorado hospitals, that it was challenging to get nurses involved in decision making. Examining the barriers to participation in shared governance, Wheeler and Foster (2013) also found that the United States and foreign educated nurses did not value participation in governance. These researchers have indicated that the engagement of direct care registered nurses in shared governance structure and processes is lacking. However, the cause(s) of the lack of engagement of registered nurses in shared governance is unknown.

The Index of Professional Nursing Governance (IPNG) is an 86-item questionnaire designed to measure governance by hospital nurses. This instrument measures overall governance and six dimensions of governance: control over personnel, access to information, resources supporting practice, participation, and control over practice, and goals and conflict resolution. Hess (2011) reported that organizations in the

Southwestern United States with robust shared governance programs and IPNG scores indicating the presence of shared governance had either stagnated in progression or regressed on the IPNG. Wilson (2013) examined the current state of shared governance at a three hospital healthcare system in Nevada and found that individually these hospitals did not achieve scores on the IPNG which would have indicated the presence of shared governance. The IPNG mean scores across all six subscales reflected traditional management structures with decisions being made primarily by management and administration. Both Hess (2011) and Wilson (2013) found that having a shared governance structure in place did not guarantee the presence of shared governance within the organization. Contemporary researchers have identified that the engagement of direct care registered nurses in shared governance is problematic, the rationale for the unwillingness of nurses to participate in shared governance, even with shared governance structures in place, is not addressed (Graham-Dickerson et al., 2013; Scherb et al., 2011; Wheeler & Foster, 2013; Wilson, 2013).

The business problem created by the unwillingness of direct care registered nurses to participate in shared governance is that the lack of participation in shared governance creates a void in the nurse manager's ability to reflect the perspectives of the professional direct care staff at the organizational level. This problem stymies the open dialogue needed between direct care nurses and nursing leadership regarding resources and information necessary to facilitate a positive work environment and direct care nurse retention. A void in shared governance participation by direct care nurses decreases the autonomy and empowerment of the professional direct care staff and results in decreased

job satisfaction and retention (Bamford-Wade & Moss, 2010; Hutchinson & Jackson, 2013).

Horstmeier, Boer, Homan, and Voelpel (2014) conducted a meta-analysis on the effects of transformational leadership on identification at work. The researchers found a stronger link between the positive effects of transformational leadership and identification with the leader than between transformational leadership and identification with the organization or team. Cowden et al. (2011), and Twigg and McCulloch (2014), found that nurse manager leadership had the ability to positively influence the professional work environment. The nurse manager plays a significant role in determining the climate of the unit as they influence direct care registered nurse job satisfaction and retention through their leader behaviors (Bormann, 2011; Feather et al., 2015). Kallas (2011) identified transformational leadership as an important behavior associated with direct care registered nurse job satisfaction and retention. Fergus (2012) found that nurse manager leadership was associated with psychological and structural empowerment of direct care registered nurses and that the transformational leadership of the nurse manager was associated with the empowerment and retention of direct care registered nurses. In addition, researchers focusing on Magnet® designated hospitals, found that nurses were attracted to work environments that promoted autonomy, enhanced interdisciplinary collaboration, and control over nursing practice (Barden et al., 2011).

The nurse manager has the ability to influence the work environment in a positive manner (Lartey et al., 2014; Twigg & McCulloch, 2014). The embodiment of a

transformational leadership style by the nurse manager is associated with empowerment and retention of direct care registered nurses (Fergus, 2012; Kallas, 2011). Bamford-Wade and Moss (2010) conducted an action study on the development of shared governance within a single hospital healthcare system in New Zealand. Over a period of five years, Bamford-Wade and Moss implemented a shared governance structure within the hospital, there was improved job satisfaction, empowerment, and retention of direct care registered nurses. The ability to effectively implement shared governance was attributed to the authors' use of a self-determined transformational leadership style. This is the only study that relates leadership style and shared governance in the healthcare literature.

In this study I quantitatively examined the relationship between the nurse manager leadership style and the enculturation of shared governance. The findings of the study assist in understanding if the nurse manager's leadership style can influence the development of shared governance at the unit level. The findings of this study have implications for positive social change relative to fostering the empowerment, job satisfaction, and retention of direct care registered nurses. Empowering direct care registered nurses to express their perspectives about the work environment and leadership allows for the creation of a mutually beneficial work environment. The creation of a satisfying work environment fosters retention which may assist organizations in mitigating organizational disruption due to the impending nursing shortage and the erosion of shared governance.

Purpose of the Study

The primary purpose of this nonexperimental, quantitative, cross-sectional study was to test the theory of transformational leadership that relates the leadership style of the nurse manager to the enculturation of shared governance in acute care hospitals in the United States. The independent variable was leadership style and the dependent variable was shared governance. The variables were quantitatively measured using the Multi-factor Leadership Questionnaire (MLQ 5X short) and the Index of Professional Nursing Governance (IPNG).

The unwillingness of the professional nursing staff to participate in shared governance creates a void in the nurse manager's ability to accurately represent the issues and concerns of the direct care registered nurses at the organizational level. The lack of representation of the issues and concerns of direct care registered nurses at the organizational table fosters a lack of autonomy and empowerment. The researcher's objective in this study was to explore perceptions of nurse manager leadership style and its relationship to the presence of shared governance. Researchers have established that both variables have independently demonstrated the ability to positively influence the work environment and impact job satisfaction, retention of the registered nurse workforce, and the quality of patient care delivered to the community (Barlow, 2013; Wong, Cummings, & Ducharme, 2013; Zhu, Riggio, Avolio, & Sosik, 2011).

Nurse manager leadership style has an impact on employee, patient, and organizational outcomes (Cowden et al., 2011; Laschinger, Finegan, & Wilk, 2011; Van Kippenberg, & Sitkin, 2013). Both active transactional leadership and transformational

leadership styles are effective forms of leadership (Bass, 1985). Active transactional leadership combines management-by-exception and contingent reward (Zhu et al., 2011). The contingent reward aspect of active transactional leadership has the leader communicating what needs to be done, how it will be done, and the reward and recognition the follower will receive if the task is done to the leader's expectations. When utilizing active management by exception, the leader focuses on the standards of compliance, defines unacceptable performance, and may punish followers if the task is not completed to expectations. In transactional leadership, the manager monitors followers' performance; in active management by exception, the manager will take corrective actions to force followers to correct work attitudes and behaviors to align with established expectations of work performance (Zhu et al., 2011). The result of active transactional leadership by the manager is the alignment between the employee and the organization of performance expectations and role clarity for the employee (Wong et al., 2013).

In contrast, transformational leaders use idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration to control the attitudes and behaviors of followers (Bakker, Albrecht, & Leiter, 2011). The transformational leader moves the follower beyond their own self-interest to focus on the vision of the organization (Zhu et al., 2011). The follower develops a positive sense of self-worth and value which increases their desire to go above and beyond expectations (Wong et al., 2013).

Dionne et al. (2014) found in a systemic review of the literature, that leaders who used a participatory leadership style had lower turnover rates. Transformational leadership was associated with the highest number of positive outcomes: unit effectiveness, extra effort from staff, and a positive organizational culture (Dionne et al., 2014). Leaders with strong communication skills and those who involved their staff in decision making, had staff with increased satisfaction and retention. Leaders were viewed as flexible, trustworthy, supportive, encouraging, and motivated toward the professional growth of employees. They had more positive outcomes for patients and staff and healthier work environments (Dionne et al., 2014).

Research Question(s) and Hypotheses

The following research questions and specific hypotheses generated for the study were as follows:

Research Question 1: What is the relationship between leadership style of the nurse manager and enculturation of shared governance?

H₀1: There is a negative or no relationship between transformational leadership style of the nurse manager and shared governance.

H₁1: There is a positive relationship between transformational leadership style of the nurse manager and shared governance.

H₀2: There is a negative or no relationship between active transactional leadership style of the nurse manager and shared governance.

H₁2: There is a positive relationship between active transactional leadership style of the nurse manager and shared governance.

Research Question 2: What is the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style?

H₀₃: There is a negative or no relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

H₁₃: There is a positive relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

For the first research question, the independent variable was leadership style and was measured by the MLQ 5X short. The dependent variable was shared governance, which was measured by the IPNG. For the second research question, the independent variable was the presence of a shared governance score on the participation subscale, which is a subscale of the IPNG. The dependent variable was the transformational leadership style, which was measured by the MLQ 5X short.

Theoretical Framework for the Study

The theoretical frameworks used in this study were Bass' (1985) transformational leadership theory and shared governance. According to Bass, transformational leadership creates a synergistic and dynamic relationship between the leader and the follower, which elevates the follower, the leader, and the organization to achieve organizational goals (Bass, 1985). Shared governance is a shared leadership model of participative management which allows front-line staff greater control over the

work environment in areas which have traditionally been controlled solely by management (Hess, 2011). I briefly explored both concepts in the following paragraphs and comprehensively explored these concepts in Chapter 2.

Transformational leadership has been defined as the elevation of the “needs of the follower in line with the leader’s own goals and objectives” (Bass, 1985, p. 21) utilizing charisma, individualized consideration, and intellectual stimulation. According to Avolio & Bass, 2004 the transformational leader is able to create a strong sense of identification with the organization that individuals are willing to move beyond their own self-interests to achieve the organizational vision. As a human-capital-enhancing leadership style, transformational leadership seeks to motivate followers to do more and perform beyond their expectations (Zhu et al., 2011).

Using these constructs Bass (1985) identified four attributes of transformational leadership. Each attribute functions to inspire followers to achieve the mission and vision of the organization, while continuing to evolve toward self-actualization. These four attributes of transformational leadership are further defined in the following paragraphs.

Idealized influence, or charisma, is the first attribute. As a role model for their followers, transformational leaders are admired, respected, and trusted. The relationship between the leader and the followers creates strong identification with the leader. This makes followers less resistant to change and allows the leader to evoke strong emotions in followers. Followers look to emulate the leader and develop a sense of pride in their contribution to the organization and the organization’s success (Scully, 2014).

The next attribute is inspirational motivation, which is focused on the transformational leaders' ability to motivate and inspire followers to commit to the vision and goals of the organization. The leaders' articulation of a compelling vision of the future inspires followers to believe in their performance of meaningful work (Bass, 1985). The motivational aspect of transformational leadership is closely tied with feelings of empowerment and works in alignment with the charismatic leadership aspect of idealized influence (Avolio & Bass, 2004; Ellemers, Rink, Derks, & Ryan, 2012).

Intellectual stimulation is the third attribute of transformational leadership and it is focused on problem-solving through the use of innovation, creativity, and critical thinking (Avolio & Bass, 2004). Leaders challenge followers to move beyond traditions and beliefs that no longer support problem resolution to take risks and foster innovation (Ellemers et al., 2012). There is no public criticism of individual followers' mistakes or the generation of ideas which differ from those of the leader. The leader encourages the challenge of critical assumptions and the visualization of options from varying perspectives.

Finally, individualized consideration is focused on the specialized attention the leader pays to an individual follower's needs. The follower is viewed as having unique needs and abilities. They are coached and mentored to develop successively higher levels of potential (Dinh et al., 2014). Two-way communication between the leader and the follower is encouraged. The leader demonstrates acceptance of individual differences while expecting a sense of cohesion in the organization (Bakker et al., 2011).

Transformational leaders use these four attributes to elevate follower performance and achieve organizational goals. Transformational leadership is one component of the full-range leadership theory developed by Bass (1985). There are three theoretical perspectives of leadership in the full-range leadership theory: transformational, transactional (active and passive), and laissez-faire. Bass' (1985) full-range leadership theory recognizes that transformational and transactional leadership styles are separate and distinct concepts which do not exist along a continuum. Transactional leadership provides the base from which it is possible to achieve the effects of transformational leadership (Scully, 2014). I have explored transformational leadership theory in greater detail in Chapter 2.

Transformational leadership style, which is the expression of the transformational leadership theory, can be ascertained through the use of the MLQ 5X short. The MLQ 5X short is a reliable and valid tool which quantitatively measures leadership style; it has been utilized to ascertain the leadership style of nurse managers (Avolio & Bass, 2004).

Shared governance is a participative management process model which replaces the traditional, centralized management with command and control structures (Hess, 2011). This decentralized participative management structure allows approximately 90% of decisions to be made on the patient care units (Porter-O'Grady, 2012). The principles of accountability, partnership, equity, and ownership at the bedside form the basis of the shared decision-making model (Porter-O'Grady, 2012).

Partnership relates to the collaborative relationship among the stakeholders. This includes the relationships among the healthcare providers, and between the healthcare

providers and the patient. Professional empowerment is driven by the collaborative relationships among all stakeholders. When direct care staff is involved in decision-making and partnership; professional empowerment grows and the effectiveness of the healthcare system improves (Blake et al., 2013; Barlow, 2013). The incorporation of the principle of equity into structures and processes levels the work environment and reflects the value that no single role or individual is more important than another in the achievement of the goals of the organization; which results in positive patient outcomes. The principle of equity is not a reflection of scope of practice, authority, or responsibility; it is the acknowledgement of the importance of every collaborative role needed to achieve positive outcomes. Participating in decision making and taking responsibility for the decisions made are the underpinnings of the principle of accountability (Porter-O'Grady, 2012). When registered nurses exhibit the principle of accountability, this facilitates partnerships and reinforces equity through collaborative decision-making. The principle of ownership by the staff at the bedside supports the principle of equity and recognizes that organizational success is associated with individual performance. Use of this principle by the direct care staff defines where work is to be done and by whom. Ownership is the commitment by each member of the staff for the work to be done and participation in the development of processes needed to do the work (Swihart & Hess, 2014).

Shared governance empowers all members of the healthcare workforce to have a voice in decision-making. This allows for diverse and creative input to advance the business and healthcare mission of the organization (Johnson et al., 2012). As each

employee is empowered and held accountable for decision-making, this model leads to increased job satisfaction and retention (Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013). Workers who are happier in their job take greater ownership and are more vested in patient outcomes (Hutchinson & Jackson, 2013). The shared governance model has been proven by researchers to provide benefits to the employee, patients, the organization, and the community the healthcare system was intended to serve.

The presence of shared governance can be assessed by the utilization of the instrument, the IPNG. This tool developed by Hess (1994) evaluates the work environment for the presence of traditional, shared, or self-governance. It contains six subscales reflective of governance: nursing personnel, access to information, goals and conflict, resources and supporting practice, participation, and control over practice. Leadership which develops, fosters, and evolves the principles of accountability, partnership, equity, and ownership theoretically should lead to the development of a shared governance work environment.

The theories of transformational leadership and shared governance were used to frame the study. Both theories were measured using reliable and valid instruments; they were appropriate to the quantitative paradigm. The theories reflected the dependent and independent variables and the research questions used in the study.

Nature of the Study

The nature of this study is nonexperimental quantitative using a cross-sectional correlational design. The quantitative approach was consistent with the research question

related to the exploration of the relationship between leadership style and shared governance. The researcher can utilize the findings of the study to assist in the identification of workplace factors which impact the enculturation of shared governance processes within the organization.

The independent variables for the study were the leadership style and the achievement of a shared governance score on the participation subscale of the IPNG. The dependent variables for the study were shared governance and transformational leadership style. All variables can be quantitatively measured using either the MLQ 5X short or the IPNG.

A random sample of nurse managers, who were members of the American Organization of Nurse Executives (AONE), the national organization for nurse executives in the practice arena and work in acute care hospitals in the United States, were surveyed through distribution of a questionnaire via SurveyMonkey®. The survey contained both the MLQ 5X short and the IPNG tools, in addition to demographic information. The data was analyzed using IBM SPSS Statistics 23 software.

Definitions

The definitions listed below are provided to ensure uniformity and understanding of these terms throughout the study:

Active transactional leadership: Leadership behavior which encompasses contingent reward and active management by exception. In this leadership style the manager communicates what is to be done, how it is to be done and the reward or

punishment which will accompany the completion of the task. This leadership style creates role clarity and organizational alignment (Bakker et al., 2012).

Acute care hospital: Hospitals in the United States which provide care for acutely ill patients. This does not include chronic, long-term, or specialty hospitals (USDHHS, 2010).

Leadership style: The manner in which a leader provides direction, implements plans and motivates people. The full-range leadership model identifies three primary leadership styles: transformational, transactional, and laissez-faire (Bass, 1985).

Nurse Manager: The middle manager role immediately above the charge nurse, regardless of title. This person has accountability for unit outcomes 24 hours per day, 7 days per week. (Cowden et al., 2011).

Participative management: Employee involvement in organizational decision-making; it may also be referred to as 'industrial democracy' or 'shared governance.' (Dinh et al., 2014)

Participation subscale: One of the subscales of the IPNG which measures nurse participation in committees. This includes actual participation in meetings, as well as determining the formation and composition of councils (Bennett et al., 2012).

Shared governance: A formal structure involving registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimize the registered nurses' power over their professional practice (Hess, 1994).

Transformational leadership: A leadership style that alters the norms and values of the employee to perform beyond their own expectations. (Tims, Bakker, & Xanthopoulou, 2011).

Assumptions

Assumptions made by the researcher for this study focused on the methodology and the integrity of design. It was assumed that the methodology chosen for this study was the best possible tool to answer the research questions. This study is survey-based, and assumes that it will be answered by the person to whom it was sent and that respondents will answer honestly and accurately to the best of their ability.

Scope and Delimitations

Although many factors may have influenced the retention of direct care registered nurses in acute care hospitals, the scope of the study addressed only nurse manager leadership style and the unit governance aspect of the work environment. Contemporary researchers have identified a lack of willingness of registered nurses to participate in shared governance, without ascertaining definitive rationale(s) for why nurses chose not to participate. The variables leadership style and shared governance were chosen to study, due to the lack of research in the healthcare literature exploring the relationship between the two variables.

Acute care hospitals in the United States were chosen as the setting for the study, as the genesis of shared governance is from within acute care hospitals. The preponderance of the literature on shared governance is also reflective of acute care hospitals in the United States. In addition, the lack of participation in shared governance,

documented in the literature (Graham-Dickerson et al., 2013; Scherb et al., 2011; Wheeler & Foster, 2013) is from acute care hospitals in the United States.

The use of a quasi-experimental design and lack of randomization from the total population of nurse managers limited the generalizability of the study. Due to the potentially large but unknown number of participants in the sample, the study was limited to a random sample of nurse managers who are members of the American Organization of Nurse Executives (AONE). The exact number of participants in the total sample of nurse managers in acute care hospitals was unknown which challenged the issue of external validity. At the outset of the study it was unknown if the sample from AONE was representative of the total population of nurse managers working in acute care hospitals in the United States.

Limitations

Limitations are issues beyond the control of a researcher and likely to affect the outcome of the study (Rouleau-Carroll, 2014). There were inherent limitations in the research conducted in this study. These included completion of the study by the intended participant, candor of the participant, demographic representation of the sample, knowledge of the topic under study, and the use of self-reported data.

Initial limitations in the current study were the completion of the survey by the intended participant and the candor of the participant. In this study, the possibility existed that the nurse manager may have provided socially desirable answers to the survey questions. It was unknown if the managers who chose to respond to the survey felt more or less strongly than those that did not choose to participate in the study. The validity of

the data received could not be verified, due to the maintenance of confidentiality of the participants.

In this study I utilized data that was self-reported by the nurse manager relative to the assessment of leadership style and unit governance. Nurse managers tend to rate themselves as more transformational or transactional than their staff members rate them (Andrews, Richard, Robinson, Celano, & Hallaron, 2012; Bormann & Abrahamson, 2014). In addition, nurse managers in high intensity units, such as critical care and oncology, tend to be more transactional than nurse managers in lower acuity settings, such as medical-surgical nursing, who tend to be more transformational (Aboshaiqah et al., 2014; Wang, Oh, Courtright, & Colbert, 2011). The use of a random sample does not allow for the control of the demographics of the sample size. This includes demographics such as gender, age, educational level, or work setting.

The study used a random sample of nurse managers who are members of AONE from acute care hospitals in the United States. It is possible that members of AONE may have known more about the topic of the study than other nurse managers who were not members. It is also possible that nurse managers in acute care hospitals in the United States may have known more about the topic of this study than nurse managers from other types of hospitals or from other countries. The data collection period for the study was eight weeks and the study closed even though the needed sample size had not been achieved.

In an attempt to diminish the limitations of bias, the survey was constructed using demographic information and two instruments that had demonstrated reliability and

validity; the IPNG and the MLQ 5X short. The demographic questions were reflective of findings in the literature. To reduce response bias, the researcher used an email survey process.

Significance of the Study

Researchers have stipulated in the literature that shared governance and transformational leadership are empowering for direct care registered nurses. Currently, there is a single reported study in the healthcare literature on the relationship between leadership style and the enculturation of shared governance. The assessment of the significance of the study was to not only reduce the gap in the healthcare literature, but also to explore the link between leadership style and shared governance. Exploring this link may assist organizational leadership in identifying why direct care registered nurses are unwilling to participate in shared governance. In this study I explored the influence of direct supervisor leadership style on cultivating a satisfying work environment for direct care registered nurses and examined if participation in shared governance impacts transformational leadership style.

Understanding the impact of leadership on creating a positive work environment is critical to healthcare leadership; especially in light of the projected shortage of registered nurses. Cultivating a work environment that is autonomous and empowering creates greater stability in the workforce. Job satisfaction and retention of direct care registered nurses is significant to the profession of nursing, to the healthcare system, and to the community the healthcare system was intended to serve. For organizational leadership, the results of this study could advance a greater understanding of the

significance of nurse manager leadership style and the ability of the nurse manager to engage direct care registered nurses in the shared governance process.

Significance to Social Change

The study may have implications for positive social change. In this study I examined factors in the work environment which influence direct care registered nurse job satisfaction and retention. Direct care registered nurses are choosing not to participate in shared governance (Graham-Dickerson et al., 2013; Scherb et al., 2011; Wheeler & Foster, 2013), this creates a void in the nurse manager's ability to represent the needs of the direct care registered nurse at the organizational table. This diminishes the autonomy and empowerment of the registered nurse. Through the use of a transformational leadership style and a participative work environment, nurse managers facilitate the autonomy and empowerment of direct care registered nurses.

The healthcare system has been traditionally a mechanistic and hierarchical system. Shared governance has pushed healthcare to become more organic and less hierarchical. Through the use of a shared governance structure and process, direct care registered nurses have autonomy over their professional practice environment (Porter-O'Grady, 2012; Varjus et al., 2011). The shared governance model places decision making at the point of service, rather than in the c-suite. When implemented fully, shared governance creates a more positive and productive atmosphere for direct care registered nurses and provides better quality outcomes for patients (Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013).

Nurse manager leadership style has been linked to the engagement and retention of direct care registered nurses (Feathers et al., 2015; Gillet et al., 2013; Jacobs et al., 2013). Transformational leaders create work environments that are empowering and encourage autonomy (Hutchinson & Jackson, 2013). Open dialogue, responsiveness, and perceptions of caring are characteristic of transformational leaders; when these characteristics are manifested by nurse managers they foster staff engagement in the work environment (Gillett et al., 2013; Jacobs et al., 2013).

The healthcare environment in the United States is undergoing change. It requires nursing leaders who can lead this change, create a vision of the future, and engage others to support the changing environment (Herman, Gish, & Rosenblum, 2015). Jurascheck et al. (2012) identified there will be a shortage of 1,016,900 registered nurses in the United States healthcare system by 2020. The NSSRN documented 11.1% of United States registered nurses are dissatisfied with their job (USDHHS, 2010). Kovner et al. (2014) found 33.5% of newly licensed registered nurses will leave their job within two years. Nurses are not satisfied with their professional practice environment. The potential for organizational disruption is significant, due to a lack of stability in the workforce and the cost of continual turnover.

In this study I examined the relationship between the leadership style of the nurse manager and the enculturation of shared governance, an identified gap in the healthcare literature. The study is amenable to scientific study and has implications for positive social change. Creating a professional practice environment that is autonomous and empowering to direct care registered nurses fosters job satisfaction and retention

(Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013). A stable and retained nursing workforce results in positive patient outcomes and decreased organizational turnover costs (Spence-Laschinger et al., 2014; Vargus et al., 2011).

Summary

The retention of direct care registered nurses in acute care hospitals impacts the ability of the healthcare system to deliver quality care to the community it was established to serve. Current trends in retention and projected future shortages of registered nurses add complexity to the problem of their retention. The purpose of the study was to examine two factors which had the potential to impact the retention of direct care registered nurses; leadership style and unit governance.

Although nurse manager leadership style and shared governance have individually demonstrated the ability to retain direct care registered nurses, there is a gap in the literature examining the relationship between the two variables. Additionally, current literature has reported challenges for nursing leadership in engaging direct care registered nurses in shared governance; it is unknown if nurse manager leadership style impacts the enculturation of shared governance. It is also unknown if achieving a shared governance score the participation subscale of the IPNG is related to nurse manager transformational leadership style.

In Chapter 1, I provided an introduction to the research study which explored the relationship between nurse manager leadership style and the enculturation of shared governance. This was a quantitative study using a cross-sectional, correlational design, conducted with a random sample of nurse managers working in acute care hospitals in the

United States. Chapter 2 provides a critical review of literature, the theoretical framework, and the critical analysis of the variables.

Chapter 2: Literature Review

Introduction

Healthcare organizations in the United States are sitting on the precipice of a significant shortage of direct care registered nurses with the projected demand expected to exceed the supply available. By the year 2020, the United States is projected to have a shortage of 1,016,900 registered nurses and the shortage is projected to continue to escalate through 2030. By this time all but two states, in the United States, are projected to experience a profoundly significant nursing shortage of a proportion and scale not witnessed before in healthcare (Jurascheck et al., 2012). The projected shortage of registered nurses has the potential to disrupt the delivery of healthcare.

In the 2008 National Sample Survey of Registered Nurses (NSSRN) researchers found that 11.1% of United States registered nurses were dissatisfied with their job. A significant number of nurses reported workplace issues, such as lack of good management and inadequate staffing as sources of dissatisfaction (USDHHS, 2010). Over 17% of newly licensed nurses will leave their first job within 1 year and 33.5% within 2 years (Kovner et al., 2014).

In addition to the projected shortage, direct care registered nurses in the United States are not satisfied with leadership and the work environment. Improvements in the work environment have been associated with lower rates of nurse burnout, intention to leave current position, and job dissatisfaction (Kutney-Lee et al., 2013). Empowerment, autonomy, nurse manager ability and leadership, staffing and resource adequacy, and collaborative relationships between the nursing and medical staff are factors which create

a positive practice environment for registered nurses (Feather et al., 2015; Fernet et al., 2015; Twigg & McCulloch, 2014).

Shared governance, a professional practice model of participative decision making between direct care registered nurses and the nurse manager, has been initiated and evolved in acute care hospitals over the last 30 years. This professional practice model has been found by researchers to be a source of empowerment and autonomy for direct care registered nurses. Researchers have associated a dynamic shared governance model with job satisfaction, retention, and positive patient outcomes (Bamford-Wade & Moss, 2010; Barden et al., 2011; Fernet et al., 2015; Hutchinson & Jackson, 2013). In the contemporary literature, researchers have documented a lack of participation in shared governance by direct care registered nurses (Hess, 2011; Wheeler & Foster, 2013). Researchers have also cited direct care registered nurses' unwillingness to be involved in decision-making (Graham-Dickerson et al., 2013; Scherb et al., 2011). The reason for this change in direct care staff behavior is unknown.

The purpose of this nonexperimental, quantitative, cross-sectional study was to test the theory of transformational leadership that relates nurse manager leadership style to the enculturation of shared governance in acute care hospitals in the United States. The independent variable was leadership style. Leadership style was defined as the way in which the leader provides directions, implements plans, and motivates people (Lin, MacLennan, Hunt, and Cox, 2015). In this study, leadership style was derived from Bass' (1985) full-range leadership theory which identifies three primary leadership styles: transformational, transactional (active and passive), and laissez-faire. The dependent

variable of shared governance in this study was defined as a formal structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimize the direct care registered nurses power over their professional practice (Hess, 1994).

Horstmeier et al. (2014) found in a meta-analysis on effects of transformational leadership on identification at work, there was a stronger relationship between transformational leadership and leader identification than between transformational leadership and organizational and team identification. Nurse manager leadership style has the ability to positively influence the work environment (Kramer et al., 2007; Twigg & McCulloch, 2014). The leadership style of the manager influences direct care registered nurse job satisfaction and retention (Bormann, 2011; Feather et al., 2015). The nurse manager's leadership style is associated with the psychological and structural empowerment of direct care registered nurses. Researchers also stipulate that shared governance and transformational leadership are associated with empowerment, job satisfaction and retention of registered nurses (Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013). With the projected shortfall of registered nurses, it has become essential for leaders in healthcare organizations to be able to provide direct care registered nurses with a work environment that is empowering and satisfying as this positive work environment cultivates retention, increases patient safety and quality, and decreased turnover costs for the organization (Bamford-Wade & Moss, 2010; Barden et al., 2011).

In Chapter 2 I have explored the healthcare literature and the key variables of transformational leadership and shared governance, the theoretical framework used in the study. I have conducted a thorough analysis of the variables includes supporting and contrasting theories of leadership styles and shared governance. In the final section of Chapter 2, I have provided a summary and conclusion related to the gap in the literature and the need for the study. At the conclusion of Chapter 2, I have provided an introduction to Chapter 3.

Literature Search Strategy

The process of a systematic literature review began with a search of management and nursing databases. The management databases included: Business Source Complete, ABI Inform, Emerald Management Insight, and ProQuest Dissertation and Theses. The nursing databases searched included: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and Health and Medical Complete. Google Scholar was also used to search the literature; this search engine produced results ranging from 28,200 to 1,580,000 for various search terms.

Each database was searched for the following terms: *transformational leadership, transformational leadership and empowerment, transformational leadership and job satisfaction, transformational leadership and outcomes, transformational leadership and retention, transformational leadership and shared governance, shared governance, shared governance and empowerment, shared governance and job satisfaction, shared governance and outcomes, shared governance and retention, shared governance and nursing, shared governance, nursing and empowerment, shared*

governance, nursing and job satisfaction, shared governance, nursing and outcomes, shared governance, nursing and retention, IPNG and participation subscale, IPNG, participation subscale and transformational leadership, and finally, transformational leadership, shared governance, and nursing. The final search of literature by the researcher for the concepts of transformational leadership, shared governance, and nursing produced the least number of returns from all databases. A single study was found by the researcher using these search terms. The preponderance of literature available to the researcher in this search was from the implementation of shared governance in academia. Due to the limited number of results from searching transformational leadership, shared governance, and nursing, the positive outcomes of transformational leadership and shared governance were searched by the researcher. These outcomes included: empowerment, job satisfaction, and retention.

I searched the literature from the period between 1970 to 2016 for the concepts of transformational leadership and shared governance. Both concepts emerged in the literature in the 1970s; this initiated the timeline for the literature review. The databases were searched for scholarly and peer reviewed literature. There were 3,407 dissertations on transformational leadership from between 1980 through 2016; there were 1,261 dissertations that met the search criteria since 2011. A total of 828 dissertations were written on shared governance; there were 249 written from the period between 2011 and 2016.

Theoretical Foundation

The theoretical foundation for the study was transformational leadership and shared governance. In the 1970s, transformational leadership theory emerged as one of the neo-charismatic approaches to leadership. The concept of charisma is at the center of the neo-charismatic leadership paradigm (Dinh et al., 2014). The development of transformational leadership theory, as part of the neo-charismatic paradigm, is outlined in the following paragraphs.

Downton (1973) provided the first inspiration for the theory based on his examination of theories of leader-follower relations in the context of rebel leadership. He identified and analyzed three types of follower commitments—transactional, charismatic, and inspirational. Based on the work of Downton, Burns (1978) conceptualized transforming leadership in his analysis of political leaders. The focus of leaders was on the values and motivation they shared with their followers (Burns, 1978). When leaders exhibited this type of leadership, the lives of people and the organization were transformed. Transforming leadership redesigned the perceptions and values of followers. This led to followers changing their expectations and aspirations. In transforming leadership, the leaders and followers engaged in a synergistic way to raise each other to higher levels of motivation and morality (Burns, 1978). Burn's transforming leadership concept was drawn from Maslow's theory of human motivation (1943). Focusing on Maslow's hierarchy of needs, Burns felt transforming leaders could elevate followers from a lower level of need to a higher level, moving toward self-actualization.

Burns stated:

Leadership is a process of morality to the degree that leaders engage with followers on the basis of shared motives and goals—on the basis that is of the follower's 'true' needs as well as those of the leaders; psychological, economic, safety, spiritual, sexual, aesthetic, or physical. [Leaders] will supply a variety of initiatives, but only the followers themselves can ultimately define their own true needs. (Burns, 1978, p. 36)

Burns believed that leadership occurred in one of two ways, transactional or transforming. Transactional leadership was based on satisfying the self-interest of the leader and the follower. Transforming leadership engaged followers to get things done; the leader was a visionary change agent and the follower was "morally uplifted" to be a leader themselves (Burns, 1978). In transforming leadership, the collective interests of the group, organization, or society were of greater interest to the leader, than the leader's own self-interests. In Burns' view, transactional and transforming leadership were mutually exclusive of each other and existed on opposite ends of the spectrum.

Extending the work of Burns (1978), Bass (1985) applied the theory of transforming and transactional leadership to business organizations. He felt that existing theories of leadership were principally focused on the follower. Bass' focus was on the psychological mechanisms underlying transforming and transactional leadership; they were theoretical approaches of behavior. He named this approach, transformational leadership.

Bass (1985) differed from Burns (1978) in his belief that transactional and transformational leadership could be displayed simultaneously by the leader.

Transactional leadership was limited to addressing only basic exchanges with followers and was focused on catering to the follower's self-interest (Piccolo et al., 2012). This type of leadership worked well during times of stability and stable exchange. Many times transactional leadership takes the form of contingent reward with the leader directing the follower as to what needs to be done in order to receive reward (Piccolo et al., 2012). Transactional leadership focused on the development of a trusting relationship between the leader and the follower (Bass, 1985). Bass believed there needed to be a paradigm shift which focused on how leaders influenced followers to transcend self-interest for the greater good of the organization in order to achieve optimal levels of performance. To change the goals, needs, and pretensions of followers, Bass believed transformational leaders needed to work cooperatively with followers to increase the level of motivation and work morale.

Bass (1985) defined transformational leaders as people who achieve the highest performance from followers while promoting the development of the individual members of the group and the organization. Transformational leadership established greater confidence in the members of the group and emphasized focus and attention on the key issues of the organization. This type of leader aligned the objectives and goals of the individual followers with the goals of the organization (Bakker et al., 2012) and provided support and mentoring to the followers. Transformational leadership was appropriate in times of disequilibrium. During situations when instability was present, transformational

leaders were better equipped to deal with the crisis by focusing on the creation of a vision and motivating followers (Mitchell et al., 2014; Piccolo et al., 2012).

Transformational leadership was driven by the charisma of the leader. It was enhanced by excellent communication and the promotion of intelligence. This type of leadership focuses on the treatment of each person within the group as an individual (Avolio & Bass, 2004). The transformational leader articulated a vision of the future that was shared, intellectually inspired subordinates, and was responsive to the differences among subordinates (Dinh et al., 2014).

Ellemers et al. (2012) identified that transformational leaders build on inspiring followers more than transactional leaders. They go beyond simple exchanges and agreements. According to Bass' theory (1985), the transformational leader is focused on achieving superior results by employing one or more of the four factors or attributes of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration.

Idealized Influence

The concept of idealized influence focused on the charisma of the leader. Charisma enabled the leader to influence followers by arousing strong emotions in followers and fostering follower identification with the leader (Bass, 1985). In this attribute, the leader was seen as a role model for the follower. The follower trusts and respects the leader. The personal integrity of the leader was a critical aspect of the leaders' ability to sell themselves and the vision to followers. The followers want to emulate the leader and internalize the leaders' ideals. Due to the trust, admiration, and

loyalty the followers felt toward the leader, they were willing to work harder than originally expected to achieve the mission and vision communicated by the leader. The leader was visible to the followers and their behaviors and attitudes demonstrated to followers how to behave. There was constancy to the leader's efforts to motivate and rally the followers. It was this unswerving commitment that propelled followers forward in challenging times. Through the use of idealized influence, the transformational leader was able to get followers to commit and recommit to the vision to keep them on track.

Inspirational Motivation

Inspirational motivation focused on the leader's ability to articulate a clear and compelling vision to followers. The leader communicated the vision with passion to ignite the followers desire to be part of the successful vision. The compelling vision of the future state was one the followers can identify with; through this identification, followers commit to the achievement of a common goal and desire the feeling of success associated with achievement (Ellemers et al., 2012; Mitchell et al., 2014). The leader challenged the followers with high standards, communicated with optimism about the future, and provided meaning for the tasks at hand. This created a strong sense of purpose in the follower and the motivation to act. The group was propelled forward by purpose and meaning to achieve a vision that was understandable, precise, powerful, and engaging. Followers were willing to commit more to achieve goals, they were optimistic about the future, and they believed in their ability to achieve the vision articulated by the transformational leader.

Followers were willing to work harder to achieve goals which were greater than their individualized self-interests due to idealized influence and inspirational motivation from their leaders. The trust and loyalty in the leader, who articulated a compelling vision, created a desire in the follower to achieve more than self-gain. Through identification with the leader, the follower developed an identity which was connected to the inspirational mission and vision.

Intellectual Stimulation

The attribute of intellectual stimulation focused on the leader challenging the follower's basic thinking, assumptions, and models. The purpose of doing this was to get the follower to think about work performance in an innovative way. This concept moved away from theory X authoritarian management to advance the concept of the knowledge worker. Acknowledgement of the knowledge worker concept focused on the internal motivation of the individual rather than the idea of controlling workers to comply with work (Bakker et al., 2012).

The transformational leader challenged the status quo by encouraging creativity among followers. Followers were encouraged to explore creative ways of doing things and new opportunities to learn. The transformational leader encouraged followers to take risks and generate new ideas leading to greater creativity. The generation of new ideas was done in a supportive environment to encourage further risk taking. The leader fostered independent thinking through nurturing and development. They valued learning and saw unexpected situations as an opportunity for learning. Followers were encouraged

to ask questions, think deeply about issues, and design improved ways to execute their tasks.

Individualized Consideration

Individualized consideration was a critical attribute of transformational leaders. It was discussed by both Burns (1978) and Bass (1985). The leader became familiar with the follower's needs, capabilities, and aspirations as a function of individualized consideration. The leader challenged the followers to develop into leaders. Through understanding followers' needs and capabilities, the leader could systematically and reliably transform followers into leaders. This grew the followers to their full potential. Individualized consideration had roots in Maslow's hierarchy of needs (1943); the follower moved from lower level needs, such as psychological safety and security, to the higher level self-actualization needs, such as higher order personal development (Bass, 1985; Becker et al., 2012; Laschinger, 2014).

The transformational leader used individualized consideration to offer support and encouragement to followers. The leader fostered supportive relationships with the follower, functioned as a coach or mentor and listened to the follower's individual needs and concerns with empathy and support. Keeping the lines of communication open between the leader and the follower, the leader placed challenges in front of the follower. The follower openly shared ideas and solutions. The transformational leader demonstrated respect for and celebrated the unique contribution of the follower to the team. This created a desire and aspiration for continued self-development in the follower and drove intrinsic motivation to achieve greater goals.

The combination of intellectual stimulation and individualized consideration drove the transformational process in transformational leadership (Becker et al., 2012; Ellemers et al., 2012). The leader needed to know the follower's needs, capabilities, and aspirations in order to understand how to get the follower to think differently. Inspirational motivation, and charisma stimulated an urgency to change or transform in the follower. This transformational leadership process allowed great change in organizations, communities and societies (Ellemers et al., 2012; Mitchell et al., 2014).

Bass' (1985), original theory of transformational leadership included the four transformational leadership attributes, known as the "Four I's" and two transactional leadership attributes. Studies conducted from 1985 to 1990 facilitated the evolution of the theory of transformational leadership into a "full-range leadership theory" (Avolio & Bass, 2004). The full-range leadership theory encompassed three primary types of leadership behavior: transformational, transactional (active and passive), and laissez-faire. These types of leadership behavior were measured across nine attributes using the Multi-factor Leadership Questionnaire (MLQ). Transformational leadership style was crucial to strategic development with the organization (Dinh et al., 2014; Top, Akdere, & Tarcan, 2015; Vaccaro, Jansen, Van Den Bosch, & Volberda, 2012).

Shared Governance

Shared governance was a formal structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimized the direct care registered nurses power over their professional practice (Hess, 1994). It was through

participative management structures which nurses can exercise professional autonomy by managing their practice (Porter-O'Grady, 2012). This shared decision-making model was based on the principles of accountability, partnership, equity, and ownership (Porter-O'Grady, 2012; Swihart & Hess, 2014).

The concept of shared governance was first introduced by Christman in 1976. He stipulated that “responsibility and accountability for establishing standards, controlling negative sanctions where professional shortfalls occur, are signs of full maturity in a profession” (Christman, 1976, p. 37). Christman (1976) believed that hospital nurses should have an autonomous nursing practice model. He advocated that nursing should have an organizational voice equal to that of physicians (Christman, 1976).

The 1974 Health Care Amendments to the National Labor Relations Act allowed nurses to engage in collective bargaining. Cleland (1978) began writing about the importance and significance of the opportunity for nurses to shift the power based in healthcare organizations from hospital administrators to nurses who perform the work at the patient's bedside. Borrowing from the participative management shared governance model in academia, Cleland (1978) first used the term shared governance as the framework for nursing governance in collective bargaining healthcare organizations. She believed that collective bargaining was essential to self-direction of the nursing profession and that nurses needed a new framework for relating to the organization while maintaining professional autonomy. This framework was based on the university model of faculty governance and distributed power between the union, the profession, and the organization (Cleland, 1978).

Collective bargaining in nursing never evolved to the levels anticipated during the late 1970s. Decentralization and participative management structures in organizations characterized organizations in the 1980s (Hess, 2004). During this time, shared governance designs grew in acute care hospital settings. The structures and processes of shared governance varied tremendously from organization to organization. By 1992, there were more than 1,000 United States hospitals with shared governance structures and processes in place (Porter-O'Grady, 2012). The models were varied and were a reflection of the individual organizational cultures in which they resided.

Attempts to measure shared governance had been limited. Surveys regarding committee composition and activities, conducted at single hospital systems, comprised the initial attempts at measuring the impact of shared governance (Wilson, 2013). Evidence of shared governance was difficult to measure. Hess (1994) developed the first tool designed to measure professional nursing governance by hospital-based nurses. The Index of Professional Nursing Governance (IPNG) classified hospital governance as traditional, shared, or self, based on the distribution of governance between nursing administration and direct care registered nurses. The 86-item instrument has achieved reliability and construct, empirical, and content validity. The IPNG has been used in multiple hospitals as a tool to evaluate the pre- and post-implementation of shared governance. With the development of the IPNG, a tool was now available to measure governance within organizations.

Transformational Leadership and Shared Governance

Transformational leaders are proactive and strive to change the organizational culture through innovation. Employees achieve objectives through higher ideals and moral values. Transformational leaders believe followers to be trusting, respectful, and self-motivated. The transformational leader motivates the followers by encouraging them to put the group interests ahead of individual self-interest. In transformational leadership, each employee is given individualized consideration and support. Leaders supply followers with the tools needed to be successful on the job. The transformational leader uses creative innovation and “out of the box” thinking for problem solving. This type of leader goes beyond the day-to-day management operations and crafts strategies to take the organization to the next level of performance. They also set goals to move employees to higher levels of performance, while providing opportunity for personal and professional growth.

The foundation of shared governance resides in the principles of accountability, partnership, equity, and ownership (Porter-O’Grady, 2012). Shared governance, irrespective of the organizational model, has the ability to foster empowerment, autonomy, job satisfaction, and retention of direct care registered nurses (Hastings, Armitage, Mallinson, Jackson & Suter, 2014). It is the hallmark of the professional practice of nursing (Porter-O’Grady, 2012).

Transformational leadership theory was an appropriate lens to view the current study. The theory postulated the charismatic nature of the leader motivated the follower to achieve organizational goals. The synergy created between the leader and follower

created a dynamic, which allowed the leader and follower to aspire to higher levels of organizational success. The interconnectedness between the leader and the follower fostered the ability to create and sustain a culture, which was nurturing, empowering, and satisfying to the follower.

In this research study I examined the relationship between transformational leadership style and the enculturation of shared governance. The results of the study provided further evidence that the transformational leadership style of the nurse manager fostered empowerment of the direct care registered nurses to create and sustain the empowering structure of shared governance. Shared governance is a structure that allows the direct care registered nurse to have control and decision making authority over the environment in which they practice. This structure aligns with the tenets of transformational leadership. Shared governance assists in creating a unified vision for the nursing unit and this vision is shared by the nurse manager and the staff on the unit. The shared governance structure and the resulting processes, facilitated by the transformational nurse manager, inspire and motivate the direct care registered nurses to achieve greater outcomes. The nurse manager, exhibiting transformational leadership, focuses on the individual needs of the direct care registered nurses, so the goals achieved are fulfilling for both the nurses, the nurse manager and the organization. Shared governance is a structure which encourages direct care registered nurses to see beyond their personal self-interest for the common good of the unit and the organization.

Transformational Leadership and Shared Governance Theoretical Framework



Figure 1. Theoretical framework for the study indicates the presence of transformational leadership and shared governance in the work environment leads to job satisfaction and retention of direct care nursing staff (Keane, 2014).

Theoretically, nurse managers demonstrating a transformational leadership style should be able to develop the empowering structure of shared governance (see Figure 1.0). In the literature researchers have found a significant positive impact of the transformational leadership style of the nurse manager and the positive impact of shared governance; however, there are no studies in the contemporary healthcare literature about the relationship between the two variables. Exploring the relationship between nurse

manager leadership style and the enculturation of shared governance was the first step in understanding why direct care registered nurses are choosing not to participate in shared governance activities.

Literature Review

Transformational Leadership

The independent variable of transformational leadership style was defined as a leadership style which alters the norms and values of employees motivating the workers to perform beyond their expectations (Tims, Bakker, & Xanthopoulou, 2011). This leadership style is strongly influenced by the concepts of charisma and leader influence. Transformational leadership is an engaging form of leadership in which leaders develop followers by creating a vision that provides meaning and motivation (Fernet et al., 2015; Mitchell et al., 2014; Piccolo et al., 2012). Transformational leaders build a strong sense of identification with the organization through the communication of an inspired vision that challenges followers to transcend personal self-interest in pursuit of achieving the vision. Zhu et al. (2011) described transformational leadership as a human-capital-enhancing resource management style.

Van Knippenberg & Sitkin (2013) linked transformational leadership style to psychological empowerment of followers. Tims et al. (2011) and Zhu et al. (2011) found that transformational leadership enhanced work engagement. Bakker et al. (2011) and Kopperud, Martinson, & Humborstad (2014), found that work engagement, enhanced by transformational leadership, enhanced personal health, job-related attitudes, extra-role behaviors, job satisfaction, retention, role performance, learning motivation, and

organizational commitment. Transformational leadership has also been found to reduce workplace stressors and increase role performance (Zhang, LePine, Buckman, & Wei, 2014). Transformational leaders provide competence and consideration during times of workplace stress, which assists the follower in viewing the stressor as a stretch opportunity rather than an impossible task. The transformational leader creates a deeper understanding and appreciation of developmental opportunities and long term goals within the organization (Zhang et al., 2014).

Transactional leadership shapes the direction of the employee interaction; it provides structure to the exchange. This type of leadership becomes transformational when the leader cultivates a collaborative relationship with the employee around a shared vision (Avolio & Bass, 2004; Mitchell et al., 2014). The collaborative relationship becomes mutually beneficial to the employee and the leader. The employee moves toward self-actualization. The employees' realization of their greater potential amplifies self-esteem and motivates the employee to accomplish more than was previously thought possible (Becker et al., 2012; Piccolo et al., 2012). It is through the use of idealized influence, intellectual stimulation, inspirational motivation, and individualized consideration that the leader encourages employees to exceed expectations (Ellemers et al., 2012). Transformational leadership is measured by the MLQ developed by Avolio and Bass (2004).

Transformational leadership and nursing. The empirical evidence suggests there are significant organizational benefits associated with transformational leadership (Carter et al., 2012; Wong et al., 2013). Within nursing, transformational leadership is

cited as the most commonly employed style of leadership. In a systemic review of the literature on leadership in nursing, Wong et al. (2013) found that 53% of the studies reviewed examined transformational leadership style.

Cowden et al. (2011) conducted a systematic review of the literature and found that relational leadership styles, such as transformational leadership, significantly impacted staff nurse retention. Similarly, a systematic literature review conducted by Lartey et al. (2014) found that transformational leadership style had a significant positive impact on experienced registered nurses' retention. These findings are consistent with Blake et al. (2013) who examined pediatric intensive care nurses intent to leave. The researchers found a statistically significant ($p < .05$) relationship between transformational leadership style and intent to leave.

Fergus (2012) in a quantitative study using a cross-sectional, research design, surveyed 203 direct care registered nurses working in an acute care, unionized hospital, on the relationship between nurse manager leadership style and staff nurse empowerment and retention. A significant relationship between transformational and transactional leadership styles and direct care registered nurse psychological and structural empowerment was identified. There was also a significant relationship between nurse manager leadership style, empowerment, and staff nurse retention.

Casida and Parker (2011) conducted a quantitative correlational research study on nurse manager leadership style and the outcomes of leader's extra effort, leadership satisfaction, and effectiveness. A total of 278 direct care registered nurses from four hospitals in the Northeastern United States were asked to rate the leadership styles of 37

nurse managers using the MLQ 5X short. Transformational leadership strongly predicted the outcomes of: leaders' extra effort, leadership satisfaction, and leadership effectiveness ($p < .0001$). The attributes of individualized consideration and idealized influence (attributed) were strong contributors to transformational leadership being a predictor of leadership outcomes. There were strong correlations between transactional leadership with contingent reward and the leadership outcomes, but this leadership style was not predictive of any of the leadership outcomes. Leadership effectiveness and satisfaction by direct care registered nurses is achieved through the use of a transformational leadership style.

Lin et al. (2015) conducted a cross-sectional survey study of 651 direct care registered nurses working in public, private, and religious hospitals in Taiwan. The study examined the relationship between the transformational leadership style of the supervisor and the quality of nurses' working lives. The study, similar to the findings of Fergus (2012), Casida and Parker (2011), and Wong et al. (2013) found that the use of a transformational leadership style by the direct supervisor had a positive influence of job satisfaction of direct care registered nurses. Supervisors exercising transformational leadership were found to be perceived as more supportive of the nursing staff. The perception of workplace support was a significant mediator variable between transformational leadership and job satisfaction.

Fernet et al. (2015), found that transformational leadership style, in nursing and among school principals, lead to favorable job attitudes and performance. Job satisfaction was related to the perception of more resources, less demands, and greater autonomous

motivation. Autonomous motivation reflects the employee's engagement with the organization due to satisfaction and pleasure surrounding the importance and value the employee places on the tasks for which they are responsible (Wang & Gagne, 2013). Affecting the employees' perception of the work environment, the transformational leader also impacts employee attitudes, performance, and psychological health (Nielsen & Daniels, 2012). Kovjanic, Schuh, Jonas, Van Quaquebeke, and Van Dick (2012) demonstrated transformational leadership was related to job satisfaction and commitment through the satisfaction of employees' needs of autonomy, competence, and relatedness.

A nonexperimental, cross-sectional, national survey was conducted by Drenkard (2005) which examined the relationship between transformational leadership of nurse managers and anticipated turnover of direct care registered nurses. A national mailing of a survey was distributed to the 1,500 members of the American Nurses Association (ANA) containing the MLQ 5X short and the Hinshaw and Atwood Anticipated Turnover Scale. The results returned a total of 344 surveys, with 280 from direct care registered nurses. The study found a moderate inverse, but statistically significant correlation between transformational leadership characteristics of nurse managers and anticipated turnover of direct care registered nurses. The characteristics included: idealized influence ($r=-.39, p<.001$), intellectual stimulation ($r=-.36, p<.001$), individualized consideration ($r=-.34, p<.001$), and inspirational motivation ($r=-.28, p<.001$). Idealized influence ($p<.001$) and Magnet® designation ($p=.004$) best predicted the turnover of registered nurses.

Additionally, Wong (2015) found that relational leadership styles, such as transformational leadership were most often associated with positive outcomes for staff and patients. Transformational leadership promotes organizational and personal change (Fernet et al., 2015; Gabel, 2012). The use of a transformational leadership style by the leader was associated with lower registered nurse burnout, increased satisfaction with leadership, and increased staff satisfaction (Munir, Nielsen, Garde, Albertson & Carneiro, 2012). Transformational leaders have also demonstrated the ability to improve the quality of patient care, improve patient safety, lower patient mortality, and enhance the work environment (Clavelle, Drenkard, Tullai-McGuinness, & Fitzpatrick, 2012; Ma, Shange, & Bott, 2015; Wong et al., 2013). Lievens and Vlerick (2014) found that transformational leadership significantly influenced safety performance and promotion. Transformational leadership significantly and positively influenced compliance with safety procedures ($p=.01$) and promotion of a culture of safety ($p=.01$). The more transformational the leader was perceived the more nurses participated in safety ($p<.001$). Paquet, Courcy, Lavoie-Tremblay, Gannon, and Maillet (2013) demonstrated that perceived manager support, through transformational leadership, was associated with reduced absenteeism, overtime, and nurse-to-patient ratios which led to decreased medication errors and patient length of stay. Hannah, Sumanth, Lester, and Cavarretta (2014) stipulated that transformational leadership behaviors engaged followers and created positive outcomes. Staff were engaged as active participants in organizational outcomes while maintaining self-determination (Hannah et al., 2014). These results suggest transformational

leadership is associated with multiple significant outcomes for direct care registered nurses.

Merrill (2011) conducted an exploratory, descriptive, correlational design study in a nine hospital healthcare system which examined the relationship among nurse manager leadership style, span of control, staff nurse practice environment, safety climate, and nurse-sensitive patient outcomes. There were 466 direct care registered nurses and 41 nurse managers who participated in the study. The study utilized the MLQ 5X short, the Hospital Unit Safety Climate Survey, the Practice Environment Scale (PES) from the National Database of Nursing Quality Indicators (NDNQI), the NDNQI nurse sensitive patient outcomes, and a demographic questionnaire. The study found a statistically significant positive relationship ($r=.582, p=.037$) between the PES in critical care and transformational leadership style of the nurse manager. There was also a statistically significant negative relationship ($r=-.636, p<.05$) between laissez-faire leadership style and the PES. In the non-critical care setting, transformational leadership was positively associated with safety climate.

Meyer et al. (2011), conducted a descriptive correlational study on the impact of nurse manager leadership style, time in staff contact, satisfaction with supervision, and span of control. The study examined a convenience sample of 558 nurses and 31 front-line nurse managers from 51 clinical areas at four acute care hospitals. Span of control ranged from 29.0 to 174.3 direct report employees, with one-third of the nurse managers having over 90 direct reports. The study revealed that transformational leadership had a positive main effect on satisfaction with supervision ($p=.003$). The impact of

transformational leadership and satisfaction with supervision varied based on span of control. When the nurse manager had a wide span of control, satisfaction with supervision was lower, despite the manager exhibiting a transformational leadership style. When span of control was lower, satisfaction with supervision was higher ($p=.024$) when the manager exhibited a transformational leadership style. Nurse managers exhibiting a transformational leadership style that had less time in staff contact had lower satisfaction with supervision scores than managers who exhibited a transformational leadership style, but who had more time in contact with staff.

Andrews, Richard, Robinson, Celano, and Hallaron (2012) conducted a cross-sectional descriptive study using a survey design to examine direct care registered nurse and nurse leader perceptions of leadership style and satisfaction with leadership at a pediatric-hospital in the Southeastern United States. A total of 16 supervisors and 179 supervisees completed the MLQ 5X short. Direct care registered nurses perceived leaders as exercising transformational leadership; with statistically significant means for idealized behaviors ($p<.001$), inspirational motivation ($p<.001$), and extra effort ($p<.001$). There were differences in leader-staff congruence in interpretation of leadership style based upon the role within the nursing department. Senior nursing leaders, nurse managers, and practice council chairs were perceived as more transformational than assistant nurse managers, who handled day-to-day operations at the unit level. Assistant nurse managers were perceived more often as transactional, rather than transformational. There was a statistically significant ($p<.01$), correlation between differences in perception of leadership style and satisfaction with leadership.

Casida, Crane, Walker, and Wargo (2012) conducted a descriptive correlational study on the relationship between direct care registered nurse perceptions of nurse manager leadership style and the nursing unit's culture. The study found that nurses educated at the baccalaureate level or higher had favorable perceptions of their nursing unit's performance and viewed the nurse manager's leadership style differently than direct care nurses with associates or diploma degrees. Nurse managers displaying transformational leadership behaviors achieved higher performance outcomes. Transformational nurse managers developed flexible unit cultures which were adaptable to changes within and outside of the nursing unit.

Ross, Fitzpatrick, Click, Krouse, and Clavelle (2014), in a descriptive correlational study on transformational leadership, found that nurse leaders educated on transformational leadership style were more likely to exhibit transformational leadership style. These findings are consistent with the findings of Andrews et al. (2012) and Ross et al. (2014), who found that senior nursing leadership, such as the chief nursing officer (CNO) and directors, were perceived as transformational more often than nurse managers. Nurse managers had also received the least amount of education on transformational leadership, when compared to directors and the CNO. When receiving education on transformational leadership, the nurse manager integrates this education into practice on the unit to exhibit a transformational leadership style. The position of the nurse manager role on the unit and the managers' responsibilities for day-to-day operations has influenced direct care staff perceptions of the exhibition of

transformational versus transactional leadership styles (Andrews et al., 2012; Meyer et al., 2011).

Researchers have shown that transformational leadership in nursing influences many positive outcomes. It is associated with staff satisfaction, positive role performance, positive work environment, and retention (Drenkard, 2005; Fernet et al., 2015; Munir et al., 2012). For patients receiving care from registered nurses, it is associated with better quality outcomes and a safer environment (Clavelle et al., 2012; Hannah et al., 2014; Lievens & Vlerick, 2014; Paquet et al., 2013). It is also important to note, perceptions of transformational leadership are influenced by the educational level of the direct care nurse (Casida et al., 2012). The perception of transformational leadership is impacted by span of control (Merrill, 2011; Meyer et al., 2011) and position within the nursing hierarchy (Andrews et al., 2012; Ross et al., 2014).

The transformational leader has the ability to create a positive work environment which leads to the achievement of positive patient and staff outcomes (Clavelle et al., 2012; Ma et al., 2015). The positive work environment fosters perceptions of autonomy and empowerment for the direct care nurse (Fergus, 2012; Hannah et al., 2014; Kovjanic et al., 2012). Transformational leadership style relies heavily on communication, responsiveness, and caring (Feathers et al., 2015; Hastings et al., 2014). This participative leadership style aligns well with the structure of shared governance.

Shared Governance

Following World War II, the concept of organizational democracy began to emerge in business and industry. Organization democracy advanced the idea of

participative management within the organization (Cheung & Wu, 2014). The use of participative management leadership and a participative work environment by organizational leaders demonstrated to employees that they were valued as an organizational stakeholder who had the knowledge, skills, and abilities to identify and resolve organizational challenges. The use of participative management by organizational leaders promoted the empowerment, engagement, job satisfaction, and retention of the knowledge worker (Cheung & Wu, 2014; Pansare & Mohammadi, 2014). When implemented successfully by leaders, participative management styles and structures allow businesses to gain a competitive advantage (Pansare & Mohammadi, 2014; Zoghi & Mohr, 2011). Leaders from corporate giants such as Proctor & Gamble, General Motors, General Electric, and Toyota found the use of participative management strategies significantly increased productivity (Alden, 2012).

Participative management was introduced into healthcare in the late 1970s. The faculty governance concept, also known as shared governance, was transplanted into healthcare via scholar-practitioners (Cleland, 1978). Shared governance was implemented in the acute care hospital environment as an attempt to recognize nursing as an autonomous profession (Christman, 1976).

Shared governance, the dependent variable in the current study, is defined as a formal structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimize the direct care registered nurses power over their professional practice (Hess, 1994). Shared governance is a

structural model through which nurses' practice with a higher level of professional autonomy (Barlow, 2013). The principles of accountability, partnership, equity, and ownership form the basis of the shared decision making model (Porter-O'Grady, 2012; Swihart & Hess, 2014).

Kennerly (1996) and Swihart and Hess (2014) described four configurations associated with shared governance:

- Unit-based models which are governance models customized to an individual nursing unit.
- Councilor models which use departmental level councils to coordinate clinical and administrative activities.
- Administrative models which uses an executive council to coordinate the activities of smaller councils.
- A congressional model in which all nursing staff are assigned to cabinets and work is directed to cabinets for completion.

Despite arriving in healthcare in the late 1970s, attempts to measure the presence of shared governance were limited. Early research focused on shared governance was conducted at single systems and examined the structure, activities, and the manifestation of management characteristics by direct care nurses. Researchers struggled to quantify the value and outcomes associated with shared governance (Hess, 1994). Porter-O'Grady (2012), a pioneer of shared governance, also felt it was a concept that was not measureable.

Hess (1994) designed the first tool to measure professional nursing governance by hospital-based nurses. Known as the Index of Professional Nursing Governance (IPNG), the IPNG addresses six dimensions of governance: “professional control over nursing practice, organizational influence of professionals over resources that support practice, organizational recognition of professional control and influence, facilitating structures for participation in decision-making, liaison between professional and administrative groups for access to information, and alignment of organizational and professional goals, and negotiation of conflict” (Hess, 1994, p. 13).

The instrument classifies hospital governance as traditional, shared, or self, based on the distribution of governance between nursing administration and the direct care registered nurses. The 86-item instrument has achieved reliability and construct, empirical, and content validity. The IPNG has been used in multiple hospitals as a tool to evaluate if the organization has achieved the successful implementation of shared governance.

The advent of a quantitative instrument to measure shared governance has led to an increase in the number of quantitative research studies on shared governance. Researchers continue to attempt to quantify the presence and outcomes related to the implementation of shared governance within the organization. The majority of studies on shared governance have been conducted in acute care hospitals with the population studied being registered nurses in various levels of organizational hierarchy.

In hospitals with and without shared governance, Anderson (2000) used the IPNG, the Reciprocal Empowerment Scale, and the Index of Work Satisfaction to

examine the difference in empowerment, professional governance, and job satisfaction among nurses. The researcher found that nurses working in the hospital with shared governance had significantly higher scores in overall governance, empowerment, and job satisfaction than nurses in a non-shared governance hospital. There was a moderate significant relationship between governance and job satisfaction and governance and empowerment in both groups.

Barden et al. (2011) had similar findings using the IPNG and the Conditions of Work Effectiveness II (CWEQ-II) at a tertiary care hospital in New York. A purposive sample of 158 nurses, across 13 clinical units which had a shared governance structure in place for six months to one year, participated in the study. The researcher found the nurses were in the early implementation phase of shared governance and perceived themselves to be moderately empowered. A statistically significant ($p < .0001$) relationship was found between perceptions of shared governance and empowerment.

Brody, Barnes, Ruble, and Sakowski (2012) conducted a qualitative, phenomenological study of staff nurse empowerment at six community hospitals in California that were part of a single health system. A total of 76 participants, including staff nurses, nurse managers, and nurse executives comprised the sample for the study. Five themes emerged as outcomes of the implementation of evidence based staff led practice councils: empowerment, meaningfulness, leadership growth, exposure to quality improvement, and vision. The researchers concluded that staff-led councils had the potential to improve the quality of care, job satisfaction, vision, and leadership, provided managers and executives are prepared to work with and support the councils.

Lu, Barriball, Zhang, and While (2012), in a systemic review of the literature on job satisfaction, had similar findings. The researchers found that job satisfaction was related to the work environment, role perception, organizational and professional commitment, and perceptions of empowerment within the work unit. Perceptions of autonomy and empowerment influence role perception and the work environment.

In a systemic review of the literature, Hastings et al. (2014) found that shared governance was associated with improved outcomes for the workforce. The outcomes identified included: decreased turnover, increased job satisfaction, and increased empowerment. Essential to achieving these outcomes were the need to build trust, increase communication, articulate a clear vision, and provide strong leadership.

In contrast, Kennerly (1996) conducted a longitudinal survey study at a Midwestern hospital to examine the effects of shared governance on nurse and non-nurse perceptions of the job and work environment. Data was collected from units implementing shared governance and units not implementing shared governance. Pre-implementation and post-implementation data was collected at baseline, six months and 18 months. The variables studied included: autonomy, organizational commitment, peer leader behaviors, role ambiguity and conflict, group conflict, anticipated and actual turnover, and unit and worker characteristics. The researcher found little differences in perception of the work environment for nurses and non-nurses on shared governance and non-shared governance units. Statistically significant differences were found in autonomy at six months; the increases were not sustained at 18 months. Job satisfaction, anticipated turnover, and perceived effectiveness were not significantly influenced by implementing

shared governance. The implementation of shared governance also did not increase role ambiguity or role conflict, but was found to increase intra-unit conflict.

Spense-Laschinger and Wong (1999) failed to find benefit from the presence of shared governance. In a cross-sectional correlational survey design study, Spense-Laschinger and Wong (1999) found that despite having a shared governance structure in place, registered nurses did not perceive themselves as empowered. This was due to the lack of authority to control their professional practice, which ultimately led to cynicism by the nursing staff and an unwillingness to participate in shared governance.

Consistent with the findings of Spense-Laschinger and Wong (1999), Howell et al. (2001) examined the IPNG scores from the Durham Veteran's Affairs (VA) Medical Center two years after implementing a formal shared governance program across the organization. Howell et al. (2001) found that despite implementation of shared governance, the IPNG score remained within the spectrum of traditional governance. Three of the six dimensions: nursing personnel, information, and goals, which related to organizational decision making, fell within the realm of traditional governance. The other three dimensions: resources, participation, and practice, which relate to basic nursing practice, were at or above the shared governance level. Although highly bureaucratic organizations pose challenges related to organizational decision making, unit-based decision making, related to nursing practice, was possible.

Similarly, Wilson (2013) conducted a descriptive study to examine the current state of shared governance at a three hospital healthcare system in Nevada that had a shared governance structure in place. The individual hospitals did not achieve scores on

the IPNG that indicated the presence of shared governance. The IPNG scores reflected traditional management structures with decisions being made primarily by management and administration for the total mean score and across all six subscales. An implemented a shared governance structure did not guarantee the presence of shared governance within the organization.

Schoombie (2013) conducted a quantitative descriptive exploratory design study at a tertiary hospital in Saudi Arabia. A random sample of direct care registered nurses and a nonprobability purposive sample of nurse managers explored whether an empowering shared governance structure would result in a high level of decisional involvement of direct care registered nurses. Schoombie (2013) found that direct care registered nurses had low levels of actual and preferred decisional involvement, implying that authority for decisions resides with the nurse manager. There was no statistically significant difference between direct care nurses and nurse managers overall perception of decisional involvement. Factors influencing decisional involvement included: educational level, experience, leadership style, work environment and a culture of shared decision making. Similarly, Ugur, Scherb, & Specht (2014) found no statistically significant difference in decisional involvement based on educational level or specialty certification. A convenience sample of 163 registered nurses from a Midwestern healthcare organization comprised of units with and without shared governance, participated in this descriptive comparative study. Actual decisional involvement indicated decisions were made primarily by management/administration. In contrast to Schoombie (2013), preferred decisional involvement indicated that a shared decision

making process between management and staff was preferred. The difference between actual and preferred decisional involvement was statistically significant ($p < .001$).

A qualitative descriptive study conducted by Graham-Dickerson et al. (2013) on direct care registered nurse perception of involvement in and impact of involvement on organizational and patient outcomes had findings similar to Schoombie (2013). The researchers sampled direct care registered nurses and CNOs from ten hospitals in Colorado. Seven themes were identified: collaboration, increased involvement, problem identification, formal/informal communication, accountability, autonomy in decision making, and empowerment. The findings indicated the involvement in decision making had a positive impact on the work environment. Both the CNOs and the direct care registered nurses felt giving nurses a voice increased satisfaction and empowerment. Getting staff involved and keeping staff engaged in the decision making process is challenging and fraught with barriers. Direct care registered nurses focus on problem identification and do not get involved in resolution, implementation of solutions, or evaluation. The perspective of the direct care registered nurse perspective was their role was problem identification and leadership's role is defining and implementing solutions (Graham-Dickerson et al., 2013).

Wheeler and Foster (2013) conducted a qualitative study of internationally educated and United States educated nurses at two southeastern urban hospitals to explore nurses' perceptions about participation in shared governance. The perspectives of internationally and United States educated nurses were similar. Both groups of nurses did not value participation in governance and did not feel it was worth their time nor did they

want to give up a day off to come in for meetings. Attending meetings while on duty was found to be next to impossible.

Participation in shared governance processes impacts the perception of the presence of shared governance. Hess (2011) found IPNG scores from a Midwestern hospital with shared governance in place, demonstrated that staff who were not involved in shared governance councils, rated the organization as possessing traditional governance with an IPNG score of 155.66. Those who participated in shared governance at the unit level scored 170.75 on the IPNG, those who participated in house-wide shared governance council scored the IPNG at 178.91, and nursing staff members who participated in both unit-based and house-wide councils scored the IPNG at 177.13 (Hess, 2011). These findings suggest a relationship between participation in shared governance and the perception of the existence of shared governance at the unit and organizational level.

In contrast, Overcash and Petty (2012) conducted a prospective, cross-sectional study at a Midwestern hospital to explore if perceptions of shared governance were related to nursing education, work experience, certification, employment position, setting, participation in shared governance, or age. The hospital scored in the shared governance range on the IPNG by the nurses. The variables of education, work experience, certification, employment position, setting, participation in shared governance activities, and age were not related to the IPNG scores. Nurses working in the inpatient setting and having a role in shared governance was predictive of higher IPNG scores. Meyers and Costanzo (2014) also found that nurses working in the ambulatory setting had difficulty

achieving shared governance scores on the IPNG. This cross-sectional descriptive study conducted the IPNG pre-implementation and three months post-implementation of a clinical nursing council. Despite the nursing council being developed collaboratively by direct care registered nurses and nursing leadership, there was no statistically significant difference in the IPNG scores pre- and post-implementation.

Shared governance and Magnet® designation. The presence of shared governance is required of organizations seeking the American Nurses Credentialing Center's (ANCC) Magnet® designation which has been awarded to 6.61% of all registered hospitals in the United States (AHA, 2011). Magnet® designated hospitals attract and retain top talent; improve patient care, safety and satisfaction; foster a culture of intra-professional collaboration; and advance the standards and practice of nursing. The achievement of these outcomes is identified in five specific domains of the Magnet® Model: transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovation, and improvements, and empirical outcomes. Two Magnet® components, structural empowerment and new knowledge, innovation, and improvements are explored in relation to the Magnet® requirements for a shared governance structure and the performance and dissemination of research.

One of the essential factors linked to the structural empowerment domain of the Magnet® Model is the presence of shared governance within an organization. Nurses are involved in shared governance decision making structures and processes to establish standard of practice and address opportunities for improvement (ANCC, 2014). The flow

of information and decision-making is multi-directional among direct care registered nurses, intra-professional teams, nursing leadership, and the chief nursing executive.

To achieve Magnet® designation and the goals of the new knowledge, innovations, and improvements component of the Magnet® Model, nurses at all levels of healthcare organizations must also be involved in conducting nursing research. The model requires the dissemination of the research findings to the healthcare community. Due to the dissemination requirement there are multiple studies reported in the healthcare literature comparing Magnet® and non-Magnet® designated organizations.

Hess, DesRoches, Donelan, Norman, and Buerhaus (2011) used data from the 2010 National Survey of Registered Nurses to determine nurses' perceptions about their profession, professional work environment, and relationships based on Magnet® status. Relative to the professional work environment, nurses working in Magnet® (35%) or journeying to Magnet® (36%) facilities were significantly more likely to rate opportunities to influence workplace decisions as "very good" or "excellent", as compared to non-Magnet® facilities (26%). At Magnet® facilities, shared governance opportunities were rated as "very good" or "excellent" by 37% of respondents, just behind opportunities to influence patient care (40%). Journeying nurses rated shared governance opportunities as "very good" or "excellent" by 32% and non-Magnet® facilities rated it at 16%. Magnet® and journeying nurses perceived greater opportunities to be involved in shared governance activities than non-Magnet® nurses.

Clavelle, Porter-O'Grady, and Drenkard (2013) conducted a study to describe the characteristics of shared governance and its relationship with nursing practice

environments in Magnet® designated organizations in the United States, using the IPNG and the nursing Work Index-Revised. The researchers found that in Magnet® designated organizations shared governance is the primary form of governance. A positive relationship was found between shared governance and the nursing practice environment. The nursing practice environment was characterized by nursing autonomy, positive nurse-physician relationships, high levels of organizational support, and evidence of control over nursing practice.

In a study at four hospitals in the Middle East, Mouro, Tashjian, Bachir, Al-Ruzzeih, and Hess (2013) found that the hospital that was Magnet® designated and the hospital pursuing Magnet® designation had significantly ($p < .001$) higher IPNG scores than the two hospitals with traditional management structures and processes in place. Four of the subscales; information ($p < .001$), goals ($p < .005$), resources ($p < .001$), and participation ($p < .001$), were statistically significant and scored in the shared governance range for Magnet® designated hospitals and pursuing Magnet® designation, then the hospitals with traditional management structures in place. The subscales related to nursing personnel and practice did not achieve statistical significance, but the practice subscale scored at the shared governance level at all hospitals. Nurses at the Magnet® designated hospitals and hospitals pursuing Magnet® designation indicated that decision making was shared between nursing management and the nursing staff. This structure promotes professional accountability and enhances individual autonomy, authority, and control.

Similarly, Newman (2011) presented a qualitative case study of a moderate sized non-Magnet® community hospital in Kentucky who had difficulty engaging staff in shared governance. A survey revealed an overall nursing engagement index of 76%. Communication and education from nursing leadership provided registered nurses with a better understanding of the benefits of shared governance. The organization was able to transform their culture to a shared governance model as part of their journey to achieving Magnet® designation.

Bennett et al. (2012) found that IPNG scores rose to the lower tier of shared governance on eight implementation units three months after a structured communication process was executed. Comparing the organizational IPNG scores, at non-Magnet® designated organizations and at Magnet® designated organizations, the researchers found that scores on the IPNG were significantly higher at Magnet® designated organizations. The implementation of a structured communication process moved IPNG scores from traditional governance to the lower tier of shared governance.

Lamoureux, Judkins-Cohn, Butao, McCue and Garcia (2014) and Wilson (2013), who studied hospitals pursuing Magnet® designation, had statistically significant differences in scores between units and between genders; with males having higher scores than females and critical care units having higher scores than other units. Al-Faouri, Ali, and Essa (2014) also found statistically significant differences ($p=.000$) between units, in a university hospital that was not on the pursuit of Magnet®, but with a shared governance structure in place. Critical care units had the highest IPNG scores.

Relative to educational level, certification, and age, Lamoureux et al. (2014) did not find statistical significance relative to the IPNG score.

Shared governance and the nurse manager. The nurse manager plays a pivotal role in the implementation of shared governance at the unit level. They are accountable for enforcing the standards of practice and care on the unit. In concert with direct care registered nurses, the nurse manager strives to improve the quality of care for patients and the practice environment of nurses using a shared decision making model.

Perceptions about the presence of shared governance by the nurse manager and direct care nurses have changed over time. In a study by Howell et al. (2001), nurse managers scored the implementation of shared governance higher on the IPNG than the direct care nurses. In a quantitative, cross-sectional, descriptive study of a university hospital in Jordan with a shared governance structure in place, Al-Faouri et al. (2014) found there was no statistically significant difference in the total score and the subscale scores of the IPNG by direct care registered nurses and nurse managers. Wilson, Speroni, Jones and Daniel (2014) in a quantitative, survey study found no statistically significant differences in perceptions of the presence of shared governance between managers and direct care nurses.

Ott and Ross' (2013) qualitative study examined the lived experience of nurse managers and direct care nurses using a five question, semi-structured interview to explore the impact of shared governance. Four themes emerged for both the nurse managers and the direct care registered nurses. The nurse managers identified: patient satisfaction, empowerment, self-management, and wellness. The staff nurses identified:

development and implementation of best practice, quality patient care, a new culture of nursing, and a variety of challenges. Collaboration between the nurse manager and staff nurses empowers nurses to achieve best practice and supports and encourages ownership in shared governance. When there was effective collaboration between the nurse manager and direct care registered nurses, shared governance was supported. Similarly, Wilson et al. (2014) found 84% of study participants' perceived support from the nurse manager was essential for successful shared governance.

The pivotal role of the frontline nurse manager is consistent with findings in the literature related to the successful implementation of unit-based shared governance. Manager transition from sole decision-maker to coach and mentor can be fraught with challenges. For some managers this may be a steep learning curve (Merrill, 2015). The manager and staff must understand that decisions made by the council may not be perfect. Mentoring managers in their new role may be of benefit in the implementation of shared governance (Hess, 2004).

While shared governance has been associated with positive outcomes for direct care registered nursing staff, the literature on the area has been generated by case studies, cross sectional or longitudinal studies and has usually conducted within a single healthcare systems. Challenges related to sustaining positive outcomes, achieving positive outcomes, and staff nurse willingness to participate in shared governance can be found in the literature. The presence of a shared governance structure does not guarantee the achievement of empowerment, job satisfaction, and retention of employees. While the nurse manager has an essential role in the successful implementation of shared

governance, so do the direct care registered nursing staff. Staff apathy is a major barrier to the successful implementation of shared governance (Hess, 2004; Bina et al., 2014; Merrill, 2015).

Shared governance is more than the creation of a structure. It involves changing the attitudes and behaviors of direct care registered nurses regarding their rights and responsibilities as professionals to govern their practice. Registered nurses have the professional right and responsibility to make decisions regarding nursing practice; despite the traditional, bureaucratic, hierarchical medical models in place within acute care healthcare systems. Beyond the system and the direct care registered nurse, the nurse manager is also challenged to understand how to effectively lead and manage in a shared governance environment. The leadership style of the nurse manager plays a significant role in the success or failure of shared governance.

Transformational Leadership and Shared Governance

In review of the literature, a single article was found on transformational leadership and shared governance in the nursing work environment. The action study was conducted in New Zealand during the reformation of the healthcare system. Healthcare in New Zealand was described as “professionally fragmented” and having undergone “corporatization,” where nurses were “demoralized” and “invisible within the corporate structure” (Bamford-Wade & Moss, 2010, p. 816). The healthcare system created a new position, the Director of Nursing, to move the profession out of its disempowered position. The action study evolved over a 10-year period where the Director of Nursing, through the use of a transformational leadership style, was able to create a shared

governance structure within the healthcare system. The creation of an empowered shared governance structure within the healthcare system fostered the culture change that led to the development of a confident, competent, and committed workforce. Unfortunately, quantifiable data on leadership style, shared governance, or registered nurse empowerment was not presented.

Studies on Magnet® designated hospitals have demonstrated the presence of shared governance and the positive outcomes associated with shared governance, such as empowerment, job satisfaction and retention (Bennett et al., 2012; Clavelle et al., 2013). It is unknown if the requirement for transformational leadership within Magnet® designated facilities influences the development and evolution of shared governance. A review of the healthcare literature on the relationship between transformational leadership and shared governance at Magnet® designated facilities produced no studies on this topic.

Participation Subscale of IPNG

The IPNG instrument contains six subscales which measure governance: nursing personnel, access to information, goals and conflict, resources and supporting practice, participation, and control over practice. Each subscale can be measured for the presence of traditional, shared, or self-governance (Hess, 1994). The participation subscale contains 12 items which examine how and at what organizational level nurses are allowed to participate in governance (Hess, 1994). A score of 25 to 48 on this subscale indicates the presence of shared governance in the area of participation.

Weston (2006) conducted the only study which isolated the participation subscale of the IPNG (P-IPNG) to validate structures which support direct care registered nurse participation in governance at the individual unit level. This was one of multiple instruments used to examine antecedents of control over nursing practice at ten acute care hospitals in Arizona. Confirmatory factor analysis demonstrated reliability and validity of the P-IPNG. The alpha coefficient for the study was 0.89. The study found that nurse manager support, implementation of formal participative governance structures, and consistent, open, and accurate communication was positively related to control over nursing practice. Nurse manager belief that participative decision-making increased organizational effectiveness; that participative decision-making did not reduce manager's power; nurse level of experience, expertise, and educational level; and nurse's desire for control over nursing practice was not statistically significant to control over nursing practice.

Lamoureux, et al. (2014) conducted a descriptive cross-sectional study to measure the perception of nurses at an academic medical center in Southeastern Florida concerning the governance status of the hospital and to evaluate the psychometric properties of the IPNG. The hospital was on a three-year journey to achieve Magnet® designation. The sample consisted of 250 nurses from direct care and management/administration. The distribution of scores on the IPNG were asymmetrical with a higher concentration of answers directed to the traditional management side of midpoint. The participation subscale had the most symmetrical distribution with a mean score of 30.12. All subscale scores fell within the shared governance range except for the

personnel subscale. Examining the perception of governance at the unit level, found a statistically significant difference ($p=.032$) between units. On the participation subscale there was a statistically significant difference ($p=.046$) between units. The emergency department exhibited the highest mean score at 37.68 and peri-surgery demonstrated the lowest mean score at 27.24. Participation subscale scores based on experience level, education, certification, and age were not statistically significant. The participation subscale score for gender was statistically significant ($p=.01$); with males demonstrating a mean subscale score of 37.68 and females generating a mean subscale score of 28.92. The study did not differentiate scores from direct care staff and nurse leaders; it is unknown if the perceptions of governance are different in the two groups.

In contrast to the findings of Lamoureux et al. (2014), a cross-sectional, descriptive study of three hospitals on the Magnet® journey in Nevada conducted by Wilson (2013), found that despite having shared governance structures in place, none of the three hospitals achieved a score of shared governance on the IPNG. The total IPNG scores between the campuses were statistically significant ($p<.01$) as were the scores on the participation subscale ($p<.01$). Years in nursing and age were statistically significant ($p<.01$); nurses having 1 to 5 years of experience and nurses aged 21 to 30 years had the highest mean scores for participation. Similar to Lamoureux et al. (2014), Wilson (2013) found statistically significant differences ($p<.01$) in IPNG scores based on unit and gender. Wilson (2013) also found that intermediate care units had the highest mean score with same day surgery having the lowest mean scores. Males had higher mean scores in

all subscales, except the goals subscale. There was no statistically significant difference in scores between males and females in all of the subscales, including participation.

Anderson (2000) conducted a descriptive correlation and comparative study using the IPNG to measure for the presence of shared governance in two hospitals in the southern United States. One hospital had achieved Magnet® designation and had shared governance structures in place for 15 years and the other hospital had traditional management structures in place. There was a statistically significant difference in the total IPNG scores; with the Magnet® designated hospital achieving scores in the shared governance range for all subscales except personnel. Leadership was concerned that the shared governance scores were not higher, given shared governance structures having been in place for 15 years. The IPNG was administered again to staff nurses at the Magnet® designated hospital in 2002 and 2006. From the initial survey in 1999 to the 2002 survey, there was little movement in the total IPNG score and the subscale scores on participation and resources. By 2006, the participation subscale score demonstrated the greatest improvement, but the overall score showed little movement, despite remaining in the shared governance range. Changes in nursing and organizational leadership, in addition to organizational expansion, were perceived to be negative factors affecting the advancement of shared governance.

Mouro et al. (2013) conducted a descriptive cross-sectional design survey in four hospitals in Lebanon and Jordan to examine staff nurse perceptions of governance. Two of the hospitals were on the Magnet® journey and two were not. The hospitals on the Magnet® journey scored within the shared governance range on the IPNG; the non-

journey hospitals scored within the traditional governance range. The participation subscale demonstrated a statistically significant difference between journey and non-journey hospitals ($p < .001$). Nurses in journeying hospitals were more involved in unit and departmental committees. While on these committees the direct care registered nurses were dealing with clinical and administrative issues. An identified area for improvement was in staff participation in the development of hospital-wide policy and procedures.

A single study conducted by Weston (2006) could be found which isolated the use of the participation subscale of the IPNG to validate participative structures in a shared governance environment. The participation subscale had been reported out in a few studies, noted above, with inconsistent findings related to shared governance structures and facilities pursuing Magnet® designation. Two studies, Lamoureux et al. (2014) and Wilson (2013), found statistically significant differences in scores on IPNG based on unit worked and gender, with males having higher mean scores in both studies. Lamoureux et al. (2014) had the only study which found statistically significant differences in the participation subscale based on unit worked and male gender. There were no studies in the nursing or management literature which examined the relationship between achieving a shared governance score on the participation subscale of the IPNG and transformational leadership.

Summary

The review of literature was focused on the characteristics of transformational leadership and the impact of shared governance as detailed by various researchers. From

the research conducted, important themes of successful transformational leadership and shared governance practices emerged which included: the importance of communication, the significance of education of the nurse manager and staff, the implications of perceived nurse manager support, responsiveness, and leadership. These themes drive direct care staff perceptions of autonomy and empowerment. As healthcare becomes more complex, it will require effective leadership to manage the critical personnel resource of the direct care registered nurse.

Previous authors have conducted thorough research to better understand leadership styles and the impact of shared governance. As reflected in the extensive review of the management and nursing literature, researchers have indicated that transformational and active transactional leadership have demonstrated the ability to achieve positive organizational outcomes (Andrews et al., 2012; Casida, Crane, Walker, & Wargo, 2012; Fergus, 2012). Likewise, researchers also revealed that through the use of the attributes of transformational leadership, idealized influence, intellectual stimulation, inspirational motivation, and individualized consideration, the leader is able to motivate the employee to move beyond self-interest to achieve exceptional performance (Bass, 1985).

The demonstration of a transformational leadership style by the leader has been associated with direct care registered nurse empowerment, job satisfaction, retention, and a positive work environment (Andrews et al., 2012; Casida & Parker, 2011; Fergus, 2012; Merrill, 2015). Researchers, in the contemporary literature, have provided evidence that both transformational and active transactional leadership are associated

with registered nurse job satisfaction (Casida, Crane, Walker, & Wargo, 2012; Cowden et al., 2011).

Nursing leadership effectiveness and satisfaction with leadership has been associated with a transformational leadership style. Transformational leadership was the most commonly employed style of leadership exhibited in nursing (Wong et al., 2013). The majority of research studies on leadership style in nursing have focused on the leadership style of the CNO (Herman, Gish, & Rosenblum, 2015). The literature lacks large scale studies focusing exclusively on the nurse manager and the significance of the role. The vast majority of studies have been done in single systems and do not articulate the function of the nurse manager role relative to operations versus administration. In the practice arena, role implementation for the nurse manager may vary by organization from direct “hands-on” operational responsibility to solely administrative oversight.

Senior nursing leaders are perceived as more transformational than direct supervisors (Andrews et al., 2012; Herman, Gish, & Rosenblum, 2015). Nurse manager leadership style is linked to empowerment and retention of direct care registered nurses (Fergus, 2012). Researchers have indicated that the perception of nurse managers’ transformational leadership style is linked to span of control. The larger the span of control the less transformational the nurse manager is perceived (Meyer et al., 2011). Nurse managers perceive themselves as more transformational than the direct care registered nurses who report to them (Herman et al., 2015; Lin et al., 2015; Shi, Zhang, Xu, Liu, Miao, 2014).

The second aspect of the literature review was to determine whether the information in the current literature supported the presence of shared governance and the impact on staff. Shared governance uses the principles of accountability, partnership, equity, and ownership to create a positive practice environment (Porter-O'Grady, 2012; Swihart & Hess, 2014). Use of this structural model of governance by organizational leaders has been associated with direct care registered nurse job satisfaction and retention (Barden et al., 2011; Clavelle et al., 2013 Hastings et al., 2014). Researchers have demonstrated that Magnet® designated or journeying hospitals are more likely to achieve shared governance than nondesignated hospitals (Lamoureux et al., 2014; Mouro et al., 2013); however it is important to note that the presence of a shared governance structure does not guarantee the presence of shared governance (Spence-Laschinger & Wong, 1999; Wilson, 2013). The nurse manager plays a pivotal role in the success of shared governance. A major part of their role is coach and mentor to assist the staff in developing the skills necessary for a successful shared governance structure (Hess, 2004; Cowden et al., 2011).

A single action study exists on the implementation of shared governance when the director implemented a transformational leadership style within a healthcare system in New Zealand. However, the relationship between the leadership style of the nurse manager and the enculturation of shared governance has not been studied, based on a comprehensive review of the healthcare literature. In light of the existing healthcare literature to analyze this relationship, I believe the influence of the leadership style of the nurse manager on the presence of shared governance in the work environment will extend

the body of knowledge for nursing leadership relative to practices which cultivate the satisfaction and retention of the registered nurse workforce.

In Chapter 3, I focused on the rationale for the research design and the methodology of the study. A detailed description of the methodology is presented which focuses on the populations, sampling procedures, procedures for recruitment, instrumentation, and operationalization of constructs. The chapter continues with a discussion on the threats to validity and ethical procedures for the study. At the conclusion of Chapter 3, a summary is provided with an introduction to Chapter 4 which presents the findings of the results.

Chapter 3: Research Method

Introduction

The purpose of this quantitative, nonexperimental, cross-sectional survey study was to test the theory of transformational leadership that relates the transformational leadership style of the nurse manager to the enculturation of shared governance in acute care hospitals in the United States. In this chapter the focus centers on the research design and methodology. Specifically, the chapter encompasses the research design and rationale; the population for the study; the sample and sampling procedures; data collection; instrumentation and operationalization of constructs; the data analysis plan, threats to validity; and ethical procedures. Finally, the chapter concludes with a summary and introduction to Chapter 4.

Research Design and Rationale

Variables

The independent variables tested in the first two research questions were leadership style and the achievement of a shared governance score on the participation subscale on the IPNG. Leadership style is the manner chosen by the leader to provide direction, implement plans, and motivate people (Lin et al., 2015). The participation subscale measures the degree of involvement of nurses in committees; it includes actual participation in meetings, as well as determining the formation and composition of councils (Bennett et al., 2012). The subscale measured the presence of traditional, shared, or self-governance.

The dependent variables for the study were shared governance and transformational leadership. Shared governance is defined as a formal participative management structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimize the direct care registered nurses power over their professional practice (Hess, 1994). A transformational leadership style can be defined as a leadership style that alters the norms and values of employees motivating the workers to perform beyond their expectations (Tims, Bakker, & Xanthopoulou, 2011).

Design

The study conducted was a quantitative, nonexperimental, cross-sectional survey design study. By definition, quantitative research design is a procedure or technique associated with the gathering, analysis, interpretation, and presentation of numerical information (Dionne et al., 2014). This design choice did not have any time or resource constraints. One of the benefits of using this design choice for the study was that it allowed for ease of access to sample the population at a low cost. In addition, the study design allowed for greater anonymity and reduced biasing error.

The research questions were generated after an extensive review of the literature and finding a lack of research on the relationship between direct supervisor leadership style and the implementation of shared governance. The participative work environment of shared governance supports professional nursing practice (Hess, 2011; Porter-O'Grady, 2012). In reviewing the literature, there was a lack of research on the

relationship between achieving a score of shared governance on the participation subscale of the IPNG and leadership style.

The quantitative paradigm was appropriate to the research questions for study as the study tested transformational leadership theory. All of the variables can be measured by reliable and valid instruments. Objective, unbiased approaches were used in data collection. The data collected was analyzed using statistical methods.

The independent variable of nurse manager leadership style reflected the background, past experiences, and attitudes of the manager, and was appropriate to the cross-sectional design. A nonexperimental cross-sectional design is the most commonly used design in social science research. Cross-sectional design includes survey research. In this study's design, participants were asked to respond to questions to describe the relationship between the variables (Dinh et al., 2014).

The intent of this study was to survey a random sample of nurse managers working in acute care hospitals in the United States and determine if there is a relationship between the two variables. The goal of the research study was not to establish cause and effect, but to examine if a relationship existed. The survey occurred at one point in time and the ability to control extraneous variables did not exist.

Methodology

Population

The population for the study was registered nurses working in acute care hospitals, in the United States, who were nurse managers. A nurse manager is defined as a registered nurse who is the immediate supervisor of direct care registered nurses. The

nurse manager has twenty-four hours per day, seven days per week responsibility for the outcomes of care provided on a specific nursing unit or in a specific nursing procedural area. Common titles associated with this role may have included: manager, unit manager, head nurse, unit administrator, clinical manager, clinical director, or unit supervisor.

The nurse manager must have been employed in an acute care hospital in the United States. The acute care hospital may have been in an urban, suburban, or rural area and could have been an academic, a community teaching, or a community hospital setting. Hospitals not included in the population were: sub-acute, critical access, long-term care, chronic-care, and rehabilitation hospitals.

Sampling Frame

Nurse managers working in acute care hospitals in the United States were the sample population for the study. According to the American Hospital Association (2014), there are 4,999 acute care hospitals in the United States, which employ approximately 1,713,668 registered nurses (BHPR, 2013). The exact number of United States registered nurses holding a nurse manager position in acute care hospitals is unknown as there is not an organization or database which contains this information. The American Organization of Nurse Executives (AONE) is the professional body representing all levels of nursing leadership; including nurse managers in the United States. The AONE had 474 members that identified themselves as nurse managers within the United States. It is from this membership that the sample population for the study was drawn.

Sampling Strategy

A probability design using a simple random sample was used for the cross-sectional survey study. A table of random digits was used to select the participants for the study. Each of the nurse managers in AONE was assigned a number. A random point on the table of random digits was chosen as the starting point for participant selection. From that identified starting point and moving in a diagonal, downward pattern, when the digits in the table of random numbers matched the number of the corresponding participant, the participant was selected for inclusion in the study. This process continued until the sample size was achieved. A total sample size of 111 participants was calculated using the G Power 3.1.9.2 calculator.

Sample Size

The sample size for the study was determined with consideration of statistical power, confidence interval, and effect size. The statistical power was established at .95 (95%). The alpha level was established at .05; which represented the 95% confidence interval. The effect size was determined by a review of the literature and established at 0.3. Using the G Power 3.1.9.2 calculator, the sample size was determined to be 111 for the current study.

Recruitment Procedure

Nurse managers were identified for participation in the study based on the list of nurse managers received from AONE. Each nurse manager was assigned a number and a table of random numbers was then utilized to identify the study participants. The identified nurse managers were contacted via email to request participation in the study

(Appendix A). The mailing contained the informed consent reiterating that their participation in the study was voluntary and a link to the survey. A second email message was sent three weeks after the first mailing and then again at Week 6. These messages were designed to remind the participants about the study and to thank those who had completed the study.

Demographic Information

Demographic information was collected from the participants in the study which included: gender, age range, ethnicity, geographic region, type of acute care hospital, highest level of education, years in nursing, years as a nurse manager, years as a nurse manager on current unit, title, type of unit, number of units reporting to the manager, number of full time equivalents reporting to the manager, registered nurse turnover rate, achievement of Magnet® designation, re-designation and duration, presence of a departmental shared governance structure and duration of the structure, and presence of a unit based shared governance structure and duration of the structure. Dropdown boxes were used whenever possible for ease of completing the demographic information.

The demographic information was collected to determine if the findings of this study were consistent with findings reported in the literature regarding transformational leadership and shared governance. Lamoureux et al. (2014) and Wilson (2013) found a statistically significant impact of gender on perceptions of shared governance, although age and ethnicity did not achieve statistical significance. Lamoureux et al. (2014) also found a statistically significant impact of type of unit worked in and perceptions of shared governance. Overcash and Petty (2012) found that level of education, years in nursing,

and years as a nurse manager did not impact perceptions of shared governance. Casida et al. (2012) found that the number of years in the nurse manager role impacted the perception of transformational leadership style. Nurse managers with large spans of control were perceived to be less transformational than managers with a smaller span of control (Meyer et al., 2011; Meyers & Costanzo, 2014; Overcash & Petty, 2012). Multiple studies have demonstrated the influence of Magnet® designation on perceptions of shared governance and transformational leadership (Lamoureux et al., 2014; Mouro et al., 2013). Wilson (2013) demonstrated that the presence of shared governance structures does not guarantee the presence of shared governance in practice. The demographic information provided by the participants further informed the results of the study.

Informed Consent

To protect the rights of human subjects, the proposal for the study was reviewed and approved by the Institutional Review Board (IRB) of Walden University. Informed consent was obtained from the participants prior to engaging in the study. The informed consent identified the researcher, the sponsoring institution, how participants were selected, the purpose of the research, the benefits of participating in the research study, the level and type of participation required by the participant, the risks to the participant, a guarantee of confidentiality to the participant, assurance that the participant can withdraw from the study at any time, and the name and contact information of the person the participant can call if they have a question (Snowden, 2014).

The survey was designed using an online survey platform called SurveyMonkey®. The SurveyMonkey® link was sent to the identified participants via

email by the researcher. The mailings contained the informed consent items outlined in the paragraph above. By clicking on the link to complete the survey indicated initial acknowledgement of informed consent and agreement to participate in the study. The first slide on the SurveyMonkey® also reinforced the informed consent elements and indicated that by clicking *next*, the participant was providing informed consent and agreeing to participate in the study.

Data Collection

The data collection tool used was a SurveyMonkey® generated by the researcher, which contained the informed consent, demographic information, leadership style survey, and governance survey. The participant was able to see the level of completion during the survey and at the conclusion of the survey in real time on the computer screen. The survey was completed at one point in time and no follow up was required. Participants were not financially compensated for participation in the study. To assist with reciprocity, the final slide of the SurveyMonkey® allowed the participant to supply contact information, if they would like to receive a copy of the summary findings of the study.

Instrumentation and Operationalization of Constructs

The research questions and hypotheses for the study were:

Research Question 1: What is the relationship between leadership style of the nurse manager and enculturation of shared governance?

H_01 : There is a negative or no relationship between transformational leadership style of the nurse manager and shared governance.

*H*₁1: There is a positive relationship between transformational leadership style of the nurse manager and shared governance.

*H*₀2: There is a negative or no relationship between active transactional leadership style of the nurse manager and shared governance.

*H*₁2: There is a positive relationship between active transactional leadership style of the nurse manager and shared governance.

Research Question 2: What is the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style?

*H*₀3: There is a negative or no relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

*H*₁3: There is a positive relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

For the first research question the independent variable was leadership style and was measured by the MLQ 5X short. The dependent variable was shared governance, which was measured by the IPNG. For the second research question, the independent variable was the presence of a shared governance score on the participation subscale, which is a subscale of the IPNG. The dependent variable was the transformational leadership style, which was measured by the MLQ 5X short.

The transformational leadership style variable for the study was defined as a leadership style which alters the norms and values of employees motivating the workers to perform beyond their expectations (Tims, Bakker, & Xanthopoulou, 2011).

Transformational leadership style, the dependent variable in the second research question, was measured by the MLQ 5X short, developed by Avolio and Bass in 1997. The survey questionnaire measures leadership style as being transformational, transactional, or passive-avoidant. Permission to use this tool was included in Appendix B.

The dependent variable for the first research question was shared governance. It can be defined as a formal structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating personnel. The governance structures and processes legitimize the direct care registered nurses power over their professional practice (Hess, 1994). The independent variable for the second research question was the achievement of shared governance on the participation subscale of the IPNG. Both variables were measured by the IPNG, developed by Hess in 1998. This tool measures traditional governance, shared governance and self-governance. Permission to use this tool was included in Appendix C. There is a high degree of isomorphism between the measuring instruments and the variables being measured (Dinh et al., 2014).

Instrumentation

Due to isomorphism, the researcher determined the levels of measurement for the instruments being used in the study. The level of measurement determines the statistical operations that can be performed on the set of numbers generated by the instrument (Dinh

et al., 2014). The tools selected to measure the variables for the study, MLQ 5X short and IPNG, produced data at the interval level.

The MLQ 5X short produces data at the interval level. The tool measures each attribute of transformational, transactional (active and passive), and laissez-faire leadership style. Each attribute produces a score from zero to four. There can be no lower score than zero or higher than four. The MLQ 5X short meets the requirement of interval level data: the distance between the scores has meaning and an average can be computed.

The IPNG also produces data at the interval level. The tool measures six dimension of governance: nursing personnel, access to information, goals and conflict, resources and supporting practice, participation, and control over practice (Hess, 1998). The total score achieved indicates the presence of traditional, shared or self-governance. The distance between scores has meaning, an average can be computed, but there is no absolute zero. All descriptive and inferential statistics can be applied to interval level data.

The data produced by the MLQ 5X short and the IPNG was at the interval level. Data at this level is considered to be parametric. Parametric statistics can be applied to data at the interval level. These statistics assisted the researcher in gaining a better understanding of the relationship that existed between the variables.

Validity

Although identification of the variables, the tools used to measure them, and the types of data produced by the instruments was important, having instruments that were valid and reliable were critical for the researcher. Validity examines the extent to which

the instrument measures the variable it is intended to measure. The validity of the measurement of the variable can impact the conclusions drawn following the testing of hypotheses (Dinh et al., 2014). The instruments in use must have had content, empirical, and construct validity.

Content Validity

Content validity is the degree to which the instrument fully assesses the variable (Dinh et al., 2014). Common types of content validity are face and sampling validity. The instruments used in this study had achieved content validity.

The MLQ 5X short contains 45 items. Nine leadership factors or attributes associated with the three styles of leadership are represented by 36 items. The remaining nine items assess leadership outcome scales (Avolio & Bass, 2004). The MLQ underwent face validity by six leadership scholars and confirmatory factor analysis (Antonakis & House, 2014). The MLQ 5X short has been sampled in business (Antonakis & House, 2014), hospitals (Hu et al., 2015), research and development (Dionne et al., 2014), and government (Muterera, 2012).

The IPNG was tested for face validity by six hospital nurse administrators. The administrators were recognized experts in nursing governance innovations. An average congruency score of .88 was achieved. The administrators suggested the addition of 13 items, the revision or combination of 14 other items and the reassignment of two items to other subscales. In a second round evaluation, 89 items were submitted to a different panel of six nurse administrators and seven direct care registered nurses. The two panels

returned congruency scores of .95 and .97 respectively. The Popham's average congruency scores for each of the six subscales was $> .90$ (Hess, 1998).

Both tools have documented face and sampling validity. The practice environment for employment of the tools was consistent with prior research. The MLQ 5X short has been used at the management level with self-rating and in the United States acute care hospital setting. The IPNG was developed to specifically measure nurse perception of governance in the hospital setting and has been used by all levels of registered nurses.

Empirical Validity

Empirical validity focuses on the relationship between the measuring instrument and the measured outcome (Dionne et al., 2014). The most common method of determining empirical validity is using predictive validity. Predictive validity estimates the results the researcher expects to obtain on the basis of some other external measure or criterion.

The IPNG has been used to validate the existence of shared governance in the hospital setting. Subsequent studies found consistency with use of the IPNG and nursing control over decision affecting practice (Cohen, 2015). The IPNG has been correlated to the Shared Governance Staff Assessment Instrument (Hess, 2011); Decisional Involvement Scale (Anderson, 2000); and the Condition of Work Effectiveness Questionnaire-II (Barden et al., 2011). The correlations with each instrument only addresses one dimension of shared governance. As an example, the staff assessment instrument measures staff understanding, commitment, and personal perception of

shared governance. The decisional involvement scale measures actual and/or preferred decisional involvement of staff nurses and nurse managers on nursing units. The condition of work effectiveness instrument measures whether staff perceives they have access to lines of power. The IPNG addresses the six dimensions of governance: professional control, organizational influence, organizational recognition, facilitating structure, liaison, and alignment (Hess, 1994).

The MLQ 5X short has been extensively researched for consistency with measurement of transformational, transactional, and passive-avoidant style. A meta-analysis of 33 independent empirical studies using the MLQ 5X short found strong positive correlation between all components of transformational leadership and both objective and subjective measures of performance (Lowe, Kroeck, & Sivasubramaniam, 1996). Piccolo et al. (2012) correlated the MLQ 5X short with Big 5 personality traits. The MLQ 5X short was correlated to the Gordon Personality Profile at a statistical significance level of $p < .01$ (Avolio & Bass, 2004).

During the study correlation coefficients were analyzed to provide indexes of how much two measures are related (Dionne et al., 2014). Magnet® designation, collected as part of the demographic information, requires the implementation of transformational leadership practices and the implementation of shared governance as a reflection of structural empowerment and exemplary professional practice (Clavelle, Porter-O'Grady, & Drenkard, 2013). The external criterion was the achievement of Magnet® designation.

Construct Validity

Construct validity examines alignment between the measuring instrument and the theoretical framework (Dionne et al., 2014). The MLQ 5X short and the nine-factor model was tested for confirmatory factor analysis, using self-rating. The Goodness of Fit Index was .93, Adjusted Goodness of Fit Index was .81, the Comparative Fit Index (CFI) was .89 and the Root Mean Squared Error of Approximation (RMSEA) was .05 (Avolio & Bass, 2004). In a study by Antonakis & House (2014) the Goodness of Fit Index for contextual conditions, using the nine-factor model with a sample size of 481, was CFI=.984, RMSEA=.044 for majority of females, which includes nurse executives. Low-level leaders, including nurses with a sample size of 1,887, had a CFI=.959, and RMSEA=.067 (Antonakis & House, 2014). A study conducted by Hemsworth, Muterera, and Baregheh (2013) using 372 chief executives in the United States Government, Confirmatory Factor Analysis (CFA) on all scales and subscales was $p=.05$. Inter-item correlations for the five subscales associated with transformational leadership were: average inter-subscale correlation for the five subscales was $r=.45$ and the average inter-item correlation for the 20 items was $r=.47$; this is above the recommended value of $r=.3$ (Hemsworth, et al., 2013). Convergent validity was demonstrated by the measurement of all five subscales and the 20 measurement items. Chi-square was significant ($\chi^2=614.94$, $df=60$, $p=.00$) (Hemsworth et al., 2013). Discriminant validity was performed using CFA on the five subscales. The inter-subscale correlations were significant ($p<.05$), but moderate, ranging from $r=.38$ to $r=.66$. The chi-square difference tests were significant ($\chi^2 > 3.84$, $df=1$, $p>.05$) between all subscales. There is high discriminant validity and

each subscale measures a distinctly different aspect of transformational leadership (Hemsworth et al., 2013).

Construct validity for the IPNG was conducted using: factor analysis; correlations among subscale scores; correlations between IPNG and Index of Centralization (IC) scores for convergent validity; and contrasting scores among seven hospitals with reported shared and non-shared governance (Hess, 1998). Factor analysis ranged from .87 to .91 with an overall alpha coefficient of .97. Intercorrelations, using Pearson's correlation coefficients, among the subscales ranged from .43 to .67 indicating moderate correlations (Hess, 1998). Convergent construct validity ranged from .67 to .83. Divergent construct validity, comparing hospitals with and without shared governance, found that in hospitals with shared governance there was a significantly higher governance score on the IPNG ($p=.0005$, one-tailed t -test). Using analysis of variance (ANOVA) and Scheffe's post hoc test, these hospitals had significantly higher scores with shared governance ($p=.05$), than without shared governance.

For the current research study, known-groups technique was used to ensure construct validity. To examine the IPNG, hospitals were identified as having or not having known shared governance structures in place. For the MLQ 5X short, comparisons were made between Magnet® designated organizations, which required the presence of transformational leadership, and facilities without designation.

Reliability

Reliability refers to the dependability of an instrument in measurement to yield the same results on repeated trials (Dionne et al., 2014). Reliability is the extent to which

the instrument produces the same result on repeated trials. It is a reflection of the stability or consistency of scores over time or across raters. The three aspects of reliability are equivalence, stability, and internal consistency. Equivalence is tested using the parallel forms procedure. Stability is assessed using the test-retest procedure. Internal consistency is determined using the split-half reliability index, coefficient alpha index, or Kuder-Richardson formula 20 index.

The MLQ 5X short was tested for reliability, using Cronbach's alpha, across six leadership factor scales. For an initial sample of 1,394, the scores ranged from .63 to .92. A replication sample of 1,498 posted a reliability of .64 to .92 (Avolio & Bass, 2004). In correlation studies in the United States using self-rating, there was a positive and significant of correlation between contingent reward and each of the five scales comprising transformational leadership of .64. A high degree of correlation was expected due to both transactional and transformational leadership being positive, active forms of leadership. Leaders can be both transactional and transformational in their leadership style. Transactional agreements builds trust, consistency, and dependency which is necessary for transformational leadership. Corrective transactional leadership in management by exception-passive and laissez-faire leadership demonstrated low positive or negative correlations with transformational and constructive transactional leadership. Scores ranged from .10 to -.36 (Avolio & Bass, 2004). The study conducted by Hemsworth et al. (2013) examined scale reliability using Cronbach's alpha was .94 for the five scales measured transformational leadership behavior. Reliability for

transformational leadership style based on the five subscales was greater than .7 for each subscale.

The IPNG was tested for reliability at two community hospitals. Data from 231 usable cases determined a Cronbach's alpha for the total instrument of .95. Subscale reliabilities ranged from .82 to .90. One month later, nurses were surveyed from the same two hospitals, 39 surveys were used to calculate the Pearson product-moment correlation coefficient between the two sets of questionnaires; the test-retest correlation was .77. Nine items from four subscales demonstrated marginal stability ($r < .20$), but were retained for construct validation as potential discriminators between professional nursing governance situations (Hess, 1998).

For this study, the test-retest method of reliability was not appropriate, as this study used a survey design. Data was collected at one point in time only. The parallel-forms technique was not appropriate due to the length of the survey. To create two separate forms of the instrument and administer them to the sample would have decreased the sample size for the study. A Cronbach's alpha was used to test for reliability of the measuring instruments.

Operationalization

Transformational leadership was the independent and dependent variable for the study. It is defined as a leadership style which alters the norms and values of employees motivating the workers to perform beyond their expectations (Tims, Bakker, & Xanthopoulou, 2011). Transformational leadership style was measured by the MLQ 5X short (Avolio & Bass, 2004). The survey questionnaire measures leadership style as

being transformational, transactional, or passive-avoidant. The 45-item questionnaire has the participant rate each item on a five-point frequency scale from 0 to 4 (0 = *not at all*, 1 = *once in a while*, 2 = *sometimes*, 3 = *fairly often*, 4 = *frequently*). Each style of leadership is equated to the reflective attributes of the style. Each attribute is scored by calculating the mean score of the four questions associated with each attribute.

The MLQ 5X short contains 36 items which represent the leadership styles of which transformational leadership was the independent and dependent variable for the study. There are 20 items attributed to transformational leadership which reflect: idealized influence attributed, idealized influence behaviors, inspirational motivation, intellectual stimulation, and individualized consideration. Eight items are reflective of transactional leadership with items that represent contingent reward and management-by-exception active, also known as active transactional leadership. Another eight items reflect passive-avoidance which represents management-by-exception passive, or passive transactional and laissez-faire leadership. The remaining nine items are representative of the behavioral outcomes of leadership, specifically: satisfaction, extra effort, and perceived leadership effectiveness (see Table 1).

For example, the trait of idealized influence attributed is reflected by item numbers: 10, 18, 21, and 25. The scores of each of these items was added and divided by four. If the respondent only answered three of the items, the total was divided by three. The mean score was then compared to the 50th percentile of the attribute listed in Appendix B of the Multifactor Leadership Questionnaire Manual and Sample Set, 3rd Edition (2004).

Table 1

Multifactor Leadership Questionnaire 5X short Item Distribution

Characteristic	Scale Name	Items
Transformational	Idealized Attributes	10, 18, 21, 25
	Idealized Behaviors	6, 14, 23, 34
	Inspirational Motivation	9, 13, 26, 36
	Intellectual Stimulation	2, 8, 30, 32
	Individualized Consideration	15, 19, 29, 31
	Transactional	Contingent Reward
Management by Exception (Active)		4, 22, 24, 27
Passive Avoidant		Management by Exception (Passive)
	Laissez-Faire	5, 7, 28, 33
Outcomes of Leadership	Extra Effort	39, 42, 44
	Effectiveness	37, 40, 43, 45
	Satisfaction	38, 41

The dependent variable for the study was shared governance. It is defined as a formal structure involving direct care registered nurses in governance decisions previously made by management, such as budgeting, scheduling, and evaluating

personnel. The governance structures and processes legitimize the direct care registered nurses power over their professional practice (Hess, 1994). The independent variable was the achievement of a shared governance score on the participation subscale of the IPNG. These variables were measured by the IPNG. This tool measures traditional governance, shared governance, and self-governance. The tool is an 86-item questionnaire which had the participant rate each item on a five-point frequency scale from 1 to 5 (1 = *nursing management/administration only*, 2 = *primarily nursing management/administration with some staff nurse input*, 3 = *equally shared by staff nurses and nursing management/administration*, 4 = *primarily staff nurses with some nursing management/administration*, 5 = *staff nurses only*). The 86-items are divided into six subscales reflective of governance: nursing personnel (22 items), access to information (15 items), goals and conflict (8 items), resources and supporting practice (13 items), participation (12 items), and control over practice (16 items). To calculate the total IPNG score, the individual scores for each section are totaled and then all of the totals are summed. The shared governance range is defined for each subscale and for the total IPNG scores (see Table 2). The governance distribution is as follows: a total IPNG score of 86 to 172 indicates the presence of traditional governance with the controlling group being management/administration only; a score of 173 to 257 indicates the presence of the early phases of shared governance with control being primarily management/administration with some staff input; a score of 258 indicates the presence of shared governance with an equal sharing of control by staff and management/administration; a score of 259 to 344 indicates shared governance by

primarily staff with some management/administration input; and a score of 345 to 430 indicates self-governance by staff only.

The tools selected measured the independent and dependent variables for the study. The MLQ 5X short measured transformational leadership style. The IPNG measured shared governance and the participation subscale. There was a high degree of isomorphism between the measuring instruments and the variables being measured.

Table 2

Index of Professional Nursing Governance Shared Governance Scores

Factor Subscales	Items	Shared Governance Range Score
Nursing Personnel	22	44-88
Access to Information	15	31-60
Goals and Conflicts	8	17-32
Resources and Supporting Practice	13	27-52
Participation	12	25-48
Control over Practice	16	33-64
Total IPNG Score	86	173-344

Data Analysis Plan

The research questions and hypotheses for the study were:

Research Question 1: What is the relationship between leadership style of the nurse manager and enculturation of shared governance?

H₀1: There is a negative or no relationship between transformational leadership style of the nurse manager and shared governance.

H₁1: There is a positive relationship between transformational leadership style of the nurse manager and shared governance.

H₀2: There is a negative or no relationship between active transactional leadership style of the nurse manager and shared governance.

H₁2: There is a positive relationship between active transactional leadership style of the nurse manager and shared governance.

For the first research question, the independent variable was leadership style and was measured by the MLQ 5X short. The dependent variable was shared governance, which was measured by the IPNG.

Research Question 2: What is the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style?

H₀3: There is a negative or no relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

*H*₁₃: There is a positive relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

For the second research question, the independent variable was the presence of a shared governance score on the participation subscale, which is a subscale of the IPNG. The dependent variable was the transformational leadership style, which was measured by the MLQ 5X short.

The data collected was analyzed using the statistical software package IBM SPSS Statistics 23. Data received from the sample was formulated into descriptive and inferential statistics. Descriptive statistics were used to profile the sample in parts and as a whole. Measures of central tendency and variability were also calculated. Pearson's product-moment correlation was utilized to identify the relationship between leadership style of the nurse manager and the enculturation of shared governance. It was also used to identify the relationship between the achievement of a shared governance score on the IPNG and transformational leadership. Two assumptions must be met to use this statistical test: "it can only be used on interval or ratio level data and the data must be normally distributed" (Prion & Haerling, 2014, p. 587).

Prior to running the statistical analysis, the scoring procedures for the IPNG and the MLQ 5X short were followed to determine the type of governance and leadership style. This data, along with the demographics were loaded into SPSS. For Pearson's correlation to be accurate there must be a linear relationship between the two variables.

The sample must be tested for the presence of outliers, as this would have an exaggerated influence on the r value. If there are outliers, then linear regression or Spearman's rank order correlation would be used. Data was analyzed to identify the presence of statistical significance ($\alpha=.05$). This represented the 95% confidence interval which had a 95% likelihood of containing the true but unknown parameter.

Threats to Validity

The study had limitations related to the sample and the design of the study. The sample was drawn from the nurse managers who were members of AONE; the findings of this study may not be generalizable to the overall population of nurse managers in acute care hospitals in the United States. The use of a proportionate simple random sample was an attempt to control this sampling limitation. The databases available from AONE may not have accurately reflected the individuals' current role within the organization, which may have hindered the sample size.

The nurse managers completing the study were self-reporting on perceived leadership style and governance. Howell et al. (2001) reported that nurse managers scored the implementation of shared governance higher on the IPNG than direct care registered nurses. Andrews et al. (2012) and Lin et al. (2015) reported that nurse managers surveyed using the MLQ 5X short were more likely to identify themselves as transformational leaders than the direct care staff they supervised. The reliability and validity of the survey instruments were individually identified in prior studies; however, the MLQ 5X short and the IPNG had not been used in conjunction in the same study. In

addition, the reliability and validity previously identified may not be found on data analysis in the study.

The potential existed for low response rates due to the mechanism to solicit participation in the survey. In this study, the survey remained open for eight weeks with the understanding that if the sample size had not been achieved, the survey would close without generalizability. The potential for e-mail to not be delivered to the intended participant due to spam filters or firewalls existed. Participation reminders were sent to the potential participants via email messaging. There were challenges associated with computer surveys with display effects across devices, screen sizes, and operating systems which could have influenced how individuals interpret the questions. To minimize this limitation, was used for consistency of presentation and accessibility. Controlling access to the survey meant that someone could have filled out the survey twice, posted it on a forum, or “bots” could have been used to supply random answers to the questions. To minimize this limitation, there was limited access by allowing only one survey per IP address and setting cookies in applicable browsers. Each participant received a password embedded in the URL, so it did not have to be manually entered. There was an inability to control for someone else completing the survey, then the intended participant.

Ethical Procedures

To protect the rights of human subjects, the proposal for the study was reviewed and approved by the Institutional Review Board (IRB) of Walden University (Approval number: 03-17-16-0258125). Informed consent was obtained from the participants prior to engaging in the study. The informed consent identified the researcher, the sponsoring

institution, how participants were selected, the purpose of the research, the benefits of participating in the research study, the level and type of participation required by the participant, the risks to the participant, a guarantee of confidentiality to the participant, assurance that the participant could withdraw from the study at any time, and the name and contact information of the person the participant can call if they have a question (Snowden, 2014).

The survey was designed as a SurveyMonkey® tool. The SurveyMonkey® link was sent to the identified participants via e-mail by the researcher. The mailing contained the informed consent items outlined in the paragraph above. Clicking on the link to complete the survey indicated acknowledgement of informed consent and agreement to participate in the study. The introduction page on the SurveyMonkey® reinforced the informed consent elements and indicated that by clicking *next*, the participant was providing informed consent and agreeing to partake in the study.

Participants were not financially compensated for participation in the study. To assist with reciprocity, the conclusion page of the SurveyMonkey® allowed the participant to supply contact information, if they would like to receive a copy of the summary findings of the study. The researcher sent a second e-mail message at three weeks after the first mailing and again at week 6 to remind participants about engaging in the study and offering thanks to those who had already completed the study. The SurveyMonkey® link was disengaged after eight weeks. Prior to sending the summary data, the researcher collected any contact information provided by the participants and

placed this information in a separate file. Once the contact information had been removed from the SurveyMonkey® data, the summary data was analyzed by the researcher.

To protect the confidentiality of the participants, all of the email, mailing contact lists, and individual contact information was kept by the researcher in a password protected file, on a password protected computer. The researcher kept the summary data and the data analysis files in password protected files on a password protected computer to assure the privacy and confidentiality of the data. Once the data had been analyzed, the researcher generated a summary report. The summary report was sent to the individuals who identified a desire to receive the report.

The email and text contact file was deleted by the researcher once the final notice had been sent at week 6. The contact information file was deleted once the summary report had been sent. The summary data file and data analysis files will be kept for a period of five years and then deleted (Snowden, 2014).

Summary

Chapter 3 provided an overview of the research design and methodology for the study. The study used a quantitative, nonexperimental, cross-section survey design to examine the relationship between the leadership style of nurse managers and the enculturation of shared governance. In addition, the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style was examined. A proportional simple random sample of nurse managers working in acute care hospitals in the United States, who were members of AONE, were used for the sample. A sample size of 111 was needed to achieve

generalizability. Informed consent, ethical procedures, and IRB approval for the study was achieved prior to the collection of any data. Data was collected using a SurveyMonkey® tool containing demographics, the MLQ 5X short and the IPNG survey. The data collection process continued until the survey had been posted for 8 weeks. The data received from the sample was formulated into descriptive and inferential statistics. Chapter 4 reports the data collection process and the results of the study.

Chapter 4: Results

Introduction

The purpose of this quantitative, nonexperimental, cross-sectional survey study was to test the theory of transformational leadership that relates the transformational leadership style of the nurse manager to the enculturation of shared governance in acute care hospitals in the United States. The research questions for the study were:

1. What is the relationship between nurse manager leadership style and the enculturation of shared governance?
2. What is the relationship between the achievement of a shared governance score on the participation subscale of the Index of Professional Nursing Governance (IPNG) and transformational leadership style?

In Chapter 4 the results from the data collection phase of the study are reported. Specifically, the elements of this chapter are: data collection, reporting descriptive statistics, evaluation of statistical assumptions, and reporting of inferential statistics. Chapter 4 concludes with a summary and introduction to Chapter 5.

Data Collection

Data collection for this research study took place over an 8-week period. The sample population for the study was nurse managers working in acute care hospitals in the United States who are members of the American Organization of Nurse Executives (AONE). Following receipt of approval from Walden University Institutional Review Board (IRB), the researcher then contacted AONE for access to nurse manager

membership. The request for access to membership information was approved and a random sample of 111 nurse managers were selected using a table of random numbers.

An automated email notification from SurveyMonkey® was sent to the researcher when a survey was submitted. The researcher then logged into a password protected computer and onto the password protected site on SurveyMonkey® to view and code the survey(s) that had been received. The individual survey responses contained no participant identification, unless the participant requested a copy of the executive summary. The coded data was entered by the researcher into a password protected excel file on a password protected computer. If the participant requested an executive summary, the participant contact information was also entered into a separate password protected file on a password protected computer. Once the email data was retrieved by the researcher, it was deleted from the survey responses. The executive summary file contained email addresses only and was not linked to the survey data file. The executive summary file will be deleted once the executive summary has been completed and emailed to the requesting participants.

The coded data in the excel file was further scored by the researcher using the scoring instructions for the MLQ 5X short and the IPNG. The scored data was copied and pasted into an SPSS data file. The SPSS password protected data file is located on a password protected computer and contained no electronic link to the excel file or the survey results. The data in the SPSS file was used to perform the data analysis for the study. At the conclusion of the 8-week survey period, the survey link on SurveyMonkey® was disengaged.

A total of 82 (73.9%) responses were received via SurveyMonkey® by the researcher. Twenty-eight surveys (34.2%) were incomplete or failed to meet the inclusion criteria for the study and were eliminated from the study. The final number of completed surveys was 54, which represented a 48.7% response rate.

There were no deviations from the plan for data collection. Discrepancies in the accuracy of AONE membership information resulted in requests for participation being sent to nurse leaders who were no longer nurse managers. Those who responded who were not nurse managers were eliminated from the study sample.

Descriptive Statistics

Demographics

The demographic characteristics of the nurse manager sample are presented in Table 3. The sample population was predominantly female (90.7%), age 45 to 54 years (38.9%), White/Caucasian (85.2%), with the job title of nurse manager (81.5%). Approximately 60% of participants possessed a Master of Science in Nursing (MSN) degree and had practiced nursing for more than 15 years (68.5%). The range of years of experience as a nurse manager was 6 to 10 years (31.5%), followed by more than 15 years (20.4%). The range of years managing their current unit(s) was 0 to 2 years (31.5%) followed by 3 to 5 years (29.6%) and 6 to 10 years (27.8%).

The number and demographic characteristics of nurse managers in the United States was not available. The respondents to this survey are representative of the profession of nursing. The 2008 National Sample Survey of Registered Nurses (NSSRN) researchers described the following characteristics of the profession of nursing as: female

Table 3

Nurse Manager Demographics

	Frequency	Percent
Sex		
Female	49	90.7
Male	5	9.3
Age Range		
25 to 34 years	9	16.7
35 to 44 years	14	25.9
45 to 54 years	21	38.9
55 to 64 years	10	18.5
65 years or more	0	0
Ethnicity		
American Indian or Alaskan Native	1	1.9
Asian or Pacific Islander	2	3.7
Black or African American	3	5.6
Hispanic or Latino	1	1.9
White/Caucasian	46	85.2
Prefer Not to Answer	1	1.9
Job Title		
Nurse Manager	44	81.5
Director	10	18.5
Highest Education Level		
BSN	15	27.8
MSN	32	59.3
DNP	2	3.7
Masters other field	5	9.3

(table continues)

	Frequency	Percent
Years of Experience as RN		
6 to 10 years	8	14.8
11 to 15 years	9	16.7
More than 15 years	37	68.5
Years of Experience as a Nurse Manager		
0 to 2 years	9	16.7
3 to 5 years	10	18.5
6 to 10 years	17	31.5
11 to 15 years	7	13.0
More than 15 years	11	20.4
Years of Experience Managing Current Units		
0 to 2 years	17	31.5
3 to 5 years	16	29.6
6 to 10 years	15	27.8
11 to 15 years	5	9.3
More than 15 years	1	1.9

Note. BSN=Bachelor's of Science in Nursing; MSN=Master's of Science in Nursing; DNP=Doctorate in Nursing Practice; Masters other field=Master's degree in a field other than nursing; RN=Registered Nurse.

(90.4%), white (83.2%), median age was 46 years old with the greatest number of nurses in the profession between the ages of 45 and 54 years, 50% or greater had a Bachelor's of Science degree or higher, and more than 50% had greater than 15 years of experience as a registered nurse (USDHHS, 2010).

The organizational demographics of the sample are presented in Table 4. The majority of the respondents (33.3%) were from the Middle Atlantic region of the United States working in academic medical centers (59.3%). Nurse managers predominantly are responsible for the management of one (37%) to two units (37%), with a range of responsibility from one to seven units. The type of units managed were most frequently

critical care (24.1%), followed by combined medical-surgical (20.4%). The span of control, represented by the number of full-time equivalents (FTEs) that the nurse manager is responsible for, ranged from 6.0 to 175 FTEs. Over 24% of the nurse managers had a span of control ranging from 61 to 80 FTEs. Turnover rates ranged from 0% to 35%, with a mean of 7.71% and a mode of 3%. A range turnover rate of 0% to 5% comprised 48.2% of the sample. Hospitals with Magnet® designation comprised 74.1% of the sample and 72.2% had both a departmental and unit-based shared governance structures in place on all units. Magnet® designated hospitals had achieved that designation for a duration range of two to five years (40.7%). The presence of departmental and unit-based shared governance structures was for a duration range of six to ten years (42.6%).

The organizational demographics of the sample population were inconsistent with national demographics. The registered nurse population in hospitals is equitably distributed across the country based on the data presented in the 2008 NSSRN (USDHHS, 2010). In this study one-third of the respondents were from the Middle Atlantic region. It is unknown if this was a reflection of the demographics of membership in AONE. Over 75% of acute care hospitals across the United States are community hospitals (BLS, 2014). Community hospitals represented 31.5% of the sample for this study, versus academic medical centers represented 59.3% of the sample.

Table 4

Organizational Demographics

	Frequency	Percent
Region		
New England	4	7.4
Middle Atlantic	18	33.3
East North Central	3	5.6
West North Central	1	1.9
South Atlantic	14	25.9
East South Central	1	1.9
West South Central	4	7.4
Mountain	4	7.4
Pacific	5	9.3
Hospital Type		
Academic	32	59.3
Community Teaching	5	9.3
Community	17	31.5
Number of Units Assigned		
One	20	37.0
Two	20	37.0
Three	7	13.0
Four	3	5.6
Five	1	1.9
Six	2	3.7
Seven	1	1.9
Unit Type		
Medical	4	7.4
Surgical	1	1.9
Combined Medical-Surgical	11	20.4
Step-down/Intermediate Care	5	9.3
Critical Care	13	24.1
Emergency Department	3	5.6
Operating Room	3	5.6
Women's Services	2	3.7
Pediatrics	2	3.7
Peri-Operative Services	5	9.3
Procedural Units	1	1.9
Other	4	7.4

(table continues)

	Frequency	Percent
Full-time Equivalents (FTEs)		
6-20 FTEs	6	11.1
21-40 FTEs	7	13.0
41-60 FTEs	12	22.2
61 to 80 FTEs	13	24.1
81 to 100 FTEs	6	11.1
101 to 120 FTEs	2	3.7
121 to 140 FTEs	4	7.4
141 or more FTEs	3	5.6
Turnover Rate		
0% to 5%	26	48.2
6% to 10%	12	22.2
11% to 15%	7	13.0
16% to 20%	2	3.7
21% or greater	3	5.6
Magnet® Designation		
Not pursuing Magnet® designation	10	18.5
Journeying to Magnet® designation	4	7.4
Magnet® Designated	40	74.1
Duration of Magnet® Designation		
0 to 1 year	9	16.7
2 years to 5 years	22	40.7
6 years to 10 years	14	25.9
10 years or greater	9	16.7
Shared Governance Structure		
No structure in place	3	5.6
Departmental structure in place only	8	14.8
Departmental and some units have structure	4	7.4
Departmental and all units have structure	39	72.2

(table continues)

	Frequency	Percent
Duration of Departmental and all Units Structure		
0 to 1 year	3	5.6
2 years to 5 years	12	22.2
6 years to 10 years	23	42.6
10 years or greater	16	29.6

Note. New England=Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut; Middle Atlantic=New York, New Jersey, Pennsylvania; East North Central=Ohio, Indiana, Illinois, Michigan, Wisconsin; West North Central=Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas; South Atlantic=Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida; East South Central=Kentucky, Tennessee, Alabama, Mississippi; West South Central=Arkansas, Louisiana, Oklahoma, Texas; Mountain=Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada; Pacific=Washington, Oregon, California, Alaska, Hawaii.

The sample population for the study was comprised predominantly of Magnet® designated organizations. This may have been reflective of the membership of AONE, but was not reflective of the national norm of 6.61% of acute care hospitals achieving Magnet® designation (ANCC, 2014). The national turnover rate of registered nurses is 18% (USDHHS, 2010). The predominant range of 0% to 5% turnover rate may be a greater reflection of the volume of Magnet® designated organizations in the sample; it is not characteristic of the national norm for turnover. Unit type being predominately critical care is not typical of unit distribution throughout acute care hospitals. Acute care hospitals have more medical-surgical units and critical care units than any other types of units; however, hospitals typically have more medical-surgical units than any other type of unit.

The nurse manager role is a subset of the larger role of registered nurse. No database is available to describe the distribution of nurse managers within the population of registered nurses. The personal demographics of the sample were representative of the general population of registered nurses. The organizational demographics did not represent the normal distribution of attributes of acute care hospitals in the United States. These demographic characteristics may be representative of the membership of AONE from which the sample was drawn.

Results

The sample for the study was drawn from a random sample of the nurse manager membership of AONE. The descriptive statistics revealed a disproportionate number of respondents were geographically located on the east coast and practice in Magnet® designated academic medical centers. Magnet® designated organizations characteristically have lower turnover rates, which was reflected in the turnover rates of the study population. The nurse manager's personal characteristics were reflective of the population of registered nurses in the United States. The majority of the sample was female, White/Caucasian, between 45 and 54 years of age, and more than 15 years of experience as a registered nurse.

Assumptions

The study is a quantitative, nonexperimental, cross-sectional survey study exploring the relationship between the variables of transformational leadership and shared governance and between the participation subscale score and transformational leadership. Pearson product-moment correlation coefficient was utilized to assess the

degree to which the variables are linearly related, provided the statistical assumptions underlying the significance for the test are met. There were two assumptions which must have been met: the variables must be normally distributed and the cases must represent a random sample from the population with the scores of the variables from one case being independent of scores on the variables for other cases.

The first assumption was related to independent scores on the variables. In this study, a random sample of nurse managers working in acute care hospitals in the United States, who were members of AONE, were selected for participation in the study. The variable of transformational leadership was assessed via the Multi-factor Leadership Questionnaire (MLQ 5X short) and the variables of shared governance and participation subscale score were assessed via completion of the IPNG. Each participant received a link to the survey questionnaire which contained both the MLQ 5X short and the IPNG. The individual participant's score on these questionnaires stands alone and is not contingent on the responses from other participants. Each variable was scored by individual response and was independent of other participants' scores. This meets the first assumption.

The second assumption was that the variables are bivariately normally distributed. If this assumption is met, then the only relationship possible between the variables is a linear relationship. Skewness and kurtosis was assessed to test for the presence of normal distribution.

The variables included in this study were transformational leadership, shared governance and the participation subscale of the IPNG. Bivariate analysis was performed

on these variables to test for the assumption of normality. The sample size for the analysis was 54. Table 5 contains the summary of the analysis.

The variable of transformational leadership was represented by the percentile rank of the mean subscale scores of: idealized influence attributed, idealized influence behavior, inspirational motivation, intellectual stimulation and individualized consideration. Transformational leadership had a mean score of 68.38 and the scores ranged from 27 to 95 with a median score of 73. Skewness of $-.630$ indicated a fairly symmetrical distribution of the data for this variable. The kurtosis was $-.817$ which represented a platykurtic distribution.

The total score on the IPNG reflects the presence or absence of shared governance. The mean total score was 203.94. Scores ranged from 109 to 327 with a median score of 202. The data was symmetrically distributed as indicated by a skewness of $.208$ and kurtosis of 2.293 . The kurtosis represented a leptokurtic distribution, with a heavier but normal tail distribution.

The participation subscale score is the mean score of the questions on the IPNG reflective of participation in shared governance. The mean score was 33.69. The scores ranged from 13 to 49, with a median score of 33.5. There was symmetrical distribution of the data based on a skewness score of $-.066$. Leptokurtic or heavy tail distribution of scores was indicated by a kurtosis of 1.213 .

Table 5

Bivariate Analysis of Variables

	<i>M</i>	<i>SD</i>	95% CI	Skewness	Kurtosis
Transformational Leadership	68.38	21.02	[62.64, 74.11]	-.630	-.817
IPNG Total Score	203.94	36.17	[194.07, 213.82]	.208	2.293
Participation Subscale	33.69	6.67	[31.87, 35.51]	-.066	1.213

Note. CI=Confidence Interval.

Conducting the statistical analysis tested the assumption that the variables are bivariate normally distributed. Skewness ranged between -.5 and .5 indicating symmetrical distribution for the total score on IPNG and participation subscale, and skewness for transformational leadership was -.630 indicating fairly symmetrical distribution. Kurtosis was less than three, and the sample size was greater than 30, indicating symmetrical distribution. There was platykurtic distribution on the variable of transformational leadership and leptokurtic distribution on the IPNG total score and the participation subscale variables. These distributions may disappear with the use of a larger sample size. The assumption of normal distribution has been met.

Statistical Analysis

The research questions for the study were: what is the relationship between the leadership style of the nurse manager and the enculturation of shared governance and what is the relationship between the achievement of shared governance on the participation subscale of the IPNG and transformational leadership? In the first research question, the independent variable was the leadership style of the nurse manager and the

dependent variable was shared governance. In the second research question, the independent variable was the achievement of shared governance on the IPNG participation subscale and the dependent variable was transformational leadership style.

Leadership Style and Shared Governance

In this study I explored the relationship between leadership style and shared governance. Mean scale scores were calculated for each of the subscales of leadership style (Table 6). Transformational leadership was derived from the subscale scores of: idealized influence (attributed and behavior), inspirational motivation, intellectual stimulation, and individualized consideration. Active transactional leadership was derived from the subscale scores of contingent reward and management by exception (active). Passive transactional leader was ascertained by the subscale score of management by exception (passive) and laissez-faire leadership style was derived from the laissez-faire subscale.

Table 6

Leadership Style Subscale Scores

	<i>M</i>	<i>SD</i>	%
Idealized Influence (Attributed)	3.22	.50	70 th
Idealized Influence (Behavior)	3.31	.51	72 nd
Inspirational Motivation	3.48	.56	69 th
Intellectual Stimulation	3.31	.50	72 nd
Individualized Consideration	3.50	.39	75 th
Contingent Reward	3.16	.56	56 th
Management by Exception (Passive)	.77	.58	31 st
Management by Exception (Active)	1.86	.70	64 th
Laissez-Faire	.45	.59	38 th

Note. %=Percentile Ranking of Mean Score.

The mean subscale scores were converted into percentile rankings based on the Percentiles for Individual Scores Based on Self Ratings (US) located in the MLQ Manual and Sample Set (Avolio & Bass, 2004). The percentile rankings provided the designation of nurse manager leadership style (Table 7). The leadership styles assessed by the MLQ 5X short were: transformational, active transactional, passive transactional, and laissez-faire. Transformational and active transactional leadership styles are considered to be engaging and passive transactional and laissez-faire leadership styles are considered to be non-engaging (Hutchinson & Jackson, 2013).

Table 7

Nurse Manager Leadership Style

	Frequency	Percent
Transformational	25	46.3
Active Transactional	12	22.2
Passive Transactional	9	16.7
Laissez-Faire	8	14.8

Note. Percent=Percentage of sample.

Leadership style, for the study, had a range of 1 to 4, with a mean of 2, and a mode of 1. Skewness was .677 and kurtosis was -.970, which indicated normal distribution. Nurse manager perception of leadership style was predominantly transformational (46.3%). This finding was consistent with the findings in the literature which indicated that managers perceive themselves more often as being transformational (Herman et al., 2015; Lin et al., 2015; Shi et al., 2014). The engaging styles of leadership which include transformational and active transactional leadership comprised 68.5% of the sample for the current study. Passive transactional and laissez-faire leadership styles comprised 31.5% of the sample. Over 80% of the sample population worked at an organization journeying to Magnet® or currently designated as a Magnet® facility. It was unanticipated to find 31.5% of nurse managers with a nonengaging leadership style.

The MLQ 5X short measures the outcomes of leadership, in addition to leadership style. The outcomes measured were extra effort, effectiveness, and satisfaction. Extra effort is demonstrated by followers to strive for superior performance and exceed the

expectations of leadership, their group or their organization. Efficiency demonstrates adeptness in the achievement of organizational objectives and the drive to generate productivity within the organization. Satisfaction with leadership measures the leaders' ability to generate interpersonal satisfaction in their followers and colleagues. The mean scores and percentile ranks for the outcomes of leadership are listed in Table 8. Overall, the sample scored above the 60th percentile in all outcomes of leadership. Extra effort was at the 75th percentile with a mean score of 3.12. Effectiveness had a mean score of 3.34, which represented the 63rd percentile. The satisfaction subscale had a mean score of 3.41 which was in the 67th percentile. The outcomes of leadership results were consistent with the sample being predominantly from Magnet® organizations.

Table 8

Outcomes of Leadership

	M	SD	Percentile*
Extra Effort	3.12	.555	75.01
Effectiveness	3.34	.462	63.03
Satisfaction	3.41	.477	67.04

Note. Percentile*=Percentile rank based on overall mean scores for each subscale.

The presence of shared governance was measured by the IPNG. This instrument yields a total score, and six subscale scores that assess unit governance. The subscale scores are: nursing personnel, access to information, goals and conflicts, resources and supporting practice, participation, and control over nursing practice. The mean scores for the subscales are reported in Table 9.

Table 9

Shared Governance Subscale Scores

	M	SD	SG Score
Nursing Personnel	35.80	8.35	44-88
Access to Information	37.39	8.70	31-60
Goals and Conflicts	19.78	4.50	17-32
Resources and Support	37.82	9.14	27-52
Participation	33.69	6.67	25-48
Control over Nursing Practice	40.02	8.76	33-64

Note. SG Score=Score range indicating the presence of shared governance.

All subscale mean scores fell within the shared governance range except the nursing personnel subscale. This subscale measured who has control over all aspects of nursing personnel; this included hiring, firing and performance appraisals. The score on this domain was reflective of traditional governance, indicating that control in this area was primarily assumed by management.

Research Question 1: What is the relationship between leadership style of the nurse manager and enculturation of shared governance?

H_01 : There is a negative or no relationship between transformational leadership style of the nurse manager and shared governance.

H_11 : There is a positive relationship between transformational leadership style of the nurse manager and shared governance.

H_02 : There is a negative or no relationship between active transactional leadership style of the nurse manager and shared governance.

*H*₁₂: There is a positive relationship between active transactional leadership style of the nurse manager and shared governance.

Pearson's product-moment correlation was conducted to explore the relationship between the variables. The first correlation explored the relationship between transformational leadership style and shared governance. The second correlation explored the relationship between active transactional leadership style and shared governance.

The first correlation identified a significant positive relationship between transformational leadership and shared governance, $r(52)=.271$, 95% BCa CI [.072, .455], $p=.048$. Based on this result, the null hypothesis is rejected. The positive relationship between transformational leadership style and shared governance (*H*₁₁) indicated that as transformational leadership scores increased, total shared governance scores increased. The bias corrected and accelerated bootstrap 95% confidence interval [.072, .455], did not cross zero indicating there was a positive linear correlation between the variables of transformational leadership and shared governance. The effect size, $r=.271$, was small indicating a weak linear relationship between the variables.

Partial correlation was conducted to explore the relationship between transformational leadership and shared governance, controlling for Magnet® designation. There was a nonsignificant positive relationship between transformational leadership and shared governance, $r(52)=.244$, 95% BCa CI [.000, .459], $p=.078$. There were minimal differences in the correlations when controlling for Magnet® designation and the effect size remained small. The bias corrected and accelerated bootstrap 95% confidence interval [.000, .459], identified a lower confidence interval of zero. A confidence interval

of zero indicated no relationship between the variables. When controlling for Magnet® designation, there was no relationship between transformational leadership style and shared governance.

Table 10 explores the relationship between transformational leadership and the leadership style subscales. There were statistically significant positive relationships between the leadership subscales of idealized influence (attributed), idealized influence (behavior), inspirational motivation, intellectual stimulation, individualized consideration, and contingent reward and transformational leadership. These scales comprised the designation of transformational leadership, with the exception of contingent reward. The contingent reward subscale was associated with active transactional leadership. The bias corrected and accelerated bootstrap 95% confidence intervals for these subscales were strongly positive with upper limits close to 1.0. The effect size was large for the transformational subscales, except for individualized consideration and contingent reward where the effect size fell into the medium to large range.

Table 10

Bivariate Analysis among Transformational Leadership and Leadership Subscales

	<i>R</i>	95% CI
Idealized Influence (Attributed)	.780**	[.654, .881]
Idealized Influence (Behavior)	.806**	[.706, .895]
Inspirational Motivation	.855**	[.759, .925]
Intellectual Stimulation	.790**	[.690, .874]
Individualized Consideration	.671**	[.518, .787]
Contingent Reward	.697**	[.575, .809]
Management by Exception (Passive)	-.199	[-.454, .025]
Management by Exception (Active)	-.111	[-.368, .148]
Laissez-Faire	-.141	[-.465, .118]

Note. CI=Confidence interval. ** $p < .001$.

The negative relationship between management by exception (active), management by exception (passive), and laissez-faire subscales and transformational leadership was expected as these subscales were not related to transformational leadership style. The correlations did not achieve statistical significance. The bias corrected and accelerated bootstrap 95% confidence intervals for these subscales crossed zero, indicating there was no relationship between the variables. The effect size was very small and negative which further indicated there is no relationship between the variables.

Table 11 explores the relationship between transformational leadership and the shared governance subscales. There was a statistically significant positive relationship between the access to information subscale and transformational leadership, $r(52)=.273$, BCa CI [.004, .506], $p=.046$. The access to information subscale is focused on who has access to information associated with the governance process. This positive, but small relationship between the variables demonstrated that as transformational leadership

increased, access to information scores increased. All other subscale scores demonstrated small to no effect and were without statistical significance.

Table 11

Bivariate Analysis between Transformational Leadership and Shared Governance Subscales

	<i>R</i>	95% CI
Nursing Personnel	.230	[.015, .396]
Access to Information	.273*	[.004, .506]
Goals and Conflicts	.170	[-.073, .397]
Resources and Support	.256	[.017, .470]
Participation	.090	[-.204, .303]
Control over Nursing Practice	.195	[-.063, .394]

Note. CI=Confidence interval. * $p < .05$.

The second hypothesis was tested exploring the relationship between active transactional leadership and shared governance. This analysis demonstrated a nonsignificant, positive relationship between active transactional leadership and shared governance, $r(52) = .084$, 95% BCa CI [-.163, .316], $p = .546$. Based on this result the null hypothesis, there was no relationship between the active transactional leadership style of the nurse manager and shared governance, was accepted. While the correlation was positive ($r = .084$), the bias corrected and accelerated bootstrap 95% confidence interval crossed zero, indicating the relationship between the variables may have been positive or negative therefore there was no linear relationship. The effect size, $r = .084$, was exceedingly small and further demonstrated a lack of relationship between the variables.

Transformational and active transactional leadership styles are considered to be positive, engaging forms of leadership. The relationship between an engaging style of

leadership, either transformational or active transactional, and shared governance was explored. A statistically significant relationship was found between the variables, $r(52)=.274$, BCa CI [.064, .464], $p=.045$. The effect size was small. The bias corrected and accelerated bootstrap 95% confidence interval lower limit was close to zero, indicating a weak, positive linear correlation between the variables. A partial correlation was conducted to ascertain if the significant positive correlation remained when controlling for Magnet® designation. The results indicated a positive, statistically nonsignificant correlation between the variables, $r(52)=.249$, BCa CI [.030, .451], $p=.072$. When controlling for Magnet® designation, there was no linear relationship between the variables of engaging leadership style and shared governance.

The relationship between passive transactional leadership and shared governance was explored. A statistically nonsignificant relationship was found between the variables, $r(52)=-.050$, BCa CI [-.318, .242], $p=.720$. The effect size was close to zero. The bias corrected and accelerated bootstrap 95% confidence interval crossed zero indicating there was no linear relationship between the variables. This result was consistent with passive transactional leadership being a nonengaging leadership style.

Exploring the relationship between laissez-faire leadership style and shared governance led to a similar result. A statistically nonsignificant relationship was found between laissez-faire leadership style and shared governance; $r(52)=-.172$, BCa CI [-.406, .116], $p=.215$. The effect size was very small. The bias corrected and accelerated bootstrap 95% confidence interval crossed zero indicating there was no linear

relationship between the variables. These results were consistent with laissez-faire leadership style being a nonengaging form of leadership.

The first research question explored the relationship between the leadership style of the nurse manager and the enculturation of shared governance. A statistically significant, weak positive correlation was found between transformational leadership style of the nurse manager and the enculturation of shared governance. The correlation became smaller and nonsignificant when controlling to Magnet® designation. Active transactional, passive transactional, and laissez-faire leadership styles did not produce statistically significant correlations with the enculturation of shared governance.

Participation Subscale and Transformational Leadership

Research Question 2: What is the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style?

H₀₃: There is a negative or no relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

H₁₃: There is a positive relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style.

Statistical analysis was performed to explore the relationship between the achievement of a shared governance score on the participation subscale and transformational leadership style. The results of the analysis were: $r(52) = -.036$, BCa CI

[-.266, .220], $p=.799$. The results were not statistically significant and the null hypothesis, there was a negative or no relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership style, was accepted. The effect size was negligible and indicated there was no relationship between the variables. The bias corrected and accelerated bootstrap 95% confidence interval crossed zero, indicating there is no linear relationship between the variables.

Bivariate analysis of the relationship between the participation subscale score and the subscale scores on leadership style are presented in Table 12. The correlations between the participation subscale score and the leadership style subscale scores were very weak and did not approach statistical significance.

Table 12

Bivariate Analysis between Participation Subscale Score and Subscale Leadership Style Scores

	<i>R</i>	<i>P</i>	95% CI
Idealized Influence (Attributed)	.038	.786	[-.175, .240]
Idealized Influence (Behavior)	.182	.189	[-.087, .404]
Inspirational Motivation	.087	.532	[-.203, .366]
Intellectual Stimulation	.044	.753	[-.222, .291]
Individualized Consideration	-.003	.981	[-.283, .238]
Contingent Reward	.091	.514	[-.149, .319]
Management by Exception (Active)	.058	.679	[-.168, .303]
Management by Exception (Passive)	.102	.462	[-.181, .373]
Laissez-Faire	-.084	.548	[-.349, .218]

Note. CI=Confidence interval.

The analysis confirmed the lack of a relationship between the participation subscale score and any of the subscales of leadership style. The bias corrected and

accelerated bootstrap 95% confidence interval crossed zero in all subscales, indicating the relationship between the variables may be positive or negative therefore there was no linear relationship.

Outcomes of Leadership

The MLQ 5X short measured outcomes of leadership in addition to leadership style. The outcomes measured were: extra effort, effectiveness, and satisfaction. Extra effort is demonstrated by followers to strive for superior performance and exceed the expectations of leadership, their group, or their organization. Efficiency demonstrates adeptness in the achievement of organizational objectives and the drive to generate productivity within the organization. Satisfaction with leadership measured the leaders' ability to generate interpersonal satisfaction in their followers and colleagues. Table 13 presents the results of exploring the relationship between leadership style and outcomes of leadership.

Table 13

Bivariate Analysis of Relationship between Leadership Style and Outcomes of Leadership

	Extra Effort	Effectiveness	Satisfaction
Transformational Leadership	.763***	.686***	.665***
Active Transactional Leadership	.330*	.248	.198
Passive Transactional Leadership	-.165	-.263	-.342*
Laissez-Faire Leadership	-.105	-.281*	-.300*

Note. * $p < .05$, *** $p < .001$.

Transformational leadership had a statistically significant linear correlation to the outcomes of leadership. Extra effort, $r=.763$, BCa CI [.809, .872], $p<.001$, the correlation was positive with a large effect size. Transformational leadership style was positively correlated to effectiveness, $r=.686$, BCa CI [.514, .815], $p<.001$. This correlation had a medium effect size and was statistically significant. Satisfaction was $r=.665$, BCa CI [.525, .779], $p<.001$. This statistically significant correlation had a medium effect size and a positive correlation. The positive correlations and medium to large effect sizes indicated a strong relationship between the variables. Increases in transformational leadership resulted in increases in extra effort, effectiveness, and satisfaction. This was consistent with the literature on the outcomes of a transformational leadership style (Avolio & Bass, 2004).

Active transactional leadership, an engaging form of leadership, had a variable correlation with the outcomes of leadership. Extra effort was statistically significant, $r=.330$, BCa CI [.086, .581], $p=.015$. The correlation was positive, but the effect size was small. The correlation for effectiveness did not achieve statistical significance, $r=.248$, BCa CI [-.014, .505], $p=.071$. The effect size was small and the correlation was positive, but the bias corrected and accelerated bootstrap 95% confidence interval crossed zero which indicated there was no relationship between the variables of active transactional leadership and effectiveness. Satisfaction did not achieve statistical significance, $r=.198$, BCa CI [-.024, .424], $p=.150$. The effect size was very small and the bias corrected and accelerated bootstrap 95% confidence interval crossed zero indicating there was no relationship between the variables. Active transactional leadership style was weakly

correlated with extra effort and not correlated with effectiveness and satisfaction. This engaging form of leadership did not demonstrate strong correlations with the outcomes of leadership for this population.

Passive transactional leadership was negatively correlated with the outcomes of leadership. The statistically nonsignificant correlation between passive transactional leadership and extra effort was $r = -.165$, BCa CI $[-.387, .055]$, $p = .233$. While passive transactional leadership increased, extra effort decreased based on the correlation. The bias corrected and accelerated bootstrap 95% confidence interval crossed zero, indicating the relationship between the variables may have been positive or negative; therefore there was no linear relationship. The effect size was very weak. Effectiveness also had a negative correlation with passive transactional leadership, $r = -.263$, BCa CI $[-.514, -.018]$, $p = .055$. The effect size was small and the correlation is negative, but not statistically significant. Satisfaction and passive transactional leadership had a statistically significant correlation. There was a negative correlation between the variables, $r = -.342$, BCa CI $[-.565, -.082]$, $p = .011$. Increases in passive transactional leadership were correlated with decreases in satisfaction. The effect size was small making the correlation between the variables weak. The nonengaging leadership style of passive transactional leadership was negatively and weakly correlated with satisfaction. The outcomes of extra effort and effectiveness were weakly, negatively correlated with passive transactional leadership, but not to a level of statistical significance.

Laissez-faire leadership style is considered a nonengaging leadership style. It was not correlated to extra effort, $r = -.105$, BCa CI $[-.384, .154]$, $p = .448$. While the

correlation statistic was negative, the bias corrected and accelerated bootstrap 95% confidence interval crossed zero, indicating there was no linear relationship. The correlation was not statistically significant. Effectiveness and satisfaction were statistically significant when correlated with laissez-faire leadership style. Effectiveness was negatively correlated with laissez-faire leadership style, $r = -.281$, BCa CI $[-.518, -.052]$, $p = .040$. The effect size was small indicating a weak negative correlation; as laissez-faire leadership increased, effectiveness decreased. Satisfaction was negatively correlated with laissez-faire leadership, $r = -.300$, BCa CI $[-.513, -.068]$, $p = .028$. The effect size was small and the correlation between the variables was weak. Laissez-faire leadership style was negatively associated with the outcomes of leadership. It was significantly, negatively correlated with effectiveness and satisfaction, but those correlations were weak.

Transformational leadership style demonstrated strong positive correlations with the outcomes of leadership. Active transactional leadership was weakly and positively correlated with extra effort. Passive transactional and laissez-faire leadership styles were associated with negative correlations to the outcomes of leadership. Both leadership styles were negatively correlated to a level of statistical significance related to satisfaction. Despite achieving statistical significance, the correlation between the leadership styles and satisfaction was weak in this population.

Summary

In this research study I explored the relationship between the leadership style of the nurse manager and the enculturation of shared governance. The second research

question examined the relationship between the achievement of a shared governance score on the participation subscale on the IPNG and transformational leadership. Multiple correlations were performed to examine the relationships between the variables.

A statistically significant relationship between transformational leadership style and the enculturation of shared governance was found. The correlation was positive but the effect size was small, indicating a weak correlation between the variables of transformational leadership and shared governance. The null hypothesis was rejected. When controlling for Magnet® designation, the correlation between transformational leadership and shared governance was not statistically significant. The lower confidence interval was zero, indicating there was not a relationship between transformational leadership style and shared governance. Transformational leadership style demonstrated a strong positive correlation with the leadership subscales of idealized influence (attributed and behavior), inspirational motivation, and intellectual stimulation. Individualized consideration and contingent reward were moderately correlated with transformational leadership. Management by exception (active and passive) and laissez-faire subscales had weak, negative correlations with transformational leadership.

The second hypothesis explored the relationship between active transactional leadership style and the enculturation of shared governance. The null hypothesis was accepted as there was not a statistically significant relationship between active transactional leadership and shared governance. The bias corrected and accelerated bootstrap 95% confidence interval crossed zero, indicating no relationship between the variables.

In the second research question I explored the relationship between the achievement of a shared governance score on the participation subscale of the IPNG and transformational leadership. The null hypothesis was accepted. There was no relationship between the achievement of a shared governance score on the participation subscale and transformational leadership.

The outcomes of leadership demonstrated a strong, positive correlation between transformational leadership and extra effort, effectiveness, and satisfaction. Active transactional leadership demonstrated a weak, positive correlation with extra effort. Passive transactional and laissez-faire leadership styles were weakly and negatively correlated with satisfaction. The outcomes of leadership are strongly linearly correlated to transformational leadership.

The findings of the study are discussed further in Chapter 5. This chapter contains the interpretation of findings, limitations, and recommendations. It concludes with implications for social change and practice.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this nonexperimental, quantitative, cross-sectional study conducted tested the theory of transformational leadership that relates the leadership style of the nurse manager to the enculturation of shared governance in acute care hospitals in the United States. Transformational leaders use idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration to control the attitudes and behaviors of followers (Bakker et al., 2011; Bamford, Wong, & Laschinger, 2013). The transformational leader moves the follower beyond their own self-interest to focus on the vision of the organization (Zhu et al., 2011). The follower develops a positive sense of self-worth and value which increases their desire to go above and beyond expectations (Wong et al., 2013).

In a systemic review of the literature, Dionne et al. (2014), found that transformational leadership was associated with lower turnover rates, increased unit effectiveness, positive patient outcomes, increased staff involvement in decision making, a healthy work environment, and increased staff satisfaction and retention. Shared governance, the hallmark of professional practice in nursing, has also been linked to positive patient outcomes, a healthy work environment, and increased staff satisfaction and retention (McGlynn, Griffin, & Donahue, 2012; Sullivan Havens, Warshawsky, & Vasey, 2013). This participative management structure and process empowers the direct care registered nurse to exercise control over areas of practice traditionally controlled by management (Bina et al., 2014). The nurse manager works collaboratively with the direct

care staff to optimize the unit outcomes for the patients and the staff. The nurse manager is able to articulate the interests of the direct care staff at the organizational table. This leads to improved patient outcomes and increased staff job satisfaction and retention.

Healthcare reform is creating an increase in the demand for registered nurses. By 2020, the United States healthcare system is anticipated to have a shortage of over one million nurses (Juraschek et al., 2012). Over 17% of new registered nurses will leave their first position within the first year, 33.5% will leave within two years. Registered nurses are the most dissatisfied employees within the healthcare system (Kovner et al., 2014).

The contemporary healthcare literature is citing lack of willingness of registered nurses to be involved in decision making (Scherb et al., 2011; Graham-Dickerson et al., 2013; Wheeler & Foster, 2013) even when shared governance structures are in place (Hess, 2011; Wilson, 2013). Why this trend is occurring is not addressed in the literature. Is there a relationship between nurse manager leadership style and shared governance? The unwillingness of the professional nursing staff to participate in shared governance creates a void in the nurse manager's ability to accurately represent the issues and concerns of the direct care registered nurses at the organizational level. The lack of representation of the issues and concerns of direct care registered nurses has the potential to impact job satisfaction, retention of the registered nurse workforce, and the quality of patient care delivered to the community (Barlow, 2013; Wong et al., 2013; Zhu et al., 2011).

In this study I explored the relationship between nurse manager leadership style and the enculturation of shared governance. A positive, statistically significant relationship was found between transformational leadership style and the enculturation of shared governance. The statistical significance of the relationship was mitigated when controlling for Magnet® designation. The study findings failed to reveal a statistically significant relationship between any of the leadership styles measured by the Multi-factor Leadership Questionnaire (MLQ 5X short) and shared governance.

Additionally, in this study I explored the relationship between the achievement of a shared governance score on the participation subscale of the Index of Professional Nursing Governance (IPNG) and transformational leadership. There was no statistically significant relationship found between the variables. A positive, statistically significant relationship was found between the access to information subscale of the IPNG and transformational leadership.

Interpretation of the Findings

In this study I examined the relationship between nurse manager leadership style and the enculturation of shared governance. Leadership style and shared governance have been shown to have a positive impact on the work environment in healthcare (Lartey et al., 2014; Twigg & McCulloch, 2014). The focus of this study was on the relationship between these variables.

The leadership style of the nurse manager has a direct impact on registered nurse job satisfaction and retention (Cowden et al., 2011; Hayati, Charkhabi, & Naami, 2014; Lartey et al., 2014). Nurse managers influenced direct care nurses' intent to stay when

they took an interest in their staff, demonstrated they cared, were approachable, promoted teamwork, and mentored more experienced nurses (Feather et al., 2015; Keyko, Cummings, Yonge, & Wong, 2016). These supportive behaviors were consistent with the four attributes of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration.

Mean scores of these attributes in this study ranged from 3.22 to 3.50, which reflects the 69th to 75th percentile (Table 6). In this study, 46.3% of the nurse managers were identified as having a transformational leadership style. This is consistent with the findings in the literature that managers often rate themselves as transformational (Andrews et al., 2012; Wong et al., 2013).

Designation as having a transformational leadership style is consistent with the literature regarding educational level. Ross (2014) found that nurses educated at the baccalaureate level or above were more likely to be classified as transformational leaders. In this study, 100% of the participants were educated at the baccalaureate level and above. The predominant educational level was a master's degree in nursing which comprised 59.3% of the sample.

Transformational leadership is a domain of the Magnet® model. In this study, 74.1% of the participants were leaders in Magnet® designated organizations. Drenkard (2005) found a statistically significant, positive correlation between transformational leadership and Magnet® designation. The finding of over 46% exhibiting a transformational leadership style is consistent with the preponderance of participants from Magnet® organizations.

Despite the overwhelming number of nurse managers from Magnet® designated organizations in this study, passive transactional and laissez-faire leadership styles were found in 31.5% of the sample. Nurse managers designated with a laissez-faire leadership style comprised 14.8% of the total sample. Fifty percent of those managers represented journeying or Magnet® designated organizations. Passive transactional leadership style comprised 16.7% of the total sample and 100% of nurse managers, who identified with this leadership style, were from Magnet® designated facilities. Magnet® designation does not guarantee that all leaders within the organization are transformational; the multitude of nonengaging leadership styles in Magnet® designated or journeying to Magnet® organizations was an unexpected finding.

Span of control influences the perception of transformational leadership style. The wider the span of control the less transformational the leader is perceived (Merrill, 2011; Meyer et al., 2011). The span of control for nurse managers who participated in this study ranged from 6 to 150 full time equivalents (FTEs). The predominant range of FTEs was 61 to 80 FTEs. The nurse managers, identified as having a transformational leadership style, were responsible for managing an average of 67 FTEs. The nurse managers with a nonengaging style of leadership, managed an average of 79.5 FTEs. In this study there was no relationship between span of control, as measured by FTEs, and leadership style, $r(53) = .197$, 95% BCaCI [-.073, .468], $p = .158$.

Transformational leadership style is associated with job satisfaction and retention (Cowden et al., 2011; Hayati et al., 2014; Lartey et al., 2014). Registered nurse turnover rates for the study had a mean of 7.71% and a mode of 3%. This was well below the

national norm of 18% (USDHHS, 2010). The predominant range of turnover in this study was 0-5%, which represented 48.2% of the sample. Non-engaging leadership style had a mean turnover rate of 8.16%, with a mode of 3%. The findings in this study were consistent with the literature, given the high percentage of nurse managers with a transformational leadership style and the significantly high percentage of organizations with Magnet® designation.

Transformational leadership is associated with job satisfaction for followers, it also creates job satisfaction for the leader (Becker et al., 2012; Piccolo et al., 2012). The outcomes of leadership scored above the 60th percentile in all domains for this study. Extra effort had a mean score of 3.12 and reflected the 75th percentile. Effectiveness had a mean score of 3.34, which is the 63rd percentile and satisfaction had a mean score of 3.41 which is the 67th percentile (Table 8). High outcomes of leadership are reflective of the transformational leadership style identified by the managers in the study.

The study findings are fairly consistent with literature related to transformational leadership. Managers often identify themselves as being transformational, transformational leadership is related to low turnover rate and job satisfaction. The single inconsistency with the literature relates to span of control; in this study there was no relationship found between span of control and leadership style. The prevalence of nonengaging leadership styles within Magnet® designated organizations is a finding not previously reported in the healthcare literature.

The second concept examined in the study was shared governance. Over 85% of the respondents, in this study, scored within the shared governance range. Of the

respondents scoring in the shared governance range, 95.6% fell into the early shared governance range. This indicates that decisions are made primarily by management with some staff input. No respondents fell into a shared governance range that was equally balanced between management and staff. A total of 4.4% scored in the late shared governance range. This range reflected that decision making was primarily by staff with some management input. The high percentage of facilities that scored in the shared governance range was expected, given the volume of Magnet® designated organizations in the sample. The majority of the facilities (45%) have been Magnet® designated between 2 to 5 years. It was noted that over 95% of the Magnet® designated facilities were still in the early phases of shared governance implementation. The total score on the IPNG should have been higher given the high percentage of Magnet® designated and Magnet® journeying facilities.

The six subscale scores of the IPNG had mean scores within the shared governance range except for the nursing personnel subscale. This subscale had a mean score of 35.80, and shared governance range for this subscale is 44-88. The mean score of 35.80 is reflective of traditional governance. This subscale measures who has control over all aspects of nursing personnel; this includes hiring, firing and performance appraisals. The mean scores of the subscales of access to information, goals and conflicts, and resources and support fell in the lower range of shared governance. The participation subscale and control over nursing practice fell into the middle of the shared governance range (Table 9). This is consistent with the total score reflecting decisions made primarily by management with some staff input.

Anderson (2000), Barden et al. (2011), and Hastings et al. (2014) found a positive correlation between the presence of shared governance and job satisfaction and retention. The respondents in this study had very low turnover rates and a high number of organizations demonstrating the presence of shared governance based on the total IPNG score. Despite these findings, there was no statistically significant linear relationship found between the type of governance and turnover rate, $r(50) = .039$, 95% BCa CI [-0.282, 0.307], $p = .785$.

In this study, 72.2% of the sample reported having both a departmental and unit-based shared governance structure in place. Those reporting the presence of a structure had achieved a score in the shared governance range on the IPNG. This is not consistent with the findings of Spense-Laschinger and Wong (1999), Howell et al. (2001), and Wilson (2013) who found that the presence of a shared governance structure did not guarantee the presence of shared governance. The managers' perception of the presence of shared governance could have been influenced by their participation in the shared governance process at the departmental and unit level. This would be consistent with the findings of Hess (2011) and Wilson (2013), which stipulated participation in shared governance influences the perception of the existence of shared governance at the unit and organizational levels. The preponderance of early stages of shared governance in the total sample may be a reflection of the managers' perception of the presence of shared governance; this perception may not be consistent with their staff. The literature is mixed regarding whether managers and staff perceive the presence of shared governance in the same manner. Hess (2011), Ott and Ross (2013), and Wilson (2013) found differences in

manager and staff perception of the presence of shared governance. Al-Faouri et al. (2014), Lamoureux et al. (2014), and Wilson et al. (2014), found no differences in the scores of direct care nurses and nurse managers on the total score and the subscales scores of the IPNG.

Magnet® designated facilities are required to have nurses involved in decision making at all levels of the organization. This requirement falls into the structural empowerment domain of the Magnet® model. Shared governance structures have been implemented by all organizations achieving Magnet® designation (ANCC, 2014). In this sample, over 74% of respondents were from Magnet® designated facilities, so it is not surprising that over 72% of the nurse managers in this study reported as having both a unit-based and departmental shared governance structure in place. One hundred percent of Magnet® designated facilities reported having both a departmental and unit-based shared governance structure in place. This was also consistent with the findings of Hess et al. (2011) and Clavelle et al. (2013), that Magnet® designated facilities have both direct care staff and leadership reporting the presence of shared governance structures. In this study, 5.6% of the respondents reported not having a shared governance structure in place, those respondent's organizations were not pursuing Magnet® designation.

Lamoureux et al. (2014), and Wilson (2013) found statistically significant differences in scores on the IPNG between genders. In this study, there were no statistically significant differences in the scores on the IPNG based on gender, $r(54) = -.039$, 95% BCa CI [-.194, .147], $p = .781$. Al-Faouri et al. (2014) and Lamoureux et al. (2014), also found higher scores on the IPNG in critical care units, than other units in

acute care hospitals. There were no statistically significant differences in the IPNG scores based on unit, $r(54) = -.188$, 95% BCa CI [-.466, .165], $p = .174$.

Participation Subscale

The participation subscale in this study had a mean score of 33.69 and the shared governance range for this subscale is 25 to 48. There was no statistically significant relationship found between the participation subscale score and transformational leadership. The participation subscale reflects the ability to form interdisciplinary teams and determine membership on those teams at both the unit and organizational levels. Transformational leaders have the ability to encourage and empower staff related to participation in organizational and unit activities (Kopperud et al., 2014; Van Knippenberg et al., 2013); this finding in the literature was not confirmed in this study. In the analysis of all of the subscale scores and transformational leadership, the only statistically significant relationship was found between the access to information subscale and transformational leadership. This subscale reflects the ability of direct care nurses to have access to information regarding unit budget, performance improvement, and regulatory designations.

Lamoureux et al. (2014) and Wilson (2013) found statistically significant differences in participation subscale scores based on gender and unit worked. In each study, males scored higher on the participation subscale than females. In this study there was no statistically significant difference in the participation subscale scores based on gender. Lamoureux et al. (2014) also found statistically significant differences related to unit worked. Specifically, nurses in critical care scored higher on the participation

subscale than nurses in other units. In this research study there was no statistically significant difference in participation subscale scores based on unit worked.

In this study I examined the relationship between the nurse manager leadership style and the enculturation of shared governance. A single action study in the literature attributed the transformational leadership style of the leader to the development of shared governance and ultimately to a reduction in staff turnover and improvement in staff satisfaction (Bamford-Wade & Moss, 2010). In this study a weak, positive, statistically significant relationship between the transformational leadership style of the nurse manager and the enculturation of shared governance was found. The statistically significant relationship was mitigated when controlling for the presence of Magnet® designation. There was no statistically significant relationships found between any of the leadership styles, active transactional, passive transactional, and laissez-faire, and shared governance.

The conceptual framework for this study was derived from transformational leadership theory and shared governance. It postulated the nurse manager, using a transformational leadership style in the work environment, could foster the enculturation of shared governance, thus improving job satisfaction and retention. In this study 46.3% of the participating nurse managers scored as having a transformational leadership style. Over 85% of the nurse managers also scored in the shared governance range on the IPNG, 100% of the managers designated as transformational leaders scoring in the shared governance range on the IPNG. Turnover rates averaged 7.71%, significantly less than the national norm, with the majority (48.2%) in the 0% to 5% range. Each of the

components of the framework scored well in the study which was most likely due to the significant presence of Magnet® designation in the organizations of the majority of the study sample. When controlling for the presence of Magnet® designation, a statistically significant relationship could not be found between transformational leadership and shared governance.

Broad concepts from the literature were found in this study such as perceptions of transformational leadership and transformational leadership style and shared governance fostering low turnover rates. Linear relationships between transformational leadership and shared governance, between the participation subscale and transformational leadership, and between turnover rates and transformational leadership and shared governance did not achieve statistical significance. Given the volume of Magnet® designated facilities with nurse managers participating in this study, the finding of over 30% of the nurse managers exhibiting a nonengaging leadership style was an unexpected outcome.

Limitations of the Study

As discussed in Chapter 1, the researcher assumed that certain variables could potentially influence both the generalizability of the findings and the validity of conclusions. The limitations of this study centered on the sample population and the responses to the survey.

In relation to the sample population, the sample for the study was drawn from a random sample of nurse managers working in acute care hospitals in the United States who are members of the American Organization of Nurse Executives (AONE). The

study was administered to the sample via an email survey. A national database of nurse managers working in acute care hospitals in the United States does not currently exist. Information concerning the job titles of registered nurses may be obtained from specialty professional organizations and/or from individual state boards of nursing. All of the state boards of nursing in the United States were contacted by the researcher to identify if they collected job title information and if this information was available to the researcher. A total of 88% of the state boards of nursing responded to the request for information. Individual state boards of nursing differed in whether or not they collected information concerning the registered nurses' job title. All respondent state boards were consistent in not providing access to that information to public or private requestors. The National Council of State Boards of Nursing does not collect this demographic information.

Due to the lack of existence or access to the information from national or state boards of nursing needed for this study, the national specialty organization for nurse managers, the American Organization of Nurse Executives (AONE) was contacted by the researcher. This organization, following a review of the proposal, completion of paperwork, and payment of fees, agreed to provide access to nurse manager members within the database. It is unknown if the nurse manager members were representative of the nurse manager population in the United States. Participant information received from AONE was in alphabetical order by last name and included an email address. The email address was either business or personal ascertained by the suffix of “.org” or “.com” in the email address. Irrespective of the email suffix designation, the identified nurse

manager received a random number which was used to determine selection for participation in the study.

A link to the survey was sent to the random sample of nurse managers; it is unknown if the survey was completed by the person to which it was sent. Due to the confidentiality of the survey responses and the anonymity of the participants, there was no mechanism to validate the identity of the respondent to the survey. There were no redundant IP addresses received, which would indicate responses came from different computers; however, that did not identify the respondent to the survey.

The respondents to the survey were representative of the population of registered nurses regarding sex, age range, and ethnicity. They were not representative regarding organizational demographics of geographic distribution, hospital type, Magnet® designation, and turnover rate. The respondents to the survey were predominantly from the Middle Atlantic and South Atlantic regions of the United States. Over 59% of the sample were from acute care hospitals in these areas. Acute care hospitals are evenly distributed across the United States based on population (USDHHS, 2010). It is unknown if this is characteristic of the demographic profile of nurse managers with membership in AONE, but it is not reflective of acute care hospitals in the United States.

The respondents primarily practiced in Magnet® designated, academic medical centers, in critical care units, and had low turnover rates; however this is not characteristic of acute care hospitals in the United States. Over 75% of acute care hospitals in the United States are community hospitals (BLS, 2014). The respondents to the survey worked predominantly in academic medical centers (59.3%). A total of 31.5%

of the sampled worked in community hospital settings. While this may be representative of the membership of AONE; it is not reflective of acute care hospitals in the United States.

Magnet® designation has been achieved by 6.61% of acute care hospitals in the United States (ANCC, 2014). In this study, 74.1% of the respondents were from Magnet® designated facilities. This may be a reflection of the membership of AONE, the respondent's interest in the topic being researched, and/or their knowledge of the topic of the study. The turnover rate for the study was significantly lower than the national registered nurse turnover rate. The mean turnover rate of 7.71% for this study is reflective of the proportion of Magnet® designated organizations who participated in the survey. Magnet® designated organizations have lower turnover rates, which is demonstrated by 48.2% of respondents who had a 0% to 5% range turnover rate on their unit(s). The national turnover rate of registered nurses is 18% (USDHSS, 2010).

Over 24% of the respondents were employed in critical care units. This is not characteristic of acute care hospitals where the most abundant unit type is medical-surgical. Medical-surgical units comprised 20.4% of the sample. It is unknown if nurse managers who are members of AONE predominantly work in critical care units as opposed to medical-surgical units. Type of unit managed was not provided by AONE.

With regard to the responses of the survey, the total response rate was 73.9%. Multiple surveys were not utilized due to being incomplete or the respondent did not meet the inclusion criteria. The number of usable surveys dropped the response rate to 48.7%. This is a high response rate for survey research; this may be indicative of the

population selected for the study. The survey closed after 8 weeks, without reaching the required response rate for generalizability.

In this study the data utilized was self-reported by the nurse manager relative to the assessment of leadership style and unit governance. Nurse managers tend to rate themselves as more transformational or transactional than their staff members rate them (Andrews et al., 2012; Bormann & Abrahamson, 2014). Over 46% of the nurse managers in this study rated themselves as exhibiting a transformational leadership style, which is consistent with the findings in the literature. Leadership within Magnet® designated organizations are required to demonstrate transformational leadership, which may have influenced the findings in this study.

Nurse managers in high intensity units, such as critical care and oncology, tend to be more transactional than nurse managers in lower acuity settings, such as medical-surgical nursing (Aboshaiqah, Hamdan-Mansour, Sherrod, Alkhaibary, & Alkhaibary, 2014; Wang, Oh, Courtright, & Colbert, 2011). In this study, 46.2% of the nurse managers in critical care rated themselves as transformational and 46.2% rated themselves as transactional. Those managers with a transactional leadership style were equally split between active transactional and passive transactional with each leadership style comprising 23.1%. Given the preponderance of Magnet® designated facilities in the sample, it was surprising to find an equal split between transformational and transactional styles.

The candor of the participant could not be controlled. It is unknown if the respondent provided socially desirable answers to the survey questions or answered each

question to reflect their actual beliefs and/or behaviors. It is also unknown if the respondents to the survey knew more or less about the topic being studied.

Transformational leadership and shared governance are requirements for the achievement of Magnet® designation. Given the high percentage of Magnet® designated facilities in the sample, it is possible the nurse managers in this study knew more about the topics of transformational leadership and shared governance than the general population of nurse managers.

The design of the survey utilized the MLQ5X short and the IPNG which created challenges due to the length of the survey. The survey response rate of 73.9% was exceptional; however, there were 25 incomplete surveys that could not be used for the study which dropped the response rate to 48.7%. The length of the survey may have contributed to the number of incomplete responses.

Recommendations

Future research will augment the findings of this study. Areas of future research should focus on: job satisfaction and retention of direct care registered nurses, aligning the sample population with the organizational demographics of acute care hospitals, exploring the significance of nonengaging leadership styles, and why nurses are unwilling to participate in shared governance. Nurse manager willingness to foster the development of empowering practice environment and nurse manager challenges related to engaging direct care nurses in shared governance are areas which should also be considered for future research. Studies conducted on a national level would provide for greater ability to generalize findings, rather than small scale, single health system studies.

The study focused on two variables which impact the job satisfaction and retention of direct care registered nurses: nurse manager leadership style and shared governance. The literature, in small scale studies, indicates direct care nurses are unwilling to participate in shared governance; thus limiting the nurse manager's ability to adequately represent the needs of the direct care nurse at the organizational level. Future research on creating a positive work environment which fosters autonomy and empowerment and leads to direct care registered nurse satisfaction is critical due to the looming nursing shortage.

The study closed without reaching the required sample size needed for generalizability. The findings in future research on this topic may be different if a larger sample size can be achieved. The sample in this study was from predominantly Magnet® designated, academic medical centers, but this is not characteristic of acute care hospitals in the United States. Future researchers should consider generating a larger sample from non-Magnet® designated, community hospitals to be more reflective of the organizational demographics of acute care hospitals in the United States. The sample would need to be evenly distributed by region of the country. In this study, the majority of the sample was from the Middle Atlantic and Southern Atlantic regions of the United States. The geographic region of the country, the setting of the acute care hospital, and the Magnet® designation of the facility are variables which may influence the outcomes of the research.

Due to the lack of research in the healthcare literature about the incidence or prevalence of nonengaging leadership in Magnet® designated facilities and the

unexpected finding in the current study of 31.5% of nurse managers exhibiting a nonengaging leadership style, additional research is required. Magnet® designated facilities are not required to demonstrate that all leaders demonstrate an engaging leadership style; rather that the culture of the organization demonstrates engagement and empowerment. Exploration into the impact of non-engaging leadership style at different leadership levels and its influence on direct care registered nurse empowerment, autonomy, job satisfaction and retention is another area for future research.

A recommendation for future study includes the presence of nonengaging leadership style and low turnover rates. The literature is replete with research on nonengaging leadership styles and high turnover rates. The ability of nonengaging leaders to allow for the development and evolution of shared governance is another area of potential research.

Why direct care nurses are unwilling to participate in shared governance requires further exploration. Variables, such as leader communication, time with staff, and manager willingness to empower staff decision making, require further exploration via research, as the literature has documented these variables influence autonomy and empowerment of direct care registered nurses. The results of this study demonstrated the presence of shared governance, but at the lower levels with decisions being made primarily by management with some staff input. The lack of progression of the evolution of shared governance, despite having structures in place for 6-10 years is a finding which requires further research. Understanding the barriers perceived by nurse managers in engaging direct care nurses in shared governance will provide additional insight into why

the shared governance is not evolving. National studies on these topics will bring a greater understanding as to the depth and breadth of the issues. Contemporary healthcare literature is replete with studies from single organizations, using convenience sampling. Future studies will provide insight into whether or not the current direct care nurse population still finds value in the shared governance process.

Implications

This study examined two research questions and hypotheses to compare the relationship between the nurse manager leadership style and the enculturation of shared governance. The literature indicated that shared governance and transformational leadership are empowering for direct care registered nurses. Participative management leadership style and process are associated with empowerment, job satisfaction, and retention of registered nurses (Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013). It is imperative for nursing leadership to understand the impact of leadership on the creation of a positive work environment. As demonstrated in the literature, the ability to foster job satisfaction and retention of the direct care registered nurse workforce is significant to the profession of nursing, to the healthcare system, and to the community the healthcare system was intended to serve.

Positive Social Change

The potential impact on social change from the research was positive. The results of the current study indicated a weak, positive correlation between the nurse manager's transformational leadership style and the enculturation of shared governance. This significant correlation was mitigated when controlling for Magnet® designation. In this

study a high percentage of nurse managers exhibited a transformational leadership style and a significant percentage of organizations had both departmental and unit-based shared governance structures in place. Turnover rates were significantly low for this sample. These findings point to strategies that might support the efforts of nurse managers to retain direct care registered nurses.

The findings in this study align with the findings in the literature regarding the creation of a positive work environment through the use of transformational leadership and shared governance. Transformational leadership is associated with job satisfaction and retention (Bamford-Wade & Moss, 2010; Barden et al., 2011; Hutchinson & Jackson, 2013), as does shared governance (Barlow, 2013; Blake et al., 2013). Both shared governance and transformational leadership are requirements for the achievement of Magnet® designation. Facilities designated as Magnet® are noted to have a positive work environment, which fosters direct care nurse job satisfaction, and retention. For the direct care registered nurse, having an empowered and autonomous work environment increases employee engagement (Wang & Gagne, 2013), improves job performance (Nielsen & Daniels, 2012), and improves psychological health (Kovjanic et al., 2012). Therefore, studies similar to this can greatly assist the healthcare organization in achieving a competitive advantage.

The creation of a positive work environment using transformational leadership and shared governance also improves the quality of patient care, patient safety, and lowers patient mortality (Clavelle et al., 2013; Lievens & Vlerick, 2014). Merrill (2011) also found that the use of a transformational leadership style fostered a climate of patient

safety. Paquet et al. (2013) found the use of transformational leadership style decreased medication errors and reduced length of stay. Brody et al. (2012) found that shared governance positively impacted the quality of care given to patients. Therefore the use of transformational leadership style by the nurse manager and the use of a shared governance decision making process has a significant role in creating a positive and engaging work environment for direct care staff which leads to better outcomes for patients.

In addition, organizational stability is created when experienced direct care staff members are able to be retained. Through the creation of an empowered and autonomous work environment, patient outcomes improve, which has a positive impact on patient satisfaction and organizational reimbursement. Direct care staff retention, especially during times of nursing shortage, results in significant organizational savings relative to turnover costs. For direct care staff an empowered and engaging practice environment promotes job satisfaction. For patients an empowered and engaged direct care nursing staff increases the quality and safety in the care provided to them. For the organization, it is lowers costs relative to staff turnover and the potential for increased reimbursement related to improved quality and satisfaction.

Recommendations for Practice

The current study was designed to test the theory of transformational leadership that relates the leadership style of nurse managers in acute care hospitals in the United States to the enculturation of shared governance. Conceptually, when transformational leadership and shared governance are present in the work environment, job satisfaction

and retention of the direct care registered nurse would occur. This study found a large number of nurse managers exhibiting a transformational leadership style and a large number of healthcare organizations with departmental and unit-based shared governance structures. There were also very low turnover rates associated with having transformational leadership and shared governance present in the work environment. The vast majority of participating organizations in the current study had achieved Magnet® designation.

Many factors impact direct care registered nurse satisfaction and retention. Unit leadership and a positive work environment are principle factors. The unit nurse manager has the ability, through the choice of leadership style, to positively or negatively influence the work environment and ultimately job satisfaction and retention. As the unit leader, direct care staff members look to the nurse manager to set the tone for practice on the unit. Leadership style choices made by the nurse manager impact the staff, patients, and the organization.

The leadership style manifested by the nurse manager is a reflection of their knowledge, skills and abilities. Education and feedback on strengths and opportunities related to leadership style can enhance the quality of leadership on the unit. Fostering the development of an engaging and empowering leadership style will enhance staff job satisfaction and retention through the use of autonomy and empowerment.

Autonomy and empowerment influence role perception and the work environment (Lu et al., 2012). Transformational leadership and shared governance foster autonomy and empowerment in the direct care nurse. Through autonomy and empowerment, trust is

built between the leader and follower, there is increased communication, and the development and articulation of a clear vision is established.

The inability to engage direct care staff in shared governance activities may be related to perceptions of decisional involvement. A significant number of participants in this study scored in the shared governance range on the IPNG. Despite having departmental and unit-based structures in place for 6 to 10 years, decision making was being done primarily by management with some staff input. For shared governance to be effective, it needs to continually evolve as a dynamic process with continual re-evaluation and growth. The model in use during years 1 to 2 of development should not be the same model the leader continues to use in years 4 to 5. This would result in the stagnation or regression in scores on the IPNG.

Failure to continue to evolve the shared governance structure is most likely the reason for the low scores on the IPNG. It may also provide some clues to the significant number of nurse managers with a nonengaging leadership style. While these managers have a higher turnover rate than nurse managers with an engaging leadership style, the lower than national turnover rate may be related to Magnet® designation. The low turnover rate is not sustainable in the long term.

The literature is clear, if staff do not perceive they are cared about and cared for by leadership, they will not remain in their current position. When staff voluntarily turnover in a position, they are leaving their leader. If nurse managers have any hope of retaining direct care nursing staff during an extreme and protracted nursing shortage, they

must choose to engage them. This can be done through the use of transformational leadership and shared governance.

Utilization of a transformational leadership style by nurse managers, positively influences direct care nurses job satisfaction and assists in preventing the turnover of registered nurses. The process of shared governance allows the voice of the direct care registered nurse to be heard at the organizational table. Transformational leadership style and shared governance, when implemented in the acute care hospital setting in the United States, can assist in improving employee engagement and reducing direct care nurse turnover. This creates stability of the workforce for the organization. The research indicates that the reduction in registered nurse turnover, especially during times of shortage, maintains a safer environment for patients seeking care within the healthcare system, reduces costs to the organization related to turnover, and maintains an autonomous, empowered workforce that continually strives to improve care provided to patients. Transformational leadership and shared governance are essential practices to reduce healthcare costs and provide quality care to the community the healthcare system was created to serve.

Conclusion

In this study I examined the relationship between nurse manager leadership style and the enculturation of shared governance. The findings of the study revealed a positive correlation between transformational leadership style and the presence of shared governance. This finding was mitigated when controlling for the presence of Magnet® designation. The majority of nurse managers perceived themselves to be

transformational leaders with shared governance structures and processes in place; these managers had very low direct care nurse turnover rates, indicating job satisfaction and retention.

The study reinforces the importance of nurse manager leadership style and shared governance on creating a positive work environment which fosters direct care registered nurse autonomy and empowerment. The creation of a positive work environment has implications, not only for the registered nurse, but also for patients and the organization. When nurses work in an autonomous and empowered work environment they experience greater job satisfaction and increased retention. Patients experience increased quality of care, an enhanced culture of safety, and increased satisfaction. The organization derives benefit from reduction in turnover costs, stability of the workforce, enhanced customer satisfaction, and increased financial compensation in the pay for performance methodology. The achievement of these outcomes were validated as part of the Magnet® designation process.

The nurse manager plays a crucial role in creating a positive practice environment for direct care nurses. They are a critical link to workforce stability in a time of impending registered nurse shortage. Healthcare organizations need to value their contribution in achieving a competitive advantage during the healthcare reformation process.

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Appendix A: Recruitment E-Mail

To: XXXX
From: Anna Keane
Date: XXX
Re: Participation in Research Study

.....

Dear (Participant),

CONSENT FORM

You are invited to take part in a research study about nurse manager leadership style and unit governance. The researcher is inviting nurse managers who work in acute care hospitals in the United States to be in the study. I obtained your name/contact info via the American Organization of Nurse Executives. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Anna E. Keane, MSN, MA, RN, NEA-BC, FACHE, CCRN, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to examine the relationship between nurse manager perceptions of leadership style and unit governance.

Procedures:

If you agree to be in this study, you will be asked to:

- Complete a onetime survey. The survey should take approximately 30 minutes to complete.
- Provide demographic information about yourself and your area(s) of responsibility
- Answer questions about your perceptions on management and the unit environment. There are no correct answers; the survey is asking you for your perspective.

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at your organization, Walden University, or the American Organization of Nurse Executives will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue or stress. Being in this study would not pose risk to your safety or wellbeing.

The study has no direct benefit to you as a participant but may assist in enhancing the practice environment for staff nurses and nurse leaders in the future.

Payment:

There is no payment for participation in this study. To provide reciprocity for your participation, you may submit your contact information on the last slide of the survey and receive an executive summary of the study findings.

Privacy:

Any information you provide will be kept anonymous. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by keeping participant lists and data collected in separate password encrypted files on a password protected computer. Any contact information will be deleted once the executive summary is sent. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email @ anna.keane@waldenu.edu or (302)233-1978. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is 03-17-16-0258125 and it expires on March 16, 2017.

Please print or save this consent form for your records.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by clicking on the link below.

<https://www.surveymonkey.com/r/PWFYNZF>

Appendix B: Permission to use MLQ 5X short

For use by Anna Keane only. Received from Mind Garden, Inc. on December 8, 2015

**Permission for Anna Keane to reproduce 150 copies
within one year of December 8, 2015**

Multifactor Leadership Questionnaire™
Instrument (Leader and Rater Form)
and Scoring Guide
(Form 5X-Short)

by Bruce Avolio and Bernard Bass

Published by Mind Garden, Inc.

Appendix C: Permission to use IPNG

Ann Keane
59 Zelkova Road
Smyrna, DE 19977

April 14, 2014

Dear Ann:

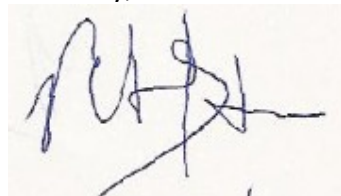
You have permission to use my instrument, the Index of Professional Governance (IPNG), or the Index of Professional Governance (IPG) to measure governance with an AONE sample of managers for your studies with Walden University. In return, I require that you:

- Report summary findings to me from the use of the IPNG/IPG, including reliability analysis, for tracking use and evaluating and establishing the validity and reliability of the IPNG, and for possible research publication without identification of the institutions.
- Credit the use and my authorship of the IPNG/IPG in any publication of the research involving the IPNG.

A pdf of the IPNG/IPG can be downloaded for the Forum for Shared Governance's website at www.sharedgovernance.org. I will email the factor analysis-derived subscales, which are different than the subscales apparent in the instrument itself, along with text that can be used to construct the six governance subscales and the overall governance score in SPSS. I can forward the SPSS codebook for data entry. You might want to revise the demographic section to reflect the organization and/or units you're surveying, which I can have done for you.

Please don't hesitate to call upon me to discuss your process or if you need help managing the data. If you need me to perform data entry and analysis and to generate a formal report with benchmarking, there is a consultant fee. I am also available for onsite speaking or consultation. Thanks for thinking of the IPNG and the Forum for Shared Governance. Good luck with your survey.

Sincerely,

A handwritten signature in blue ink, appearing to read 'RH', is written over a light-colored rectangular background.

Robert Hess, RN, PhD, FAAN
Founder, Forum for Shared Governance