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Servant Leadership and Its Effect on Employee Job Satisfaction and Turnover Intent

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Abstract

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Abstract

Experts expect a shortage of more than 900,000 nurses by 2022, according to the United States Bureau of Labor Statistics Employment Projections. Turnover in nursing contributes significantly to the shortage and often results from poor leadership of nurse managers. The purpose of this quantitative study was to investigate how servant leadership behaviors affected the psychological state and behavioral response of staff nurses as reflected by job satisfaction and turnover intention. Specifically, the research question addressed whether servant leadership positively contributes to the psychological states and the behaviors of staff nurses leading to greater job satisfaction. The study design was correlational, nonexperimental, and cross-sectional. Use of a questions from existing surveys combined into a single survey, from 284 staff nurses at a Pennsylvania hospital, provided the data for the research. Correlation analysis determined the strength and direction of servant leadership constructs and the dependent variables of turnover intention and job satisfaction. Multiple linear regression analysis predicted the influence of job satisfaction and turnover intention, demonstrating a strong, positive correlation linking servant leadership behaviors, the psychological state of engagement and job satisfaction. The study contributed to filling the gap in health care management by providing a picture of how servant leadership behaviors influenced job satisfaction and retention of nursing staff. Implications for positive social change may lead hospital administrators to encourage the adoption of servant leadership behaviors, by nurse managers, resulting in greater staff nurse job satisfaction, improved patient quality outcomes, sustainable organizational financial success, and expanded community health.

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Dedication

I dedicate this dissertation to my biggest cheerleader and wonderful wife, Heather. Words cannot not express my deepest gratitude to you. Without your strength, support, and encouragement, this journey would have never materialized. You made many sacrifices along the way, yet you continually inspired me to complete my dream. Thank you for believing in me and keeping me focused throughout this journey.

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Chapter 1: Introduction to the Study

Leader behaviors influence employee engagement leading to organizational outcomes. With health care costs expected to comprise 25% of the United States' gross domestic product by 2025 (Shi & Singh, 2014), leaders must enact proven leadership behaviors that improve employee engagement, leading to activities that reduce the financial burden on the United States health care system. One expense associated with the operations of a health care organization is the cost related to nursing dissatisfaction resulting in turnover. Creating a positive work environment for staff nurses that contributes to providing safe patient care is an ongoing challenge for health care leaders. To accomplish this feat, the health care executive's myopic view of leadership, specifically nursing leadership, must shift to include nontraditional leadership styles.

The nursing shortage has reached a global crisis as the demand for health care continues to grow while projections of the supply of nurses show a reduction in many countries (Buchan, O'may, & Dussault, 2013). For example, Buchan, et al. (2013) reported that Canada projected a shortage of 600,000 nurses by 2022, Australia will need 90,000 to 105,000 nurses by 2025, and the United Kingdom anticipates a need for 309,000 nurses by 2021. The United States expects a shortage of as many as 1.1 million nurses (McMenamin, 2014) or an overall turnover rate of 17.8%, an increase of .7% since 2013 (Colosi, 2015) with a slight decrease to 17.1% in 2014 (Colosi, 2016). While many factors contribute to this global crisis, one factor is nursing leadership.

Chapter 1 includes an overview of the problem that nursing leadership has not demonstrated reliability in addressing the reasons for the nursing shortage and associated

consequences (Blake, Leach, Robbins, Pike, & Needleman, 2013). Nursing managers who do not recognize that their current leadership style is ineffective are encouraged to adopt new approaches. Nurse managers may discover that by embracing a leadership style, such as servant leadership, staff nursing satisfaction will increase and turnover intention will decrease, while patient outcomes and financial sustainability improve.

Within the context of providing medical services and delivering those services in a cost-effective manner, health care executives must look at the nursing department's impact on expenses, specifically turnover. It is within the executive's scope of practice to determine the leadership factors that contribute to a nurse's decision to leave an organization or the profession and change the variables contributing to the loss. The goal is to increase nurse retention to reduce the financial burden on the organization and society. By looking at longstanding leadership behaviors and determining the effectiveness of traditional constructs, executives may discover a need for change.

Sun (2013) explained that servant leaders go beyond traditional leadership by selecting the needs of and serving others as the primary focus. According to Sun, servant leadership is different from other leadership styles, in its distinctiveness and its potential to have a unique influence on organizations and their stakeholders. Emphasizing the worker provides a competitive advantage as employees are more engaged in their work and are more likely to be satisfied (Anitha, 2014).

This chapter includes the background and statement of the problem, as well as the purpose, significance, nature, and conceptual framework of the study. An overview of the

data collection procedure and the process of evaluating the lived experiences of nurses in one Magnet certified hospital are also included.

Background of the Problem

The United States health care employed 15.7% of the workforce in 2011 (Moses et al., 2015). Registered nurses (RN) are one of the largest groups of professional health care workers (Bureau of Labor Statistics, 2013), comprising more than 2.3 million in the United States. Despite these numbers, the United States is experiencing an unprecedented shortage of RNs, which is having a significant impact on health care organizations and the delivery of services. According to the Bureau of Labor Statistics' Employment Projections, a shortage of more than 900,000 nurses and possibly more than 1 million nurses (as cited in McMenamin, 2014) will occur by 2022.

As the world population of baby boomers turns 65, the demand for nurses will increase despite a diminishing supply. By 2020, the majority of working RNs will reach a peak average age of 44 years old, with the more experienced nurses in their 50s (Auerbach, Buerhaus, & Staiger, 2015). As baby boomer nurses consider retirement, their departure will add to the future nursing shortage predictions and the cost of health care delivery for organizations.

Many factors contribute to the increasing cost of delivering health care in the United States. Hospital charges (4.2% increase per year), professional service fees (3.6% increase per year), pharmaceutical expenses (4.0% increase per year), and administrative overhead (5.6% increase per year) are a few of the factors contributing to the increase in

health care costs (Moses et al., 2013). Another cost incurred by health care organizations, as in other industries, is employee turnover (Gilmartin, 2013).

Nurses represent the largest labor expense of a hospital. Thus, the turnover of nurses directly influences the profitability of health care institutions (Gilmartin, 2013). When nursing positions remain vacant, labor costs increase, thereby affecting organizational profit margins. Li and Jones (2013) calculated health care organizations could spend a minimum of $3.36 million per year to replace staff nurses and up to $6.4 million per year for specialty nurses, depending on the rate of turnover.

In addition to direct labor costs, individual hospital facility leaders spend thousands of dollars on recruiting nurses. The challenge, however, is retaining them. Continuous recruitment translates to spending over $8.5 billion for new nurses that add significantly to society's health care costs (Yin & Jones, 2013). These expenses do not account for the potential loss of quality in patient outcomes when hospitals replace an experienced nurse with a new nurse. Therefore, the retention of nurses is paramount to prepare for the ever-burgeoning demand of health care services by an aging United States population and an increase of newly insured Americans.

Delivery of quality patient care is another factor affected by the shortage of nurses. When hospitals are unable to staff patient units, the nurse-to-patient ratio increases. McHugh, Berez, and Small (2013) determined that high nurse-to-patient ratios increases the likelihood of patient readmissions.

In their longitudinal study, Twigg, Geelhoed, Bremner, and Duffield (2013) researched the economic impact of nursing hours on patient outcomes and found that

assuring correct RN staffing levels would improve patient outcomes and be cost-effective for hospital organizations. They examined the effect of sufficient nurse staffing on the rate of infections and return on costs (based on life years gained). Twigg et al. reported a positive correlation existed between better patient outcomes with adequately staffed nursing units, and units that were understaffed, resulting in an estimated decrease in 6,700 patient deaths per year. Martsolf et al. (2014) also conducted a longitudinal analysis to determine the effectiveness of nurse staffing on the quality of care and concluded proper nurse staffing contributed to improved patient quality without increasing operational costs.

A significant factor in the nursing shortage, particularly in hospitals, relates to nursing dissatisfaction (Cicolini, Comparcini, & Simonetti, 2014). The challenge for health care executives is ensuring a quality driven nursing workforce during this labor shortage. Understanding the impact of job satisfaction in nursing is vital to solving nurse attrition. Job satisfaction is important because of its relationship to lower turnover, increased productivity of staff, enrichment of work-life quality, and improvement in patient outcomes resulting in enhanced organizational performance.

With the scrutiny of patient outcomes brought on by the Affordable Care Act, executives must critically look at the relationship of nurse leadership behaviors and staff satisfaction (Longenecker & Longenecker, 2014). With the proficiency of delivery, the cost of care and quality of outcomes already suspect (Hussey, Wertheimer, & Mehrota, 2013), the most conservative estimates of the nursing shortages could weaken the United States health care system further.

Although many unknowns about the factors that determine job satisfaction still exist, researchers have established a correlational link between job satisfaction and reduced turnover (Bao, Vedina, Moodie, & Dolan, 2013). Job satisfaction is multidimensional with factors such as salary and benefits, staffing levels, the opportunity for career advancement, input into decision making, support, and respect from and trust in managers. Salary and staffing levels are operational while the remaining variables (i.e., input in decision making, managerial support, respect, and trust) are directly attributable to behaviors of the nurse manager. As pointed out by Wong, Cummings, and Ducharme (2013), the nurse manager is essential to job satisfaction and ultimately nurse retention.

After conducting a purposive sampling of 1,283 nurses, Lee, Dai, Park, and McCreary (2013) concluded that job satisfaction is complex with a range of determinates, many of which rely on unit-level leadership. Empirical data from the United States as well as Europe suggested that nursing manager's leadership style, which creates supportive structures, such as the capacity to adapt innovations and improvements, invest in social capital, enhance a sense of personal accomplishment, and manage aspects of the work that influence work demands beyond nurse-to-patient ratios, directly impacts both nurse-assessed quality of care and job outcomes (Van Bogaert, Kowalski, Weeks, & Clarke, 2013). Work demands include concepts, such as examining how work is structured and organized to support nurse well-being, team performance, safety, and quality of patient care (Van Bogaert et al., 2013).

Leadership style influences the psychological state and the behavioral response of employees as well. Behavioral outcomes of internal stakeholders manifest in job

satisfaction and attainment of organizational goals, and, in the case of health care, improved patient outcomes are possible. Leaders exhibit specific behaviors and attitudes that influence staff engagement affecting organizational outcomes. Leader behaviors are measurable and categorized into specific leadership styles or traits. High-performing organizations seek to capitalize on leadership behaviors that mediate positive relationships with staff. Amundsen and Martinsen (2014) showed, with the Empowering Leadership Scale, that employees had greater satisfaction, commitment, and performed better when leaders demonstrated specific leadership behaviors.

Nursing traditionally has taught, emphasized, and supported transformational leadership (Hutchinson & Jackson, 2013) as the preferred style expected of health care organizations seeking Magnet recognition (American Nurses Credentialing Center, 2015; Choudhary, Ahktar, & Zaheer, 2013). Current research measuring nursing satisfaction, turnover intention, and patient outcomes demonstrates that by embracing other leadership styles, a change in the current trajectory of nursing could occur.

Researchers have discoursed on the benefits of servant leadership behaviors in many organizational settings outside the health care sector. They have determined that servant leadership is effective in leading organizations (Beck, 2014; Hunter et al., 2013; Liden, Wayne, Liao, & Meuser, 2014). Unlike health care organizations, many high-performing organizations seek people-centered leaders who embrace their position in an honorable and positive way. Servant leadership is people-centered with leaders who subscribe to a high level of empowerment and other moral constructs, such as sharing

decision-making, valuing people, building relationships, acting authentically, and demonstrating accountability (OLA Group, 2014).

Despite the surge of research on servant leadership in nonhealth care businesses, there has been limited research on the relevance of servant leadership in health care and even less in its application in nursing leadership. Parris and Peachey (2013) and Trastek, Hamilton, and Niles (2014) established the benefits of servant leadership on organizational performance, ethical decision making, education, and bringing value to the delivery of care. The gap in the related literature in desired hospital outcomes, ineffective management activities, and servant leadership literature provided the rationale for this study.

Statement of the Problem

The overarching question addressed in this study was why nursing leadership continues to encourage leadership styles that do not resonate with staff nurses (Cicolini et al., 2013; Khamisa, Peltzer, & Oldenburg, 2013), leading to job dissatisfaction and turnover intention when more appropriate leadership styles exist. McMenamin (2014) reported the nursing shortage would exceed 1 million RNs by 2022. Coupled with a potential turnover rate of 27% of nurses (Rondeau & Wager, 2016), the gap in nursing supply and available nurses will adversely affect health care organizations. Because of the deficit, Li and Jones (2013) calculated health care organizational leaders could spend a minimum of $3.36 million per year to replace staff nurses and up to $6.4 million per year for specialty nurses, depending on the rate of turnover.

The specific problem is the continued emphasis on transformational leadership style encouraged by the nursing profession and its inability to meet the reported expectations of retaining qualified and experienced nurses who deliver quality patient care (Cicolini et al., 2014). Transformational leadership does not properly address the nursing needs of society (Shi & Singh, 2014), which continues to add to the financial pressure (Leary et al., 2013) of health care organizations and society.

The United States Department of Health and Human Services Administration (2014) reported that each area of the United States differs in the degree of need. For example, according to Colosi (2015), the northeast United States nursing turnover rate is 17.2%, while the south-central area of the United States is experiencing a 22% turnover rate. Juraschek, Zhang, Ranganathan, and Lin (2012) cited The United States Registered Nurse Workforce Report Card and Shortage Forecast (2012) that Pennsylvania would have a shortfall of slightly over 49,000 RNs by the year 2030. Hospital nursing turnover data go unreported, and many state agencies do not collect this information adding to the challenge of collecting detailed institutional turnover information. Further, individual hospital leadership reluctantly divulges turnover information to researchers adding to the inability to quantify the actual need for nurses.

Purpose Statement

The purpose of this quantitative, nonexperimental study was to establish a servant leadership model for health care employees and test whether nursing leaders' servant leadership behaviors correlated to follower nurses' psychological states, leading ultimately to increased job satisfaction and a decrease in turnover intention. The

independent variables of the study were nursing leaders' servant leadership behaviors; the dependent variables were nurses' job satisfaction and turnover intention, and the psychological states of the nurses in the leadership process were the intermediate variables. A Magnet certified, Level II trauma center located in Pennsylvania was the research site for sampling of this study.

Research Questions

Greenleaf (1977) coined the term *servant leader* describing the character of one who serves others first. Numerous scholars (Liden et al., 2014; Parris & Peachey, 2013; Sun, 2013; Trastek et al., 2014; van Dierendonck, 2011) have subsequently written on the benefits of servant leadership behaviors within the workplace. The study's independent variables (IV) were nurse management's servant leadership characteristics of humility, empowering, communication, and commitment to employee growth. Staff job satisfaction and turnover intention were the dependent variables (DVs). The research data answered the following central research questions:

RQ1: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting a positive psychological state of nurses and the dependent variable job satisfaction?

RQ2: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting positive behavioral responses of nurses and the dependent variable of job satisfaction?

RQ3: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting nurses reporting greater job satisfaction and decreased turnover intention?

RQ4: Does positive job satisfaction in nurses correlate to a negative response to turnover intention?

Hypotheses

$H1_0$: There is no or a negative correlation among the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the psychological state of nurses.

*H*1a: There is a positive correlation among the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the psychological state of nurses.

$H2_0$: There is no or a negative correlation among servant leadership behaviors measured by the independent variables of humility, empowering, communication, and commitment to employee growth and the behavioral responses of nurses.

*H*2a: There is a positive correlation among servant leadership behaviors measured by the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the behavioral responses of nurses.

$H3_0$: There is no or a negative correlation among servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contributing to nurses reporting greater job satisfaction.

*H*3a: There is a positive correlation among servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contributing to nurses reporting greater job satisfaction.

$H4_0$: Job satisfaction does not correlate or positively correlates to turnover intention.

*H*4a: Job satisfaction negatively correlates to turnover intention.

Theoretical Framework

Many theories have evolved since researchers began studying leadership: behavioral theory, contingency, situational, transactional, and transformational. While many of the early leadership researchers focused primarily on controlling the workforce and developing methods to improve efficiencies, modern leadership theories have focused less on control and more on developing relationships and using knowledge as it relates to organizational improvement.

Servant Leadership Theory

Greenleaf (1977) introduced servant leadership on the foundation of social exchange theory by proposing that a connection exists in the relationship between followers and their leader. Social exchange theory proposed that social behavior is the result of an exchange process. This process explains the cost-benefit of engaging in a relationship between people. In the employment relationship, employees search for

positive benefits associated with leaders' behaviors, and as a result, respond positively. For example, followers are more motivated and job satisfaction improves when the behaviors of the leader are conducive to building a mutually beneficial and trusting relationship (Chan & Mak, 2014). The first dimension of servant leadership involves forming relationships (Hunter et al., 2013). A leader who creates genuine relationships with followers creates an environment that influences the behaviors of the follower.

Greenleaf did not define servant leadership in his original essay (Staats, 2015). Instead, he described the basis for servant leadership as a service to others that emphasized individual growth, mutual trust, and empowerment (Staats, 2015). The servant leader puts his followers first by humbly subordinating themselves to obtain greater satisfaction. Four principles of moral authority are at the core of servant leadership: sacrifice, commitment to a worthy cause, teaching that the ends and means are inseparable, and enduring relationships (Du Plessis, Wakelin, & Nel, 2015). In follow-up research, Greenleaf proposed 10 characteristics as independent variables that a servant leader should display (as cited in Russell, Broomé, & Prince, 2015). These variables included listening, empathy, awareness, healing, foresight, stewardship, persuasion, conceptualization, commitment to growth, and community building. Since the introduction of these concepts, researchers have identified and reported on additional constructs related to emerging servant leadership models.

For example, Ehrhart (2004) identified seven constructs: forming relationships, empowering subordinates, helping subordinates grow and succeed, ethical behavior, putting subordinates first, having conceptual skills, and creating value for the

organization. Liden, Wayne, Zhao, and Henderson (2008) reported on seven constructs: emotional healing, creating value for the community, helping subordinates grow, conceptual skills, putting subordinates first, behaving ethically, and empowering others. van Dierendock and Nuijten (2011) linked empowering, standing back, authenticity, interpersonal acceptance, accountability, humility, courage, and stewardship to servant leadership behaviors.

Four servant leadership characteristics, found in leaders who guide many organizations, have particular relevance to nurses as they correspond and apply to the relational aspect of nursing practice. The constructs discussed in this research are communication, commitment to growth, humility, and empowering and each variable has a foundation in both servant leadership and nursing practice (Benner, 2004).

Conceptual Models

A conceptual model provides a visual roadmap of the relationship between theory and variables measured. The relevance of identifying the variables and their relationships leads to the formulation of empirical testing of those relationships (Bettis, Gambardella, Helfat, & Mitchell, 2014). This conceptual model looked at servant leadership constructs that created positive psychological states in which the behavioral responses of nurses resulted in an increase in nurse job satisfaction and a decrease in turnover intention. The model, as shown in Figure 1, focused on the relationship between three variables:

1. The characteristics of servant leaders that determined how positively a nurse responded to leadership actions;

2. Psychological engagement was present for internal motivation to develop in nurses;
3. The behavioral responses of nurses that led to an increase in employee job satisfaction and a decrease in turnover intention.

The purpose of this research study was to evaluate the relationship between the predictor variables of servant leadership (humility, empowering, communication, commitment to employee growth) and the response variables (job satisfaction, turnover intention) and showed the progression of this relationship through two intermediary variables (psychological state of engagement and employee behavioral response). Social change could result, as indicated, after achieving organizational goals. The predictor variables and response variables were the focus of this research.

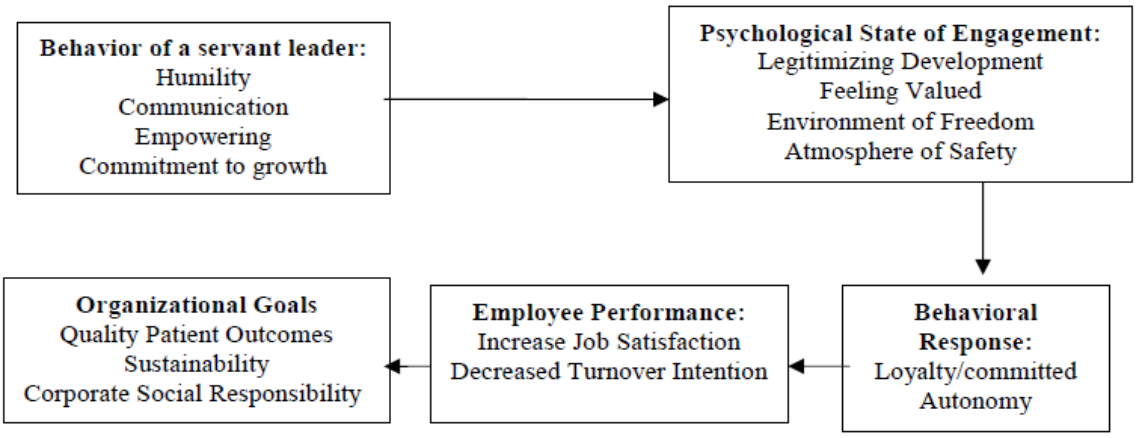

Figure 1. Conceptual model of servant leadership. Conceptual model flow chart of the effect servant leadership has on the nursing psychological state of engagement and the behavioral response leading to employee performance and achieving organizational goals.

Corporate Social Responsibility Theory

Assessing the theoretical framework from an economic, corporate social responsibility, or organizational perspective was also possible. Corporate social responsibility is a practical, theoretical framework that provides valuable insight into the leader's need to consider all stakeholders' involvement in organizational sustainability (Korschun, Bhattacharya, & Swain, 2014). Integrating social psychology and organizational justice into the evaluation of leadership's behavior, researchers can determine the ultimate effect of leadership behavior on the health of society. Tapping into the wealth of knowledge related to the characteristics of servant leadership can help shed light on how leaders contribute to nurse stakeholder satisfaction and patient outcomes within the context of internally applied corporate social responsibility concepts.

Corporate social responsibility models look at the organization's actions related to its employees, the environment, external stakeholders, and sustainability (Aguinis & Glavas, 2013). Leaders of socially responsible organizations recognize the need to provide services to society. Decision makers should understand the importance of service providers, such as nurses, and factors that reduce the ability to provide services. Increasing human resource expenses because of high turnover related to poor management practices should lead executives to change management practices to retain staff, leading to an improved opportunity for goal obtainment.

Corporate social responsibility relies on an organization's core competencies and integration of these concepts within the strategy, routines, and operations of the health care organization (Aquinis & Glavas, 2013). Health care organizations, in general, are

social organizations, and, as such, should create systems that align routine functions with operations that lead to strategy implementation. Organizational system designs should consider the internal stakeholder's need for total job satisfaction. By evaluating job satisfaction and turnover intention, executive leadership can better predict the nursing turnover rate and resulting expense and evaluate the alignment of strategic organizational goals with nursing staffing patterns and operational activities. Nurses are the backbone of the delivery system and figure prominently in the routine, operation, and strategy.

Greenleaf's (1977) servant leadership model provided conceptual constructs that identified characteristics specific to the nursing profession and provided a foundation for measuring the behavior of managers through the identification of distinct variables. In this dissertation, I considered four constructs as the independent variables: humility, empowering, communication, and commitment to employee growth. Implementing these behaviors led to a psychological state of engagement in which employee development was a priority and employees felt valued and were free to make decisions in a safe environment. Engagement led to behaviors that consisted of loyalty, resulting in staff taking creative risks to solve problems autonomously. Positive behaviors and engagement potentiate positive job satisfaction and decrease turnover intention.

Nature of the Study

In this research, I used a quantitative method, correlation, nonexperimental, cross-sectional design. The relevance of this methodology is important in evidence-based practices, such as nursing. This nonexperimental study involved administering a Likert-type survey to 701 clinical nursing staff and 18 nurse managers at a Magnet certified,

Level II trauma center located in Pennsylvania. Accurate interpretation of the results required a return of at least 35% of the survey population. A correlation, nonexperimental, cross-sectional design was chosen because of the lack of quantitative research available focusing on servant leadership and job satisfaction in nursing. A review of the literature revealed the need for more empirical research for studying the relationship between servant leadership and the correlation between job satisfaction and turnover intention. By analyzing the results of collected data, an assessment of the relationship between servant leadership and job satisfaction confirmed that servant leadership has a positive effect on the psychological state and behavioral response of nurses and the self-reporting of job satisfaction.

Definition of Terms

Corporate social responsibility: Corporate social responsibility defines the variable that a business or organization demonstrates social responsibility by embracing the expectations of society from a fiscal, legal, ethical, and discretionary position (Aguinis & Glavas, 2013).

Job satisfaction: Job satisfaction is the contentment a person feels, positive or negative, about a job and viewing it either in its entirety or with particular aspects, such as type of work, pay, promotion, supervision, and coworkers. Job satisfaction is an affective behavior indicating contentment with the condition of employment or the extent to which people like or dislike their jobs (Wong & Laschinger, 2013).

Nurse manager: A registered nurse assigned to directly manage clinical staff, and plan, monitor, and ensure implementation of patient care delivery, fiscal management, and unit operations (Wong & Laschinger, 2013).

Nursing shortage: The operational definition measures the difference between a region's demand for staffing levels, and the region's ability to supply nursing resources to fill the demand for nursing services (Juraschek, et al., 2012).

Registered nurse (RN): A health care professional responsible for implementing the care and treatment prescribed by other health care professionals and who executes nursing processes in collaboration with other health care professionals (Juraschek et al., 2012).

Safety: A conceptual definition that embraces the physical, psychological and social aspects of staff that refers to a shared belief about the consequences of risk and is reflected in a commitment to reduce avoidable loss by creating an atmosphere free of fear (Kessel, Kratzer, & Schultz, 2012).

Stewardship: A conceptual definition for providing service to an organization or person over retaining individual control and self-interest (van Dierendonck & Nuijten, 2011).

Turnover: An operational variable that demonstrates the departure of staff despite there being an opportunity to continue to work (Regts & Molleman, 2013).

Turnover intention: A conceptual definition that describes an individual's mental decision regarding a job and the decision to stay or leave, which can lead to an action of remaining in the job or terminating employment (Bothma & Roodt, 2013).

Assumptions, Limitations, and Delimitations

Assumptions

Several assumptions were attributed to this research study. The first assumption was that all participants were actively licensed RNs and provided honest and truthful responses to the survey questions. It was assumed that research participants would read the instructions carefully and interpret the questions accurately. Undesirable responses could influence the outcome of the study if the instructions and questions were interpreted incorrectly. It was also assumed that nursing managers were interested in and supportive of the research. Uninterested or unsupportive managers may not encourage staff to participate in the research study, thus negatively affecting the outcome of the study.

Limitations

Conducting this research study revealed several limitations. The first limitation centered on the number of participants who agreed to participate in the survey. RNs and nurse managers who met participation criteria had access to the online survey. Nurses voluntarily and randomly participated. Additionally, this method of research introduced bias related to the exclusion of RNs whose understanding of the internet was limited, or they did not read the email communications regarding the study. The online survey inhibited participation from certain subpopulations, such as generational cohorts who were less likely to participate in online studies because of unfamiliarity with online technology.

Nonresponse bias may have occurred when conducting the online survey, which is a bias affecting the exclusion of participants who elected not to participate in the study (Choung et al., 2013). I used a Likert-type scale that may have produced a method bias, which is a tendency for participants to perceive the question format to be similar and thus increase the probability that questions would be answered similarly (Gallan, Jarvis, Brown, & Bitner, 2013). Additionally, the survey measured nurses' self-reported job satisfaction and turnover intention at one point in time, and any changes that occurred in the variables, over time, were not examined.

Participants were expected to complete the survey one time; however, there was no way to identify if the survey was completed more than once. To assure participant anonymity, the Internet Protocol address software tracking option was disabled. This decision was made because of the concern that participants may elect not to take part in the survey if the internet protocol address were traceable. Another limitation regarding statistical analysis and the quantitative study model was the inability to infer meaning beyond the results achieved through statistical analysis.

Delimitations

This research study included several delimitations. The online survey was conducted at one institution with participation limited to RNs who were (a) actively licensed to practice, (b) currently employed as an RN at the selected institution, (c) had completed the hospital orientation process and were employed for greater than 6 months, and (d) were not undergoing any disciplinary action. This quantitative study had a limited

focus to measure the nurse's perception of management behavior and the effect on job satisfaction.

Scope of the Study

In this quantitative study, I explored the relationship between four principles of servant leadership (independent variable) in nurse managers and staff nurse job satisfaction (dependent variable) in a Magnet certified Level II trauma hospital in Pennsylvania. To investigate the principles of servant leadership that resonated with staff nurses and the relationship of these principles to job satisfaction, a validated survey was made available to all staff nurses. The sampling frame of 701 nurses was invited to participate in the study. A confidence level of 95% produced a sample of 255 nurses from the survey population. Both male and female nurses were included in the survey population. Nurses who successfully completed hospital orientation, were employed for 6 months or longer, and were not in disciplinary action also met qualifying criteria.

Significance of the Study

Through continuous research on servant leadership actions and the effects on nursing satisfaction, health care executives may be able to use results to assist in determining what, if any, investment is needed in nurse management education to change the tide of the exodus of staff nurses from health care organizations. Nursing executives can positively affect the quality of care delivered to the health care consumers by improving the environment of health care and enhancing the financial standing of the organization by holding nurse managers accountable for their behaviors. The results are useful for leaders of health care organizations throughout the world who seek to reduce

nurse turnover resulting in improvement of the overall delivery of care and the costs associated with that care.

Organizational Level

At a health care organizational level, nursing turnover creates operational, quality, and financial challenges for executives. The results of this research demonstrated that by increasing job satisfaction, nursing turnover intention was positively affected and empowered nurses were more willing to help solve organizational problems. Additionally, the quality of care delivered conceivably would improve by retaining satisfied, experienced nurses who remained at the bedside. Finally, retaining satisfied nurses could potentially reduce the financial challenges related to poor outcomes and the cost of recruitment of new nurses.

Community and National Implications

At the community or social level, health care consumers expect consistent, high-quality care at a reasonable cost. The results of this research directly impact the quality of the care delivered to patients, as satisfied and experienced nurses were better able to reduce hospital-acquired infections and patient falls, thus decreasing the length of patient stay, lowering costs, and improving patient outcomes. At a national level, payers, whether private or governmental, desire to reduce their financial obligation to funding health care while insisting on better patient outcomes. The research exhibited a financial gain for all health care payers.

Any improvement in the relationship between the nurse manager and nursing staff generates a reciprocal increase in job satisfaction and a reduction in turnover intention

creating an environment whereby an improvement in the quality of care delivered occurs with a corresponding financial savings associated with the delivery of medical treatment (Chan & Mak, 2014). By evaluating employees' psychological and behavioral responses to managerial behaviors in the hospital nursing setting, the findings show that servant leadership improves job satisfaction and decreases turnover intention.

The essence of leadership theory is the need for followers. Coupled with a leader's self-perception, researchers need to understand the staff's perceptions of the nurse leaders. Ongoing research qualifies and quantifies the effect that a leader's actions have on followers. The resulting information from this study has the potential opportunity to help stakeholders understand the relationship between nurse manager behaviors and staff nurse responses and the effect nurse managers' behaviors had on staff nurse's job satisfaction.

Summary

In this chapter, I presented the research by describing the challenges of the nursing profession, the impact of leadership on staff nurse's job satisfaction, and the intent to leave in the context of management behaviors. I also explained how nurses are major stakeholders in the complex environment of healthcare and as such, administrators of health care organizations must understand the effect of nurse managers' behavior on nursing staff. Through the background information, statement of the problem, and the purpose of the study, support for the relevance of the research study was established. The research questions and hypothesis revealed the conceptual foundation of the research study leading to understanding the purpose of the study and scope of the study.

In Chapter 2, I will present an examination of the literature related to the identified problem and the implication to nursing, patients and other health care stakeholders. An evaluation of the history of traditional nursing leadership, servant leadership, and the constructs that support job satisfaction are the focus of Chapter 2. The chapter concludes with the identification of a gap in the related literature that supports the rationale for conducting this study.

Chapter 2: Literature Review

Introduction

The review of the literature on the influence of leadership style and behavior affecting job satisfaction and turnover intention is covered in five major sections. While much research cited addressed the reasons why nurses leave an organization, in this literature review, I focused on leadership behaviors that contribute to job satisfaction in nurses and the effect on an organization's ability to deliver quality health care and maintain financial viability.

To understand the relationship between servant leadership behaviors and nurse satisfaction and turnover intention in this section, I review the literature in the following areas:

1. The current status of health care, its complexity, and effect of leadership on the environment in which nurses function.
2. Traditional health care leadership and management influence and competency.
3. Nursing's current state and contribution to organizational performance.
4. Staff nurse's response to leadership behaviors.
5. Servant leadership and its effect on nurse satisfaction, turnover intent, and quality indicators.

Business and Leadership

A successful business differentiates itself from other similar organizations by aligning interactions between the needs of the customer (patient), employees (nurses), organizational systems and external influences (Homburg, Stierl, & Bornemann, 2013).

In organizational environments with increasing complexity and dynamic changes, leaders need to adapt business processes to meet organizational demands and changing conditions while simultaneously incorporating follower needs. Zhang, Waldman, Han and Li (2015) coined this activity as paradoxical leader behavior, which refers to competing, yet interrelated behaviors. Homburg, Stierl, and Bornemann (2013) described business processes as the activities that produced measurable outcomes and added value to the customer. Individuals implemented business processes through organizational systems. Leaders should be competent to manage business processes as a strategic asset by optimizing stakeholder contributions through defined resource allocation to achieve strategic goals.

On a macro level, for an organization to achieve strategic goals, it requires the input of identifiable resources and processes that convert the resource into a discernable outcome. Hospital resources include a qualified and educated workforce, medical equipment, and technology. The goal of management is to transform resources (input) through systems' processes to achieve organizational outcomes (output). Pavitt (2014) described this as the input-process-output model (as shown in Figure 2). Pavitt recognized that the output would only exists with the successful implementation of the process.

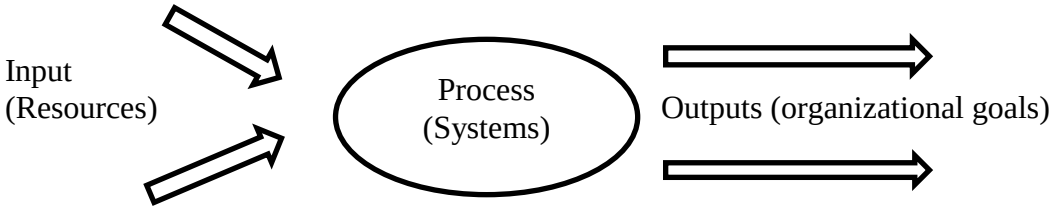

Figure 2. Input-output model.

On a micro level, employees achieve organizational goals (output) when they too have sufficient resources (input). The inputs must address employee's needs, as employment is a mutual exchange of activities between an employee and an organization where both gain something from the relationship (Agarwal, 2014; Biswas & Bhatnager, 2013). As stated by Biswas and Bhatnager (2013), input resources for employees include, but are not limited to, organizational support, psychological safety, autonomy, and healthy interpersonal interactions. Achieving organizational goals occurs with talented employees who are committed and emotionally and physically engaged in their work (input). Cicolini, et al. (2014) explained that having an engaged workforce increases the ability for the organization to remain competitive and assures sustainability (output). Organizational resources (supervisor behavior, autonomy, and individual feedback), and personal resources (self-efficacy, optimism, and confidence) increase staff engagement (Agarwal, 2014).

Agarwal (2014) posited that employees can only be truly engaged when they feel they are treated with justice, there is shared decision-making, and they are supported by peers and supervisors. Employee engagement involves investing personal energy in the pursuit of organizational goals, which open the employee to vulnerability. Becoming vulnerable requires an intention to take a risk while depending on the encouraging behavior of another person (Fulmer & Gelfand, 2012). An employee who does not trust the leaders of the organization would not be motivated to engage in prescribed work activities.

An ideal leader is one who uses power and influence to build trust and inspire followers. McAlearney and Robbins (2014) pointed out that the importance of addressing employees' needs through effective management practices has a net effect of creating a more engaged workforce leading to greater performance. An organization with successful leadership becomes a high-performance organization when it achieves greater financial and nonfinancial results more than its peer group spanning at least a 5-to-10-year period (de Waal & Jansen, 2013). Further, de Waal and Jansen, (2013) discussed how organizations that focused on superior performance and consistently scored high on these factors and attained better results than peer organizations that scored lower on performance factors and ranked at the bottom of their industry.

A health care organization's performance is measured by financial results and assessing the success of the systems that deliver positive patient outcomes through a motivated nursing workforce. High-performing health care organizations establish systems that evaluate all operational functions including leadership development, financial sustainability, risk management, health care delivery, patient outcomes, and employee growth. A comprehensive system also establishes mechanisms to correct deficiencies identified through reviews, inspections, and monitoring.

The System of Health Care Organizations

According to Shi and Singh (2014), the United States does not have an actual health care system despite the reference. It remains a fragmented patchwork of stakeholders, all of whom attempt to control the complexity of delivery of care. Health care is a $3.0 trillion industry undergoing constant and rapid change (Martin, Hartman,

Benson, Catlin, & The National Health Expenditure Team, 2015). The performance of health care is characterized by long wait times, inefficiency, low productivity, stressed professional staff, and dissatisfied patients. Structurally, health care organizations function chaotically while the delivery of care expands.

Separate clinical and administrative teams steer health care organizations through the labyrinth of challenges in an effort to coordinate the delivery of health care. Best practices, established through medical research, guide these clinical decisions. However, administrative teams are slow to adopt best practices for management despite the research that supports better health care outcomes (Porter & Lee, 2013). As a result, the primary goal of improving individual and social health becomes lost to a business approach.

The mission of health care is increasingly subordinate to a profit-oriented mentality. Health care systems overemphasize and institutionalize management. In an attempt to keep the organizational structure under control, managerial behaviors focusing on power become dominant, and an insular bureaucracy emerges and grows. As a result, traditional bureaucratic management strategies and hierarchical organizational structures exist that are not flexible enough to meet the changing demands of healthcare.

The hierarchical administrative structure is a variant of mechanistic activities that highlight command and control, production and planning, and organizing and directing activities (Trastek et al., 2014). Morgan (2006) discussed how bureaucracies organize in a hierarchical manner with defined lines of control and a distinct division of work was established to achieve the goal of the organization. This common belief is based on the lack of a manager’s understanding of the importance of establishing a balanced

relationship between staff success and reaching business goals, resulting in managers who often control all aspects of work. Managers neglect to make positive connections with staff and rule the work environment in a prescribed manner because of fragmentation and competing business.

Mechanistic organizations avoid problems or address them with traditional methodologies. When setbacks occur, managers invoke policies and procedures and deliberate the troubles in ad hoc meetings or form committees to discuss the situation. This approach is often disjointed and shortsighted. Employees in mechanistic organizations adopt mindless attitudes that create passivity and dependency (Morgan, 2006). Apathy, inattentiveness, or insensitivity fosters a mechanistic approach because it discourages initiative, expects obedience, and dissuades questioning of authority.

The mechanistic approach to health care delivery is evident in classical management theory. Traditional methods of management decision making occurred when executives

- Set goals and objectives and communicate these down the hierarchical chain.
- Organize the work and processes rationally and efficiently.
- Develop descriptors, evaluations that describe, in detail, the job employees perform, and the degree of accountability.
- Continuously plan, organize, and control. (Kitsen, Muntlin Athlin, & Conroy, 2014)

The mechanistic approach limits developing humans to their fullest potential, thus reducing the opportunity to capitalize on the collective knowledge of highly educated

professionals that could lead to organizational growth (Morgan, 2006). Unruh and Zhang (2013) found that by using an instrument developed by Kovner and associates, employee response to mechanistic behaviors often leads to disengagement, job dissatisfaction, and increased turnover intention. Managers with traditional views create an unhealthy work climate resulting in lower commitment and leading to burnout that feeds into turnover intent, resulting in a higher turnover (Caricati et al., 2014). Burnout is the state of physical and emotional depletion as a result of prolonged exposure to stressful work environments, including one factor of poor supervision (Khamisa, Oldenburg, Peltzer, & Ilic, 2015).

Leadership

Positive leadership models emphasize the importance of valuing, listening to, and empowering employees (Anderson, Manno, O'Conner, & Gallagher, 2010). The ability of leaders to resonate with others is a vital element when transforming the lives of internal stakeholders. In high-performing organizations, managers build trusting relationships, by consistently treating employees with respect and by creating and valuing their loyalty (Brennan & Monson, 2014). Leaders sustain follower loyalty by establishing long-term relationships by increasing the employee's psychological well-being. Additionally, high-performance organizations are not mechanistic, nor do leaders adopt leadership styles that focus on organizational goals at the expense of relationships (Brennan & Monson, 2014).

Economic cost-benefit relationships that describe leader behavior regarding goal setting, giving direction and support, and reinforcing expected behaviors are often the

basis for traditional leadership models. Traditional leadership theories stress command and control (transactional leadership) or leadership by vision and example (transformational models). Authority figures provide direction and order to the group. Traditional leadership is dependent solely on an individual who leads the organization, through leader-centric activities, discounting relationship building with subordinates (Olge & Glass, 2014). They also discussed how traditional nursing leadership is seen as distant and exerting controlling influence to frontline nurses. Ogle and Glass recognized that the lack of organizational structure hinders the ability to transcend the traditional nursing hierarchy to improve nursing care.

Followers often view nursing leadership cynically because of the hierarchical structure. Nurses follow because they have to, rather than by choice. Ogle and Glass (2014) concluded that implicit leadership has less to do with the effectiveness of the leader. More often, effectiveness or ineffectiveness of the leader is in the mind of the follower. Leadership theories are developed to measure the performance or the optimization of leadership and organizational success (Gregersen, Vincent-Höper, & Nienhaus, 2014), not with the employee in mind. Researchers have frequently operationalized leadership using established leadership constructs. Traditional leadership research assesses exchange models that describe the behavior of the leader and its effect on the follower, such as organizational goal setting, establishing direction, and correcting behaviors.

Leadership in Healthcare

Medicine is great at solving technical problems. Medicine has developed an entrenched hierarchical design that traditionally assigns one person or a group of individuals to act as the operational experts and authorities. A hierarchical organization can be effective when solving technical problems as lines of authority and responsibility naturally develop. The work design of many hospitals is characterized as a technically enriched organization such that when clinical problems arise, a quick-fix solution founded on evidenced-based practice occurs.

However, the hierarchical structure does not support adaptive environments (Trastek et al., 2014). Adaptability requires a degree of flexibility. Perkins (2013) described how managers in traditional health care organizations are accountable to superiors, and the staff expectation is to serve up. While health care workers (nurses) serve up, they take direction from top-down, while simultaneously being directed to serve down (patients), thus reducing the ability to adjust to a changing environment.

Health care literature referred to nursing leadership in terms of the people who hold a formal position and have the ability to advance policy (Olge & Glass, 2014). While leadership establishes goals, formulates strategies, provides work guidelines, and incorporates organizational values, tradition continuously describes managerial work as fragmented and extremely shortsighted. Consequently, longstanding bureaucratic nursing management strategies and traditional organizational structures are not flexible enough to meet the evolving demands of a challenging and changing health care environment, or the "lock-step approach to decision making" (Pollard & Wild, 2014, p. 620).

In traditional health care organizations, nurse promotions occur because of clinical expertise and upward influencing skills. Many nurses excel in organizations based on political skill and luck without demonstrating any talent for leadership. Since many nursing promotions result from a nurse's ability to solve clinical problems, adhere to the hierarchical structure, manage clinical activities, or hold others accountable for outcomes, nurse managers are unable to develop systems that prevent problems from occurring (Homburg, Heijden, & Valkenburg, 2013). In their research, Homburg, Heijden, and Valkenburg (2013) found promotions to nursing management positions were a reward for political acumen and clinical proficiency, and not on management skill or leadership ability. When nurses were unable to achieve organizational goals, they often leave organizations or assume nonmanagement positions (Djukic, Jun, Kovner, Brewer, & Fletcher, 2016). As a result, hospitals struggle to recruit and retain nurse managers.

Nurse managers represent the largest segment of managers in health care at 300,000 professionals (Djukic et al., 2016) and are instrumental in the operational success of a health care organization. They play an essential role in providing leadership in a rapidly changing environment, morale and retention of staff, and performance of nurses. Despite the critical role of nursing care in determining high-performance health care delivery, most of this effort is lost or invisible to policy makers, administrators, and managers (Dubois, D'Amour, Pomey, Girard, & Brault, 2013). Because of the rate of change that occurs, nurse managers are not prepared to deal with the resulting sequelae of staff stress, job dissatisfaction, and turnover.

Education of Nurse Leaders

Professionals involved in health care management need proper education in nursing and knowledge from other disciplines, such as business and leadership (Milton, 2014). Hospitals commonly promote individuals to leadership roles from clinical environments, providing minimal opportunity to develop leaders' knowledge, skills, and abilities, in addition to, offering the required support (Leeson & Millar, 2013).

Additionally, nurses earning a Master of Science in Nursing are believed to be competent in leadership roles, even if the advanced nursing degree only focuses on clinical knowledge. Many hospitals require a Master of Science in Nursing for promotion to leadership roles, thus, a masters prepared nurse could be promoted to a significant decision making role, despite the nurse's minimal exposure to leadership concepts. Educating potential nurse leaders would improve the competencies of nurses who aspire to move into management. Education influences the development as a leader as it affects leaders' thoughts, opinions, and leadership styles.

Nurse leadership development is relatively new in health care, which contributes to the overall perception that leadership practices are haphazard. Lacasse (2013) recognized that arbitrary nursing leadership practices create a sense of crisis on how health care organizations will meet their leadership needs in the future, yet few health care organizations have allocated any funds for educating and developing their nurse leaders.

Ritchie and Yen (2013) identified a link demonstrating traditional management development and the subsequent application of behaviors that are associated with the

style of management taught in formal education. Ritchie and Yen discussed the need for greater diversity in core knowledge areas, greater awareness to operational and strategic decision making, to engender change. Teaching or emphasizing one leadership style during formal education, having nursing organizations support one leadership style, and developing an organizational culture that supports traditional leadership, managers' behaviors will continue to embody this structure, thus, limiting the opportunity to learn and adopt new ideas.

Anecdotal evidence suggests that health care is reluctant to adopt new initiatives from other industries regarding quality improvement methodologies and employee development (D'Andreamatteo, Ianni, Lega, & Sargiacomo, 2015). Leadership training within hospitals is nonexistent to minimal, offering a low probability of goal achievement (Kelly, Wicker, & Gerkin, 2014). A traditional pedagogical approach provides the structure for any formal education. Pedagogy involves the teacher or trainer determining learning outcomes and developing both content and timing, much like educating children. Health care leadership is dynamic and requires active participation from motivated learners who are willing to break the barriers of tradition to achieve organizational goals requiring a dynamic approach to education.

Chametzky (2014) discussed how extrinsically motivated, independent learners, who are able to apply past experiences, are more likely to embrace new concepts. Hospitals that do not expose leaders to nontraditional leadership concepts report a work environment supporting a bureaucratic structure where managers rely on superiors for guidance and decision-making (Duffield, Roche, Blay, & Stasa, 2011). New leaders,

educated under traditional design, continue to expect followers to adhere to the bureaucracy.

Enterkin, Robb, and Mclaren (2013) discerned that contemporary learning and management education progressively build nurse's capacity to respond to the changing needs of health care. They reported that managers who participate in relational leadership development felt greater confidence, increase their feelings of empowerment, have intensified organizational awareness, and gain a greater ability to empower others. Avey, Palanski, and Walumbwa (2012) expressed that contemporary leadership development should focus not only on the leader but also on follower's responses to leadership behaviors. Jorge Correia de Sousa and van Dierendonck (2014) went one step further and determined that servant leadership strongly affects work engagement during times of high uncertainty with organizational identification and psychological engagement as mediating variables. With the uncertainty of health care and as it continues to change, nursing education on leadership and the behaviors associated with managers should also reflect current evidence-based knowledge.

Traditional Nursing Leadership Model

To adapt to new clinical challenges in the health care environment, nursing organizations have established criteria and goals for nursing leadership grounded in evidenced-based practices. Nursing researchers look at empirical research and clinical outcomes to determine the nursing practices to implement. Using the same evidence-based practices model when implementing leadership practices would seem to be a logical progression. Evidence-based practice should also be used to evaluate current

leadership research and adjust leadership activities consistent with new knowledge. As pointed out this is not the case. Nursing leadership often relies on professional organizations to provide guidance in these areas.

Designations, such as Magnet, have become a merit badge for hospitals to demonstrate their commitment to leadership development, employee satisfaction, and positive patient outcomes. The framework of the Magnet Program promotes transformational leadership as the style best suited for Magnet's vision for nursing leadership (American Association of Colleges of Nurses, 2015). As reported by Stimpfel, Rosen, and McHugh (2014), the Magnet framework is built on the five Model Components of Magnet Status, which include, "structural empowerment, exemplary professional practice, new knowledge, innovations and improvements, transformational leadership, and empirical outcomes" (p. 10).

Dominating the research of nursing leadership is one traditional model (Hutchinson & Jackson, 2013). Nursing leadership relies on the theory of transformational leadership. Transformational leadership is the most frequently cited style in nursing leadership literature and the most supported by the nursing profession because this style is purported to establish a vision and encourage adaptation and change.

The American Nurses Credentialing Center (2015) noted that transformational leadership enhances the ability of health care organizations to prepare for future challenges of health care delivery. One of the goals of Magnet designation is to promote leadership development. However, many health care organizations continue to function

with leaders who exert authority by directing staff through rules, procedures, and dictates, as opposed to using the tenants of transformational leadership, which is encouraged.

Leadership with authority is positional power, given to people through election or appointment. Authority serves as the point of coordination for activity and discipline. Traditional nursing leadership, and the accompanying authority, follows a hierarchical flow, top-down, without regard for the socialness of nursing (Jefferson, Klass, Lord, Nowak, & Thomas, 2014). Nursing leadership is a social process and people in leadership positions can transform organizations through influence. Despite knowing the positive nature of relational leadership and its ability to make a significant social change, accomplishing the work of a health care organization becomes more difficult when nursing organizations support nonrelational leadership styles.

According to Landry, Vandenberghe, and Ayed (2014) new leadership models, emphasize leader behaviors that include a commitment to individuals, foster psychological bonds, attend to individual needs, and provide intellectual growth opportunities. They went on to say that effective leaders are dyadic, relational, and understand the challenges of complex social dynamics. If the intent of health care organizations is to deliver quality care and remain financially healthy, focusing on tasks, compliance, and then measuring leaders on achieving financial goals blurs the relationship between leaders' behaviors, follower needs, and patient outcomes. Mannix, Wilkes, and Daly (2013) summarized their research by stating that effective clinical leadership is the key to healthy, functional, and supportive work environments for nurses.

Adverse Patient Outcomes

Health care volatility occurs because of the actions taken by powerful stakeholders in the external environment; thus, leaders must consider the impact of their actions on external stakeholders, one of which are the patients. The impact of leadership behaviors not only influence staff nurses but also encompass the well-being of patients, and extend to the local communities. Nursing has a vital role in assuring patient safety and the quality of care they receive. Kirwan, Matthews, and Scott (2013) determined that a positive practice environment significantly enhances patient outcomes. Patient outcomes are the critical drivers of any hospital organization.

Adverse patient outcomes occur from injuries or complications caused by errors in care. According to a literature review, conducted by Twigg and McCullough (2014), patient outcomes reflect the quality of the nurse's work environment. Clinical leaders are essential to creating safe work environments in which patient care is a priority. A systematic review of research reveal leaders who demonstrate a positive, relational style attain an increase in patient satisfaction and a reduction in adverse patient outcomes (Wong, Cummings, & Ducharme, 2013). Silber et al. (2016) found that hospitals who have better nursing environments (nurse-to-patient ratios of 0.69 versus 1.51), have a 4.8% versus 5.8% 30-day mortality rate, resulting in a better overall value for patients. Recognizing that leadership behavior negatively affects the constituency, health care leaders should recognize the need to act. Additionally, when executives direct organizational actions that reduce adverse patient outcomes, they meet stakeholder expectations by recognizing the social implication of the organization's performance.

Boey, Xue, and Ingersoll (2015) indicated that the greatest cost to health care organizations, attributed to high nursing turnover rates, are higher patient mortality. Instability in nursing has a significant negative impact on care delivery outcomes. An analysis of the literature reveals an increased mortality risk for patients on understaffed units as compared with fully staffed units. In addition, researchers found that when a nurse's workload increases, because of a smaller nurse workforce, mortality risk increases creating a climate of instability that has implications for patient care (Shekelle, 2013). Higher incidence of patient safety events occurs as nursing vacancy rates increase, as measured by nursing full-time equivalents.

Corporate Social Responsibility

According to Aguinis and Glavas (2013) and Tziner (2013), one perspective of Corporate Social Responsibility theory considered the ethical behavior of an organization and the organization's benefit to society. Leaders of socially responsible corporations realize, through proper management of stakeholder relations, more positive outcomes are possible. Tziner discussed that Corporate Social Responsibility theory has undergone many iterations with the current emphasis placed on business ethics, legal, discretionary and sustainability of an organization's commitment to activities that enhanced a social good.

Aguinis and Glavas (2013) posited that leaders who adopt corporate social responsibility are concerned with treating all stakeholders ethically or in a responsible manner as deemed acceptable by civilized societies. The wider goal of corporate social responsibility is to create higher standards of living and well-being, while preserving the

sustainability of the organization, for both internal stakeholders (nurses) and external stakeholders (patients): therefore, corporate social responsibility consideration should represent both internal and external stakeholders. Adopting a corporate social responsibility philosophy is a choice made by the leadership of an organization. Subsequent employee behaviors that extend beyond an economic benefit occur when organizations make the choice to adopt corporate social responsibility philosophies (Tziner, 2013).

Analysis of an organization's social responsibility occurs at three levels; institutional, organizational, and individual. Tziner (2013) concluded organizations should reframe how decision-makers view social responsibility so that achieving both internal and external outcomes occur, with a unique emphasis on the employee. Thus, leaders must determine the degree of importance that each level provides the organization. The challenge for managers is to balance the expectations of various needs expressed by both external and internal stakeholders.

Corporate social responsibility is an important concept to employees and management. A study conducted by Farooq, Payaud, Merunka, and Valette-Florence (2014) determined that corporate social responsibility indirectly influenced many employees' attitudes and behaviors. Glavis and Kelley (2014) concluded that employees who deem their organization as socially responsible, considerate, and benevolent are more likely to stay with their employer and less prone to seek employment elsewhere. Glavis and Kelley also found that employees' perceptions of corporate social

responsibility decreased employee turnover intention (TI) and increased organizational citizenship behavior.

Korschun, Bhattacharya, and Swain (2014) indicated that employees identify with organizations whose leadership has an employee and customer focus. The greater the perception of an organization's commitment to corporate social responsibility values, greater is the employee's performance. Korschun et al. also determined that an organization's level of corporate social responsibility focus relates to the positive job performance of employees.

Arnaud and Wasieleski (2014) studied how promoting corporate social responsibility values produced socially minded outcomes at all levels by applying a relational philosophy to leadership. Management is relational when managers recognize and understand human needs and are oriented to the development of each person within their sphere of influence (Arnaud & Wasieleski, 2014). When managers are relational and engage in humanism, the autonomy of followers increase resulting in socially responsible behavior. Aguinis and Glavas (2013) contended, employers who embrace corporate social responsibility behaviors, create an environment in which deontic justice is applied, and normative treatment of employees occurs.

Following the humanistic underpinnings of corporate social responsibility, developing employees' abilities for self-determination, the manager must seek to understand and attempt to satisfy internal needs of employees. This occurs when employees work in an environment characterized by five employee focused concepts, autonomy at work, having opportunities for stimulating challenges, a culture of trust,

receiving recognition and acceptance, and to not be considered as a means to an end for the organization.

Arnaud and Wasieleski (2014) demonstrated that relational or humanistic behaviors lead to an autonomous supportive work environment. An autonomous employee is able to self-determine the type and amount of work necessary to achieve organizational goals. Promoting self-determination at work supports the concept of social responsibility, with autonomy as a central tenet. Internally motivated corporate social responsibility behaviors focus on treating employees with respect and consideration for their well-being, satisfaction, and self-actualization because corporate social responsibility constructs consider all stakeholders.

Researchers believe that corporate social responsibility behaviors, with a focus toward employees, are the strongest predictor of employees' trust (Hu & Jiang, 2016). Exchange theorists suggest that trust between parties is a primary outcome of social exchange relationships (Vanneste, Puranam, & Kretschmer, 2014). The impact of corporate social responsibility on employee trust also implies that the manager's actions reflect the organization's character, benevolence, and genuine concern for its employees. Trust is an antecedent of turnover intention, organizational citizenship behaviors, and job performance.

Organizational behaviorists suggest when an organization performs in a socially responsible way employees demonstrate positive work behaviors and less turnover intention (Glavis, & Goodwin, 2013). Treating staff with respect and developing employees increases job satisfaction and decreases turnover intention. Organizational

behaviorists define turnover intention as a measure of the psychological objective to quit. Employee job-related discontent and the desire to seek better opportunities create turnover intention (Omar, Majid, & Johari, 2013). Turnover intention is one determinant of actual turnover.

There is a growing body of evidence regarding the positive relationship between managing human assets and a firm's performance. Ericsson and Augustinsson (2015) concluded that awareness of management practices affects organizational performance through workers' attitudes and behaviors, or what they called regenerative work. Managers with an internal, socially responsible focus improve performance when they show concern for workers' needs. Performance, regarding meeting organizational interests (quality patient outcomes), and employee well-being occur simultaneously when corporate social responsibility practices are applied and when respect for workers' interests followed (Ericsson & Augustinsson, 2015). When managers treat employees as valuable and they are free to achieve work-related goals, employees perceive these actions as high internal social responsible behaviors. The positive affect is an increase in overall organizational performance.

The adoption of proactive, socially responsible strategies, both internal and external, lead to high-relational managerial practices, which describes servant leadership constructs. When managers encourage employee involvement, the work environment improves. Internal corporate social responsibility practices increase employee empowerment because of a flexible organizational structure facilitating the flow of information, resulting in improved financial performance (Cavaco & Crifo, 2014).

Research demonstrates that job meaningfulness and job satisfaction increases, and turnover decreases with internally generated corporate social responsibility activities (Glavis & Kelley, 2014). Glavis and Kelley (2014) also determined that when corporate social responsibility influences work behaviors, there is a measured increase in organizational value.

Overview of the Nursing Environment

Shi and Singh (2014) stated the registered nurse is the primary provider responsible for assuring medical treatment to the sick and injured 24 hours per day, every day of the week. Nursing's identity promotes and sustains the values of the profession and serves as the essential component of caring for others. This distinction is seen in a global perspective by looking at Mother Theresa (Parris & Peachey, 2013) or be traced back to Florence Nightingale, the founder of modern nursing, whose fundamental principles were built on the concept of service to others (Hutchinson & Jackson, 2013).

According to the United States Census Bureau (2013), the United States health care system employed 6.1 million people in various hospital settings. The largest group of health care professionals in the United States is represented by Registered Nurses (RN) at approximately 2.6 million (2014) down from 3.2 million in 2011 (United States Department of Labor, 2014). McMenamin (2014) cited sources projecting that by 2022 there would be an estimated need for 1.1 million nurses.

The general business problem is that the forecasted nursing shortage challenge is compounded by 22% to 44% of nurses reporting job dissatisfaction (Li & Jones, 2013). Low job satisfaction or dissatisfaction results in an increased intention to leave (Cicolini

et al., 2013). A high percentage of nurses reported management leadership, or the lack of good management behavior as the deciding factor to leave their job.

Job satisfaction is an important component of nursing that can have an effect on patient outcomes, productivity, quality of care, turnover, and organizational commitment (Moneke, & Umeh, 2014). Baum and Kagan (2015) confirmed that specific domains influence job satisfaction. Domains identified were work/life balance, supportive management, and job demand. The findings suggest that a manager's control of the work environment has significant implications for nurse job satisfaction and subsequent turnover intention.

Nurse managers positively or negatively influence nursing outcomes (Wong & Laschinger, 2013). Positive factors that contribute to nurse retention are the relationships with the nurse manager and the environment in which the nurse work. Conversely, Khamisa, Peltzer and Oldenburg (2013) reported nursing dissatisfaction was highly correlated with poor relationships with management. 60% to 70% of working adults rated their direct superior as the most stressful aspect of their job, degrading their quality of life (Vught & Ronay, 2014).

Negative leader-follower relationships lead to low job satisfaction, burnout, and increased turnover intention (Cleary, Horsfall, Jackson, Muthulakshmi, & Hunt, 2013). Li and Jones (2013) reported that 28% of United States nurses surveyed responded that they would leave their place of employment if their supervisors were not adequate.

Price of Failed Management to Health Care and the Economy

Adjusted for inflation, the estimated costs of failed management range from $500,000 dollars to $2.7 million dollars per leader as reported by Leary et al. (2013). Between the years 2007 and 2012, the rate of voluntary nurse turnover in hospitals ranged from 8.4% to turnover rates exceeding 36% per year in hospitals sampled nationwide (Kovner, Brewer, Fatehi, & Jun, 2014). New graduates and younger nurses have a higher incidence of turnover, which complicates the nursing shortage. According to their review of the literature, both Pfaff, Baxter, Jack, and Ploeg (2014) and Unruh and Zhang (2014) reported that recently graduated nurses voluntarily separated from their first hospital job within one to 2 years at a rate as high as 60% with many leaving the profession permanently.

Health care organizations are unable to calculate the true economic cost of turnover because administrators tend to focus on direct costs ignoring variable cost because variable costs are difficult to measure. However, estimates are possible by looking at known variables. With each nurse that terminates from a health care organization, the cost of replacing them, considering the salary, specialty, and longevity, the final calculated dollar value ranges from 40% to twice the annual salary (Li & Jones, 2013). However, Li and Jones (2013) found inconsistencies in estimating an accurate cost to health care organizations. They did conclude that nursing turnover expenses were costly to health care organizations. Depending on the rate of loss, an organization can spend millions of dollars per year replacing nurses.

According to United States Department of Labor (2014), the most recent date reported the national median salary for a registered nurse was $66,640. Using the research conducted by Li and Jones (2013) and applying a 1.3 factor, to replace a single nurse costs a health care organization roughly $93,664. An average facility with 400 beds that replaces 80 registered nurses (RNs) per year, assuming a 20% turnover rate, would incur a minimum cost of $3.36 million per year. The estimated cost of replacing a specialty nurse could be $145,000 with an approximated annual organizational cost of $5.9 million to $6.4 million depending on the rate of turnover.

Nursing Leadership; Job Satisfaction and Turnover Intention

Nursing is a hospitals' largest labor expense. Thus, turnover has a direct impact on the bottom line. In the best interest of health care organization's sustainability, executives and nurse leaders must find ways to focus management behaviors that support and improve nurse job satisfaction and retention. Choudhary, Akhtar, and Zaheer (2013) reported that when managers committed to serving others, the result was a strategic competitive advantage.

The way leaders relate to followers has implications for job satisfaction and turnover intention. Attitudes, such as job satisfaction, shape both affective states and thoughts about the job. Job satisfaction, forwarded by Trivellas, Reklitis, and Platis (2013) is defined as an emotional state one has about work in which an attitude for achieving (satisfaction) one's job values.

Job satisfaction is one of the constructs that describes nursing personnel's work environment and its relatedness to other variables, such as patient outcomes, turnover,

and financial success. Empirical evidence has shown that management behavior contributes to nurses' job satisfaction. Raes, Bruch, and De Jong (2013) concluded that leadership behavior directly improves satisfaction, loyalty, and productivity when managers consider an employee's well-being. They also determined that a positive relationship exists between leadership behavior and job satisfaction.

Ramoo, Abdullah, and Piaw (2013) and Roulin, Mayer, and Bangerter (2014) found a positive correlation between job satisfaction and organizational commitment and an inverse relationship between job satisfaction and turnover intent. The research also reported that quality of manager/staff relationships has a positive correlation to job satisfaction and a negative relationship to continuous position turnover.

Trivellas et al. (2013) posited that nurse managers create hospital environments that are either supportive or not. Wong and Laschinger (2013) discussed how the style of the nurse leader is crucial to staff satisfaction and patient outcomes, resulting in a positive or negative influence on organizational performance. A leader's actions either alienates or creates committed workers. Ultimately, nurse managers are responsible for the retention of staff nurses once they are recruited; thus, leadership styles are an important factor in a nurse's decision to stay in a current position, transfer, pursue employment elsewhere, or leave the nursing profession.

A significant relationship exists between leadership style and a staff nurse's intent to stay. A genuine connection between leader and follower is essential in reducing burnout, job dissatisfaction, and turnover intention to assure high-quality patient outcomes. Wong and Laschinger (2013) determined, as nurse satisfaction increased, the

quality of care provided to patients and organizational commitment was enhanced. As the intention to stay at work increases, the high cost associated with nurses leaving their position decreases and patient outcomes improve.

The nursing shortage and ability to provide safe care influences the quality of the work environment. Unsupportive environments create an increase in absenteeism, emotional exhaustion, and intention to leave an organization, and negatively influences the nursing shortage reported worldwide (Buchan et al., 2013).

Leadership Self-Reporting

One challenge in identifying the solutions for nurse dissatisfaction and turnover intention is the discrepancy between the respective views of nurse leaders self-reporting of successful leadership behaviors and the views expressed by staff. Self-ratings of personal leadership behaviors differ from the staff's assessment of leadership behaviors. Seventy-three percent of leaders who self-rated their leadership behaviors as high experienced an elevated discrepancy between their self-ratings and staff ratings, suggesting that supervisors overestimated themselves (Collinson & Tourish, 2015).

Collinson and Tourish (2015) noted that leaders, who learned conventional approaches to leadership, specifically transformational, express a more optimistic view of themselves, and the world around them, underestimate the problems occurring in their organizations, because of the leader-centric approach. A leaders' self-rating of superior behavior reflects their optimistic view of their unit. This self-centric view, erroneously, produces a corresponding belief that they have a positive influence on followers' energy and task performance measured by improved organizational success.

When supervisors self-rate successes, the ratings are often related to employee performance and unit outcomes, and less correlated to the well-being and growth of the follower. Manager's self-ratings show little to no predictable relationship between the employee's well-being and the employee's internal psychological motivations (Chen, Chen, & Li, 2013). Chen, Chen, and Li (2013) demonstrated that obtaining an unbiased self-assessment of leadership style from supervisors is not accurate and can be difficult.

Nursing Job Satisfaction

Traditional hierarchical management models fail, as highly talented people do not need and are unlikely to put up with, outdated management styles. Job satisfaction is an essential factor in this regard. Leadership is a significant factor in developing and maintaining job satisfaction and depending on the style, affects the factors that influence the degree of job satisfaction. Managers are considered effective, by staff nurses, when the manager creates an empowering workplace, shared decision-making occurs, and staffing levels are adequate (Wong & Laschinger, 2013). The conclusion drawn is that nurses who remain in the job stay because of a positive relationship between the supervisor and staff. Several studies' findings have shown that turnover intentions increase and are associated with the nursing work environment and unit characteristics that are less supportive of employee needs and well-being (Gellatly, Cowden, & Cummins, (2014); Ramoo, Abdullah, & Plaw, 2013).

Turnover Intention

Turnover intent claims to start with psychological responses to negative aspects of the leader, organization, or job. The core of the process includes a cognitive component

involving a decision to leave and withdrawal behavior (Boamah & Laschinger, 2016). Turnover is the movement of staff out of an organization. Voluntary turnover can occur in two ways; individuals who willingly leave an organization and individuals who move between units within the same organization. Boamah and Laschinger (2016) discussed how turnover intention is an important predictor of actual turnover. Turnover is an outcome result, while turnover intention is a psychological deliberation. Turnover is particularly hard to determine in health care, as the statistics are not freely available in the literature.

Turnover intention (or intent to leave) is an outcome resulting from affective variables, such as job satisfaction. Ramoo et al. (2013) discussed, as dissatisfaction increases, the intent to leave significantly increases. The authors posited that the reasons given by nurses as justifications for leaving center on issues known to affect job satisfaction, such as ineffective supervisory relationships and insufficient opportunities for professional development, rather than external labor market forces of which managers would justifiably feel unable to control.

Relationship Orientation of Nursing Leadership

With the growing need to alter the tide of nurse turnover, changing from task-oriented leadership style to relationship-oriented leadership is necessary for nurse managers. Early leadership models described leader-follower relationships as hierarchical or top-down. The traditional, one-way, top-down communication of vision and directives often leads to a decrease in supervisor-follower relationships.

A poor supervisor-follower relationship is one of the most common sources of stress in organizations. Employees reported that low supervisor support, minimal communication, and lack of feedback reduced individual well-being and contributed substantially to feelings of stress and increased turnover (Kelloway, Weigand, McKee, & Das, 2013). Alternatively, Vogelgesang, Leroy, and Avolio (2013) conducted a longitudinal study on leader behavior as it relates to follower work engagement and found that leaders who exhibit more transparent communication increase follower engagement and higher performance. Organizations, who seek to affect the delivery of health care, need to evaluate leadership behaviors that negatively affect employees that deliver the care.

Organizational change and service improvement requires more than just a charismatic leader or an effective communicator. Task-oriented leaders organize and define the role of their staff, whereas relationship-oriented leaders maintain personal connections allowing for greater flexibility and individual task development (Wong & Laschinger, 2013). Nurses need a relational leader more than control by a leader as nurses respond positively to the support they receive from their supervisor and negatively when controlled. Relational leadership emphasizes the situation in which leaders perform as opposed to a person in control.

Leadership, grounded in the relationship between a leader and follower, achieve agreed-upon goals. Numerous researchers recognize the need to build effective relationships with all staff (Mager & Lange, 2013; Trivellas, Reklitis, & Platis, 2013). The findings show that leaders, whose behaviors are more relational-oriented,

demonstrate an interest in and respect staff, was approachable, accepted input from others, and treated everyone as an equal, creating a work environment that positively influenced job satisfaction.

If the quality of the mutual relationship, viewed from the employee's perspective, is of particular relevance to their well-being, one may ask what predictors are necessary for this relationship. One possible predictor might be a description of a particular leadership style that leads to a high-quality mutual relationship between the employee and supervisor. That style would seek to put the follower before the needs of the leader or organization. When asked what makes a good leader, participants listed several qualities, such as having integrity, enabling trust, being listened to by their leader, honesty, and acting in a fair and consistent manner (Hutchinson & Jackson, 2013). Additional essential elements of leadership include valuing every individual and their contributions, recognizing the reciprocation of earning and receiving trust, embracing change, continuing to learn, empowering others, correcting practice, and mentoring. Relationship-centered leadership provides these elements by enabling staff to feel valued and appreciated.

Relationship-Centered Leadership

Nursing leadership should understand that strong relationships are an example of social capital. Internal social capital is a resource formed by relationships between individuals within an organization. Social capital is an indispensable asset. Financial physical capital measures the dollar value of tools or machines. Developing human capital occurs through employee education, development, or exposing staff to new

experiences. Investing in social capital reflects the increase in close interpersonal relationships. Three specific aspects of nursing social capital are

- Structural dimension-considers the extent of the relationships that exist in organizations.
- Relational dimension-reflects on the quality of the connections between individuals, characterized by trust, respect, or caring.
- Cognitive dimension-relates whether employees share a common viewpoint (Sun, Zhao, Yang, & Fan, 2012).

Leaders focused on the relational dimension of social capital demonstrate the desire to know, understand, support others in the organization, and emphasize the importance of building long-term relationships. Relational leadership has many positive outcomes for individuals and organizations as their behaviors complement an adaptable and flexible organization (Kelloway et al., 2013).

Additionally, Kelloway, Weigand, McKee, and Das (2013) demonstrated that managers, who are positive, increase the confidence of employees by expanding employee affect, thus, provide a favorable environment for task performance and goal achievement. Sullivan-Havens, Warshawsky, and Vasey (2013) discussed that relationship-oriented nurse managers enrich individuals resulting in improved performance and goal achievement. Additionally, he determined nursing leadership's ability to engage staff has shown a positive impact on the quality of patient care and health outcomes.

When staff receive support and feedback, stronger leader-follower partnerships develop. Empirical research demonstrates when employees receive support from the manager, in the form of feedback and recognition, trust develops; thus, perceived stress and burnout are reduced (Tuckey, Bakker, & Dollard, 2012). A common theme among researchers is that relational-oriented behaviors foster follower respect and encourage staff to focus on group and organizational goals. Additionally, high-quality relationships increase organizational learning by connecting employees who engage in distinct yet interdependent roles in an organization. Research is clear that a positive work environment fosters a staff's organizational commitment.

Employees who have greater organizational commitment are more likely to experience greater satisfaction and a reduction in turnover intention. Positive exchange relationships with managers have shown to increase employee commitment toward organizations. Findings from a study conducted by Ahmed, Wan Ismail, Amin, and Ramzan (2013) determined one critical predictor of commitment is an employee's perception of organizational support. Employees who feel supported report a greater, positive relationship with their manager (Agarwal, 2014). Such relationships increase an employees' level of commitment and reduce their intention to quit. Support from managers is evident when nurses feel individual empowerment, personal control of care delivery, and shared decision-making. Together, these factors positively correlate with the intention to stay (Cicolini et al., 2013).

Leaders, who promote supportive relationships, elicit motivation, facilitate more positive and less negative emotions, lead to more effective outcomes than traditional

leaders who tend toward task-directive techniques. In their study of 628 nurses, Gregersen, Vincent-Höper, and Nienhaus (2014) recognized that supervisors who develop a qualitatively high-valued relationship with each of their employees marked by positivity, mutual trust and respect, achieve organizational goals.

Leaders are instrumental in developing a culture that enable individuals to coalesce around a shared purpose when the leader is relational (Landry, Vandenberghe, & Aved, 2014). An important indication of high-quality associations occurs in relational coordination. According to Gittell, Godfrey, and Thistlethwaite (2013) relational coordination develops through sharing goals, knowledge, and mutual respect. Leadership qualities focusing on relational-oriented behaviors improve follower satisfaction with the leader (DeRue, Nahrgang, Wellman, & Humphrey, 2011).

In a review of the literature, Allio (2013) found employees often look to leaders to clarify purpose and values, set direction, build community, and manage change. Studies have shown that relationship-oriented leadership, particularly the behaviors of sharing, supporting and developing, are associated with job satisfaction (Wong et al., 2013). Amundsen and Martinsen (2014) described relational-oriented behaviors on empowering and its positive influence on job satisfaction. Amundsen and Martinsen (2014) determined that the quality of leader-follower relationships is the foundation of a productive work environment.

Research on the positive contributions of leadership on organizational and employee success has shown a strong relationship between the manager and the employee. Innovative behaviors and creative engagement among staff increased with

relational leaders (Tuckey et al., 2012) and a positive work climate create improved job satisfaction (Wong & Laschinger, 2013). Braun, Peus, Weisweiler, and Frey (2013) discussed the complex characteristics related to leaders whose behaviors encourage greater job satisfaction and reduce turnover intention. These factors include inspiring, mentoring, relationship development, trust building, compassion, and recognition.

Cicolini et al. (2013) conducted a review of the literature and found significantly healthier work environments occur when leaders demonstrate a high degree of relational tendencies resulting in increased staff engagement and improved patient outcomes. Leaders that involve staff in decision-making and unit problem solving lead to higher performance and less turnover intent. Teamwork effectiveness will increase, which lends greater support for the concept that nurses value relation-oriented leadership because a relational leader is a reciprocal process.

Servant Leadership

Early research of leadership styles concentrated on operational variables, and the influence leadership had in bringing about organizational changes (Olesia, Namusonge, & Iravo, 2014). As discussed, relational leadership practices provide a compelling argument for health care to adopt leadership styles that resonate with staff. Researchers have reported on the relationship between a healthy work environment, job satisfaction, and retention in the nursing profession (Cicolini et al., 2013). Treating colleagues with dignity and respect, and not a cost of doing business, have improved organizational performance (Hunter et al., 2013).

Parris and Peachey (2013) determined through their literature research, that servant leadership is a humanistic leadership style that encourages followers to adopt behaviors based on societal values and shared beliefs. Servant leadership considers organizational goals as a secondary priority that, even when leaders focus on the needs of employees first, would eventually be achieved (Liden et al., 2014). Liden, Wayne, Liao, and Meuser (2014) found that servant leadership inspired followers to become more committed, develop trusting relationships, embrace learning, and seek work fulfillment.

Sun (2013) explained that servant leaders go beyond traditional leadership by selecting the needs of and serving others as the primary focus. Managers who embrace servant leadership behaviors experience greater flexibility in a changing environment, preserve open-mindedness for new ideas, enjoy optimistic employees who are creative and willing to learn. According to Sun (2013), servant leadership is different from other leadership styles and, in its distinctiveness, offers the potential to have a unique influence on organizations and their stakeholders. Servant leadership is a practice that places the good of others over self-interest by valuing others (Choudhary et al., 2013; Trastek et al., 2014).

The challenge for leaders to accept servant leadership, as a practice in health care, is the lack of broad acceptance because of construct clarity. Researchers have not developed consensus on the definition, scope, and relationships with other constructs and coherency (Brown, & Bryant, 2015). The idea of putting the needs of followers first runs counter to the logic of entrenched leadership styles (transformational) that focuses on organizational mission-driven orientation.

Servant Leadership and the Individual

Servant leadership provides opportunities for people to learn, grow, and share in power by increasing awareness of the internal and external environments (Rachmawati & Lantu, 2014). Self-actualization occurs through continuous communication and feedback, feelings of autonomy, and in an atmosphere of safety. Greenleaf (1977) proposed that followers' well-being improved and they became more autonomous when managers showed flexibility in response to making mistakes.

A correlation exists between servant leadership and workplace attitudes and commitment (Chan & Mak, 2014), which influences job satisfaction. As a management strategy, research conducted by Bobbio and Manganelli (2015) found that servant leaders improved the job satisfaction and retention of nursing staff. This improvement relates to a positive increase in the intrinsic motivation of followers (Chen et al., 2013). Bambale (2014) found nurse managers who demonstrate servant leadership behaviors help followers achieve their potential by increasing individual self-confidence, creating an environment of trust, communicating necessary information, providing constructive feedback, and allocating crucial resources.

Current health care delivery requires management's awareness of the need for competence in how the leader manages relationships with others. Nursing staff, who reported that their manager had a high servant leadership orientation, also reported higher job satisfaction (Bobbio & Manganelli, 2015). Ehrhart (2004) related that servant leadership added 5% of the variance in employee commitment, 7% of the variance in satisfaction with supervisor, and 4% of the variance in perceived supervisor support,

beyond that of transformational leadership. Thus, theory and empirical data support the notion that servant leadership is a unique leadership theory that can extend managers' knowledge about leadership processes and outcomes (Dihn et al., 2014).

Servant Leadership and the Patient

There should be alignment with how nurses treat patients, work together, and how their leaders care for them since health care is about caring people caring for others. Servant leadership aligns with the professional and ethical duties of health care providers when delivering the high-value care patients deserve while developing stronger team bonding through service to peers. Servant leadership, focused on trust and empowerment, demonstrated better provider-patient relationships (Trastek et al., 2014).

According to McDowell, Williams, and Kautz (2013), a shift occurs when leadership styles that traditionally focus on planning and controlling, realign to a leadership style encouraging decentralized decision-making. McDowell et al. (2013) found that by increasing the availability of information that supports the abilities and facilitates staff empowerment, leads to improved patient outcomes. Assessing patient outcomes would be a logical step, given the traditional, moral imperative of nurses to serve their patients.

Liden et al. (2014) revealed a positive relationship between servant leadership and a serving culture. Their nonexperimental, random study indicated a relationship existed between followers' perceptions of their formal leaders' servant leadership behaviors and the degree in which employees focused on serving others. If the basis of organizational success is on quality outcomes of patients (external stakeholders) and nurses (internal

stakeholders), who have the most direct interaction with patients and are influenced by servant leaders, it makes sense that managers would meet organizational goals by aligning with servant leadership behaviors.

Servant Leadership and the Organization

Parris and Peachey (2013) described how servant leaders established clear goals and direction, resulting in a more satisfied workforce. When employees perceive that their supervisors are committed to service, empowerment, and a shared vision, they are more likely to see the organization as one that embraces servant leadership (Beck, 2014).

A strong focus on supporting followers suggests that servant leadership might strengthen the link between goals and team processes by elevating each member's commitment to shared organizational goals. The importance of the commitment of followers is exemplified by its relation to improved organizational and job performance and a decrease in absenteeism, tardiness, and turnover (van Dierendonck , Stam, Boersma, De Windt, & Alkema, 2014). Committed employees who are encouraged to be creative, help develop learning organizations where individuals feel safe to take risks and make mistakes (van Dierendonck & Nuijten, 2011). Servant leaders create the conditions for learning.

Beck (2014) and van Dierendonck (2011) reported two categories of servant leadership: functional and accompanying. Within these categories, researchers identified numerous attributes. Functional attributes of servant leadership include; creating a vision, emphasizing a service orientation, encouraging honesty, becoming a role model through trust, appreciating the thoughts of others, and empowering staff. Accompany attributes,

described by researchers, include being an effective communicator, an engaged listener, knowledgeable and competent, encourage through coaching, and appropriate delegators (Beck, 2014).

According to social learning theory, individuals learn by modeling the attitudes, values, and behaviors of role models in their environment. Liden et al. (2014) posited when leaders demonstrate servant behaviors, followers model the same behaviors. Servant leaders are credible role models because followers perceive their motivations to be altruistic and authentic.

Servant leadership support the work environment and culture through high levels of trust, teamwork, and flexibility (Latham, 2013). Servant leadership style also generates superior organizational performance by encouraging followers to emulate leaders' behaviors by emphasizing that followers should put the needs of others first. In a study conducted by Liden et al. (2014) found that when leaders demonstrated servant leadership, followers' perceptions of leaders improved resulting in a stronger serving culture.

Consequently, customer service behaviors that align with the organizational and group goals result in positive customer experiences. Followers cognitively associate service behaviors with doing the right thing, because individuals experience personal satisfaction from serving others. Servant leadership increases the positive psychological response of staff leading to improved job satisfaction. On the other hand, traditional leaders seek to align their interests away from individuals and focus the outcomes that may benefit himself or herself, the group, or organization.

Servant leadership differs from other leadership styles in its uniqueness, offering the potential to influence nursing and health care organizations positively. Bambale (2014) found servant leaders, focused on personal integrity, had formed strong, long-term relationships with employees. Liden et al.'s (2014) study established the superiority of servant leadership over transformational leadership on predicting, in-role performance, organizational commitment, and community citizenship behaviors. Their work is significantly different from previous conceptualizations of leadership because of the emphasis placed on personal integrity and serving all the organization's stakeholders including employees, customers, and communities.

Based on a study that evaluated nurse managers' responses to surveys delineating what they perceive as important, Anderson, Manno, O'Conner, and Gallagher (2010) concluded that servant leadership should be the new paradigm of nursing leadership. The new nurse leader serves employees who in turn serve the customer.

Behaviors of Servant Leaders

Combinations of tasks, characteristics, and behaviors influence people to achieve goals. A healthy work environment occurs when leaders exhibit identifiable behaviors, characteristics, traits, and demonstrate a command of specific competencies. Greenleaf (1977) identified 10 characteristics common to servant leaders: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment, and community building. Spears (1995) (as cited in Parris & Peachey, 2013) identified 10 characteristics of servant leaders that included; listening, empathy, healing, awareness, persuasion, philosophy, conceptualization, foresight, stewardship, commitment to the

growth of people, and building community. Laub (1999) and his Organizational Leadership Assessment identified six key variables of a successful servant-led organization,

- Valuing people. Leaders believe in, serve, and nonjudgmentally listening to others.
- Developing people. Leaders provide learning and growth opportunities while encouraging, and affirming.
- Building community. Leaders develop strong collaborative and personal relationships.
- Displaying authenticity. Leaders are open, accountable, and willing to learn from others.
- Providing leadership. Leaders foresee the future; take initiative to set a course, and establishing goals for people and the organization.
- Sharing power. Leaders facilitate and share authority and responsibility.

Ehrhart (2004) identified seven dimensions; forming relationships, empowering others, assisting the growth of followers, behave ethically, demonstrate conceptual skills, placing followers first, and value others. Van Dierendonck and Nuitjen (2011) identified eight dimensions; standing back, forgiveness, courage, empowerment, accountability, authenticity, humility, and stewardship. Based on the variety of characteristics, researchers agree that developing specific servant leadership constructs remains challenging.

Berger (2014) reviewed leadership literature and determined a variety of constructs describing servant leadership exist. Berger reviewed literature that explored attributes, qualities, and unique characteristics, such as vision, honesty, integrity, trust, service, modeling, pioneering, appreciation of others, and empowerment. Berger also described research that discussed attributes, such as, communication, credibility, competence, stewardship, visibility, influence, persuasion, listening, encouragement, teaching, and delegation.

Along with the broad interpretation of Greenleaf's (1977) concepts, challenges defining servant leadership remains just as inconsistent when trying to identify which behaviors apply to leaders as primary constructs versus supportive characteristics or qualities. Defining factors, that influence the effectiveness of leadership activities and follower responses are inconsistent in the literature and are often interchangeable.

For example, Courtright, Colbert, and Choi (2014), in one sentence, described withdrawal *behavior* as one who misses meetings, is absent from work, or lacks any response to problems and a *characteristic* of laissez-faire leadership. In this example, withdrawal describes both a behavior of an individual's actions and a characteristic attributable to a specific leadership style. This inconsistency leads to multiple uses of single descriptors owing to confusion about what leadership is.

Regardless of the words used to describe leadership, a healthy work environment occurs when leaders exhibit identifiable behaviors, characteristics, traits, and demonstrate a command of specific competencies. DeRue, Nahrgang, Wellman and Humphrey (2011) suggested that certain behaviors are an important predictor of leadership effectiveness.

Owing to the challenges in quantifying which servant leadership constructs are considered traits, attributes, characteristics, or behaviors, for the purpose of this research, all constructs are behaviors and represent the distinguishing quality of an individual. The constructs considered are humility, communication that includes listening, commitment to the growth and development of staff, and empowering behaviors.

Behaviors are a consistent way in which a person acts or conducts himself or herself based on stimulation (Merriam-Webster, 2014). Through an extensive literature search, Derue et al. (2011) identified four categories of leadership behavior: task-oriented, relational-oriented, change-oriented, and passive leadership. Traditional leadership behaviors lean toward task-oriented activities and interactions with others or change-oriented action in the organization. Relational-oriented behaviors relate to interpersonal actions. Sejeli and Mansor (2015) suggested that the relational-oriented leader's conduct is observable actions manifested by empowering others, developing relationships, and creating value. Leaders who adopt these actions recognize the need for employee development, notice greater risk taking, and observe motivated employees that perform above expectations.

Researchers have identified multiple actions that they have labeled behaviors, such as empowerment (MacPhee et al., 2014), self-serving or self-sacrificing activities (Effelsberg & Solga, 2015), and humility (Owens & Hekman, 2012). They have labeled concepts, such as inspirational motivation, intellectual stimulation, individualized consideration, idealized influence into leadership styles, such as transformational leadership, as behaviors. The importance of leadership behaviors cannot be

underestimated. According to Derue et al. (2011), leadership behaviors accounted for 51% of the variance in a follower's job satisfaction.

Wong et al. (2013) described positive leadership behaviors as being supportive, accessible, visible, and they adequately communicate information to staff. Regarding two factors in a study (supportive and visibility), conducted by Duffield, Roche, Blay, and Stasa (2011), found only 50% of nurses surveyed reported that their leaders were visible and available when needed, and a smaller majority thought their managers were supportive of nurse decision-making.

Humility

Defining humility is an evolving process. Current research identifies two distinguishing aspects of humility, intrapersonal and interpersonal. The intrapersonal component of humility involves an accurate assessment of self (Davis & Hook, 2014), whereas, the interpersonal component encompasses an orientation to others. Because of the limited available research on humility, consolidating the known research into a broader operational definition yields unique challenges. Operationally, humility can be defined as the ability to balance the needs of self, one's accomplishments and talents (Davis et al., 2013), and other's needs, accomplishments, and talents through an accurate view of self and others (Davis & Hook, 2014). Ou et al. (2014) described humility as

- Having an accurate assessment of personal abilities and achievements.
- The capacity to acknowledge mistakes, imperfections, gaps in knowledge, and limitations.
- Ability to consider new ideas, contradictory information, and advice.

- Keeping personal accomplishments in perspective.
- Relatively low, self-focus.
- Appreciation for the fact that all people can contribute to the world.

Ou et al. (2014) also offered that leadership humility indicates a state of decreased self-focus with a high degree of self-relevant beliefs that unites rather than divides. Humility is the understanding of personal strengths, and thus, there is no need to feel entitlement or desire dominance over others. Humility leads to various outcomes. For example; Kruse, Chancellor, Ruberton, and Lyubomirsky (2014) suggested humble people demonstrate a higher degree of both self-reported and social generosity. Argandona (2015) discussed how humble managers contribute to teamwork through the concepts of helpfulness, expressing gratitude, and expanding responsibility. Leaders who demonstrate humility appreciate the positive worth, individual strengths, and contributions of others (Owens & Hekman, 2012).

Leaders who place the interest of others first, facilitate performance, and provide continuous support, demonstrate humility. The result of an others-view creates positive, unintended outcomes. Humility often entails the recognition and appreciation of knowledge and guidance beyond self. Owens and Hekman (2012) concluded, when leaders demonstrate humility, employees engage in behaviors that exceed their job duties. Tremendous benefits occur, regarding organizational performance and customer satisfaction, when employees go beyond the expectation. The literature on servant and self-sacrificial leadership suggest that leaders that have committed to bottom-up

behaviors have resulted in followers who are more loyal and organizations that are financially better off (Chancellor & Lyubomirsky, 2013).

Management that reflects on the needs of staff provide critical feedback, remain accessible, communicate willingly, and embrace employee involvement in organizational processes are shown to have more satisfied staff who recognize the supportive quality and openness of management. Followers appreciate managers who learn to recognize self-limitations and forgive others' mistakes for being open and vulnerable. In addition, managers who listen to the needs of employees are more willing to invest in employee's growth, both personally and professionally.

When leaders exhibit humble behaviors, followers reciprocated by demonstrating greater commitment to the leaders and organization. Leaders who exercised humility stimulated stronger leader-follower relationships (Owens, Johnson, & Mitchell, 2013) and improved decision-making (Chancellor & Lyubominsky, 2013). Additionally, when leaders are humble they recognize the value of sharing collective values, which builds a greater sense of community (Davis et al., 2013).

Owens and Hekman (2012) conducted a qualitative study evaluating employee response to a humble leader's behavior. Their findings indicate humble leaders produce an increase in relational satisfaction and loyalty. Survey responses suggest that humble leadership behaviors shape the feelings of follower's work activities and their attitudes toward development. Followers reported that a leader's humble behavior legitimized followers' evolving learning goals allowing followers to experience psychological freedom and organizational engagement.

When a leader shows interest in followers, a positive psychological state develops. Owens, Johnson, and Mitchell (2013) described how followers are more likely to trust a leader that demonstrates humility. Followers felt safer to be transparent about their developmental process leading to increased job engagement when leaders demonstrated humble behaviors (Owens & Hekman, 2012). By internalizing development and focusing on intrinsic motivational factors, followers appear to shift from seeking to meet external performance standards to learning and mastering job tasks, leading to greater performance. Followers who witnessed leadership humility behaviors convey enhanced personal and professional motivation and continuous growth. Owens and Hekman (2012) suggested that humble leadership behaviors went beyond nurturing staffs' feeling of psychological safety and focused on employee's intrinsic needs by developing follower behaviors that led to a service orientation.

Given that humble leaders validate health care uncertainty, followers' adaptability reflected a greater understanding of new environmental challenges. Nursing requires leaders who understand the changing environment and can inspire others to adopt new paradigms for solving problems. Hutchinson and Jackson (2013) recognized humility as an essential trait of nursing leadership. His research connected nursing leaders, who exhibited humility, identified the needs of the environment, and rallied followers to find solutions. In doing so, the humble leader recognized individual and team accomplishments, talents, and abilities. Humble leaders also had a strong self-awareness of their contribution but kept them in perspective.

Communication

Communication is a fundamental aspect of leadership and management. As much as it is a skill, communication, as a behavioral attribute, translates readily from clinical practice to the managerial/leadership role. Leaders, who honestly share all information, positive and negative, and follow through with consensual decisions, will ultimately enhance the well-being of the group. Leaders promote positive, trusting relationships with their subordinates by enhancing communication (Dumas, Phillips, & Rothbard, 2013). The successful leader articulates the organization's vision in a persuasive and stimulating manner.

One-way communication is ineffective in building relationships. Thus, hierarchical structures limit management's ability to develop sustainable interpersonal relationships. Communication entails, not only providing information, but also listening. Leaders benefit from listening because they learn as they listen and this empowers followers. The servant leader listens as a way of encouraging others by asking questions to determine if anyone has valuable knowledge or insight into a problem. By fostering participative decision-making, the leader improves the confidence and self-efficacy of others.

Effective communication between nurses and leaders builds trusting relationships. Interpersonal relationships that develop through good communication skills positively affect the performance of nurses. Beneficial communication optimizes patient care as colleagues cooperate and collaborate on care issues. Open communication encourages

continuous involvement in decision-making between staff and nurse leaders **(**Wong & Laschinger, 2013**).**

Sankowska (2013) conducted a cross-sectional survey to determine the causal relationship between communicating knowledge, listening intently, and trust improvement. Sankowska (2013) established the effect that trust had on problem solving. His study found clear links to communicating information, openly listening to feedback and new ideas, and trusting development in management resulting in a positive impact on employee innovativeness. To build trust and improve problem-solving, leaders should communicate knowledge necessary to create a work environment that inspires and engages employees, listens to employee's ideas and concerns, and then allows staff to implement agreed-upon actions.

A core element of leadership is relational communication. In their review, Bakker-Pieper and de Vries (2013) indicated follower satisfaction is more frequently associated with an affable communication style. Their nonexperimental study indicated that relational leadership styles are highly communicative, while a task-oriented leadership style is notably less communicative. Their results also found narrow constructs, such as communicating information and listening to feedback, out-performed broader measurements, such as personality traits, when conceptualizing relevance of leadership communication. Bakker-Pieper and de Vries (2013) also noted that knowledge sharing, clarity and precision, and empathetic communication were found to improve higher job satisfaction and individual commitment.

Empowering

Providing a sense of personal control is the goal of empowering behaviors. Success comes when leaders foster a proactive, self-confident attitude among employees. Empowering leadership behavior includes sharing information (communicating), and coaching employees to strive for more innovative performance. Empowering and developing employees is demonstrated by increased autonomy and allowing followers to perform tasks and letting them engage in organizational decision-making (van Dierendonck et al., 2014). Some theorists believe that people receive intrinsic satisfaction from their work and tend to be more productive and better motivated when given control over their work (Tuckey et al., 2012).

A shift in focus from a leader-dominated view to a broader employee-empowering and power-sharing perspective demonstrates a commitment to the involvement of followers. Leadership depends on receptive followers who are involved in creating the direction and maintaining organizational activities. Power is not the same as leadership. Power in an organization has three identifiable forms that exist together symbolizing an individual's position, current state, and personal qualities. Shifts from hierarchical leadership focused on planning and control to a leadership style that encourages decentralized decision-making, and the availability of information leads to facilitating staff empowerment (van Dierendonck, 2011).

Empowering occurs when the manager essentially inverts the status hierarchy within the work unit. Employee responsibility increases and accountability shifts to a greater degree from the manager to the nursing staff. Inversion is important to the

employee because it signals empowerment and respect. In the context of nursing, role inversion allows the nursing professional to engage in autonomy and role of expert with the nurse manager acting as a facilitator of the nurses' work.

Results from empowering behavior research included employees who sought work that is more meaningful and expresses the desire to participate in decision-making resulting in increased confidence (MacPhee et al., 2014). MacPhee et al. (2014) determined that empowering leaders facilitate goal accomplishment, provide autonomy from bureaucracy, and support employee involvement in the decision-making and any actions taken to achieve legitimate organizational goals. Empowering and supportive work environments link to higher levels of job satisfaction in nurses resulting in organizational commitment and an increase in high-quality standards in nursing care (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2013). Empowering behaviors entrust power to those who performed the work.

Regarding empowerment, de Waal and Jansen (2013) posited when nurse leaders empower staff through encouragement and sharing information they also give freedom and permission to make decisions. Empowering leaders play an essential role in knowledge management and knowledge accessibility resulting in more knowledge sharing. Additionally, when staff is satisfied with the quality and openness of their management, the more empowered, spontaneous, and stimulated employees are. Thus, they feel able to develop themselves, correlating with a higher performing organization (de Waal & Jansen, 2013).

For the servant leader, empowering involves practicing effective listening, developing people's feelings of value, putting an emphasis on teamwork, appreciating the effects of loving others, and assuring equality (van Dierendonck, 2011). Empowering is imparting meaning, attending to followers' needs, caring for them, and expressing appreciation for servant behaviors. Servant leaders empower followers to be the best.

Sun, Zhang, Qi, and Chen (2012) described how staff empowerment is represented in two ways, structural and psychological. Laschinger, Nosko, Wilk, and Finegan (2014) found that psychological empowerment is the degree that an employee perceives empowerment and autonomy and is comprised of four dimensions: meaning, competence, self-determination, and impact. Their research found a positive effect among employees toward their organizations and verified that positive psychological empowerment positively affected job satisfaction and performance. Increasing the meaning and fulfillment of work, ability to self-determination, and building competence represented employee psychological empowerment.

Laschinger, Wong, and Grau (2013) advanced that structural empowerment provides access to organizational information, support, and resources that augment employee work success and opportunities to do the job. Organizational resources that staff value include access to necessary and timely information, management support, and development opportunities. Nursing researchers have shown that when leaders ensure access to organizational resources, staff feel empowered by leadership actions. Laschinger, Wong, and Grau (2013) determined that structural empowerment contributes to higher levels of satisfaction.

Research on the positive relationships between psychological empowerment and organizational commitment has its limitations as MacPhee et al. (2014) found. Nurses who were already disengaged from the organization did not respond to positive empowering behaviors from leaders despite research showing that a leader's empowering behaviors serve as a catalyst for staff empowerment and job satisfaction.

Breau and Réaume (2014) determined empowering behaviors and positive work environments are compelling predictors of job satisfaction. Pineau Stam, Laschinger, Regan, and Wong (2015) verified these same findings by determining that structural empowerment explained a 38% variance in job satisfaction when employees worked on units whose leaders embrace empowering behaviors. Greater job satisfaction occurs when the work environment and empowerment focuses on specific factors like; leadership support, access to organizational resources, and shared power. When nurses perceive empowerment, they are motivated to perform because they experience a high degree of purpose and meaning in their work (Wong & Laschinger, 2013).

Trust. The multi-dimensionality of trust provides a wealth of definitions and difficulties in narrowing the referents of trust. Within an organizational context, trust is a behavior of leadership (Fulmer & Gelfand, 2012). Creating trust is an essential facet of leadership, especially servant leadership. The basic element of sincere leadership is trust. Trust in a leader is the willingness of a follower to be susceptible to the behaviors and actions of a leader, which are outside the follower's control (Chan & Mak, 2014). Leaders must demonstrate genuine concern for people and demonstrate integrity to build trust. Longenecker and Longenecker (2014) emphasized the important connection

between organizational outcomes with goal achievement and trust in the leader. Chinomona, Mashiloane and Pooe (2013) demonstrated that servant leadership has a positive influence on employee trust ($\beta = 0.805$, $t = 22.591$). When people did not trust their leaders, they were unlikely to provide maximum effort.

Trust is closely linked to, what some researchers call, social exchange relationships. As social exchange relationships develop, psychological safety increases (Fulmer & Gelfand, 2012). Management research determined when leaders reliably demonstrate trusting relationships; staff respond by increasing their commitment and loyalty to the manager and organization. Interpersonal trust stimulated satisfaction and commitment of employees and is a fundamental method of enhancing organizational effectiveness. Fulmer and Gelfand (2012) found the importance of referent trust, or trust in leaders, to be an important aspect of high-powered organizations. To increase the trust between leader and follower, the manager's behavior must avoid self-interest, but be driven by the desire to boost the well-being of staff.

Parris and Peachey (2013) described how trust is an essential characteristic of the servant leader. A critical leadership factor in organizational and interpersonal relationships is trust (Wong & Giallonardo, 2013). When trusting in followers' abilities, the leader communicates confidence by empowering staff through self-directed decision-making. Empowered employees take ownership of their jobs (Avey, Wernsing, & Palanski, 2012). Employees who embrace their jobs create a stronger organization. Fulmer and Gelfand (2012) suggested that trust in a manager mediated the relationship

between turnover intention and loyalty, withdrawal behavior and commitment, and turnover intention and CSR.

Parris and Peachey (2013) found that the values of integrity and honesty solidified interpersonal and organizational trust and lead to credibility, which is essential for leadership. Parris and Peachey determined, when followers perceive their leader have superior servant behaviors, significantly higher trust levels occur as compared with followers who perceive that their leaders exhibit lower servant behaviors.

Wang and Hsieh (2013) reported meaningful, positive relationships between leaders who are trusted and follower job satisfaction, organizational citizenship behaviors, job performance, and organizational commitment. Wong and Laschinger (2013) discussed how nurses' trust in the organization improves work environmental factors, commitment, and job satisfaction. Wong and Laschinger (2013) also discussed how organizational trust improves the perception of unit-level quality of care.

Finally, Singer and Vogus (2013) discussed that medical errors decreased when leaders develop high-quality relationships by creating an environment of psychological safety, punctuated by trust in leaders. Staff nurses develop and engage in safety behaviors when their trust in nursing leaders increases resulting in improved patient safety outcomes. Nurses are more likely to discuss errors and question organizational practices when they feel the work environment is safe to do so.

Wong (2015) discussed how leaders earn employee trust when the staff is respected, supported, and feel leaders show justice. Additionally, when the leader treats employees fairly and consistently, encourages employee growth and development, and

promotes work-life balance, perception of trust are enhanced (Gordon, Gilley, Avery, Gilley, & Barber, 2014). According to Goh and Zhen-Jie (2013), a high level of trust exists when staff expresses their thoughts, fears, views, and feelings more openly. The environment, however, must be safe for followers to express concerns.

When employees have an emotional connection with the leader, characterized by trust, individual performance positively influences the mediating effect of psychological safety. Leader-staff trust increases the followers' respect for the leader who then allows followers to speak up without fear of recrimination. When employees trust their leader, an emotional connection intensifies providing staff with a higher degree of psychological safety, allowing for an increase in openness and sharing of information with others (Li & Tan, 2013).

Management respect and attentiveness increases the likelihood of greater trust from staff and deeper personal feelings of understanding and support. The consistent dialog between managers and staff, including appropriate appraisal performance processes and internally generated satisfaction inducements (e.g., words of encouragement), provides the needed recognition and mutual respect for staff to feel satisfied.

Organizational citizenship behavior research demonstrated how trust is a bridge between organizational constructs like leadership style and personality (van Dierendonck, 2011) and outcomes, such as goal achievement, turnover, and organizational commitment (van Dierendonck et al., 2014). The importance of nurses' sentiments toward

management had a direct link between nurses' trust and performance-oriented behaviors (McCabe & Sambrook, 2012).

Commitment to Employee Growth

Management commitment to employee growth occurs when the environment allows the employee to meet his/her career needs and the manager reinforces those needs through recognition of accomplishments (Ertűrk, 2014). Job development is a significant dimension in the process of employee engagement as it allows employees to acquire the skills to perform their job role effectively, ultimately meeting personal, professional, and organizational goals. Job development improves service accuracy and thereby influences service performance and employee engagement (Truss, Shantz, Stone, Alfes, & Delbridge, 2013).

When an employee undergoes learning development programs, his/her confidence increases in the area of the development motivating them to be more engaged in their job. Akkermans, Schaufeli, Brenninkmeijer, and Blonk (2013) discussed the role of career competency on employee engagement. The Job Demands-Resource Model (JD-R) is a heuristic model of employee well-being that characterizes every work environment by occupation-specific *job resources* and *job demands*, which leads to increased well-being (e.g., work engagement). Akkermans et al. (2013) described job resources as those physical, psychosocial, social, or organizational aspects of the job that are either functional in achieving work goals, reduces job demands, or stimulates personal growth, learning, and development.

According to Schaufeli and Taris (2014), improving job resources leads to increased levels of motivation in the form of work engagement. Employees who experience greater opportunities for development lead peers to actively search for ways to become further educated and formulate an action plan with goals for personal development; thus, developing career competencies. Akkermans et al. (2013) hypothesized and confirmed that job resources and career competencies have a positive relationship ($\beta = .32$, $p < .001$), and career competencies have a positive relationship with worker engagement ($\beta = .23$, $p < .001$). The results demonstrate that job resources and work engagement *partially* mediate career competencies and that the relationship between career competencies and work engagement *partially* mediate job resources.

Psychological State of the Employee

The psychology of an employee refers to the mental health or mental wellness of an individual in an occupational setting. Luthans, Youssef, Sweetman, and Harms (2013) noted occupational health applies psychology to the occupational setting for promoting improvement in work-life balance, ongoing protection and safety of workers, and a healthy work environment. When employees experience a positive psychological state, healthy work environments exist, people feel good about themselves, are high performers, and experience high levels of well-being. The psychological state also refers to the quality of mental health of an employee remaining constant despite the dynamic nature of the environment with which the employee functions.

Researchers have constructed various meanings for the occupational wellness state experienced by employees as psychological engagement (Paterson, Luthans, &

Jeung, 2014), psychological capital (Luthans, Youssef, Sweetman, & Harms, 2013), psychological well-being (Page & Vella-Broderick, 2013), or psychological safety (Kessel et al., 2012) and the key role of having a psychological contract with leaders (Agarwal, 2014). Agarwal (2014) described psychological contracts occur whenever a reciprocal agreement or a social exchange between people ensued.

Luthans et al. (2013) looked at how the psychological aspects of the relationship between psychological well-being and positive organizational behavior achieves the desired organizational outcomes by emphasizing the positive constructs that are valuable to individuals. Employees who experience psychological safety experience symptoms of both positive feelings (hedonic) and positive functioning. Luthans et al. (2013) identified multiple work constructs that indicated positive mental health. These constructs included,

- Hope and optimism.
- Acquiring, maintaining, and fostering necessary resources.
- Psychological well-being self-acceptance, positive relationships, personal growth, and autonomy.
- Social well-being–contribution, integration, and acceptance.

Van der Vaart, Linde, and Cockeran (2013) stressed that employee well-being mediates the relationship between the psychological contract with leadership and the employees' turnover intention. Van der Vaart et al. (2013) found that enhancing an employee's well-being leads to an increase in organizational health as measured by performance and turnover. Since patient outcomes are one measure of performance, health care decision makers can also measure turnover intention to determine

organizational health. Wright (2014) found that job satisfaction is a valid predictor of performance and consequently is a sub-set of employee well-being or the psychological state of an employee. Regts and Molleman (2013) assessed the relationship between job satisfaction, well-being, and voluntary turnover and determined that nurses are more likely to leave their jobs (turnover) when the nurse is dissatisfied and experiences low well-being about their job.

Luthans et al. (2013) discussed how employees, who were positive, had hope, demonstrate resiliency, and are optimistically engaged in agentic activities. Being purposeful and having control of self-directed behaviors are more likely to increase energy and creativity. Employees also engage in proactive learning, rather than reactive responses to situations (Spreitzer & Porath, 2013). Positive psychological states occur when employees are better able to control outcome variables because of their desire for personal actualization, relate meaningfulness to the goals of the vocation and organization, and recognize that job conditions are right for sustained personal growth.

Work engagement is a state of mind characterized by energy, commitment, and identification with work (Anitha, 2014). According to Sullivan-Havens et al. (2013), nurse work engagement leads to higher worker initiative, lower patient mortality, and higher profitability in health care organizations. Anitha (2014) discussed that the antecedents of employee engagement are job characteristics, perceived organizational support, perceived supervisor support, rewards and recognition, procedural justice and distributive justice. On the other hand, the consequences of disengagement are job dissatisfaction, decreased organizational commitment, and increased intention to quit.

Beck (2014) stated that employee engagement positively relates to employee performance motivation and is often associated with job characteristics that includes increased decision-making, autonomy, participation, and the perception of support by leadership. Job engagement involves employees that are enthusiastic about their jobs.

Rigg (2013) conveyed that employee engagement is an emerging construct in the study of industrial and organizational psychology (I/O Psychology). Rigg (2013) believed engagement overlaps with other well-known constructs and thus, may be redundant. Despite the redundancy, Rigg (2013) discussed limited, but important, empirical evidence differentiating engagement constructs from traditional work-related behaviors, such as job involvement and organizational commitment. The most significant differentiating factor between engagement and other constructs is the relationship to employee health outcomes. Employee engagement, as discussed, encompasses employees' passion, commitment, and willingness to invest oneself in an organization.

Employee engagement is associated with a high degree of energy and the desire to act with enthusiasm (Dalal, Baysinger, Brummel, & LeBreton, 2012). Employee engagement is characterized by energy, dedication, and absorption, which leads to high-quality work performance and lower turnover intention (Gabel-Shemueli, Dolan, & Ceretti, 2014; Kerns, 2014). A high degree of enthusiasm, in turn, contributes to job satisfaction and represents a positive work-focused psychological state. In their study, Dalal, Baysinger, Brummel, and LeBreton (2012) demonstrated the importance of job satisfaction and the relationship to employee engagement. Their meta-analytical data

suggests that employee engagement and job satisfaction are important determinates of employee contributions to an organization, beyond other multidimensional constructs.

Legitimizing Development

Knowledge is required for continuous engagement in health care activities, including professional and personal growth. Access to knowledge provides a method for nurses to creatively solve problems and remain innovative. Nursing leaders' roles in knowledge management and knowledge sharing is critical. By assuring the availability of knowledge from internal and external sources, the nurse leader showed commitment to individual growth and success (Carmeli, Gelbard, & Reiter-Palmon, 2013).

Leader supportive behaviors are essential to developing and shaping the work environment conducive to knowledge sharing. Open, communicative environments nurture nurses' capacities for innovative problem solving. Carmeli, Gelbard, and Reiter-Palmon (2013) discussed how creative employee performance is dependent on knowledge sharing. These findings offer creditability to knowledge management theories, creativity, and the distribution of knowledge between stakeholders, resulting in achieving desired organizational goals.

The process of knowledge sharing is vital to encouraging nurses to solve problems creatively. Nurses possess expertise, are capable of developing innovative and practical solutions for health care problems, and create new knowledge. Leaders, who allow an open, communicative process, provide staff with opportunities to use their nursing expertise to solve unit specific or organizational problems create a more responsive institution.

Another aspect of legitimized development is the effort by leaders to grow their followers, or at the very least allow self-development. Yoshida, Sendjaya, Hirst, and Cooper (2014) pointed out that employees who are actively engaged in learning and development are essential for organizational adaptability and competitiveness. They discussed that servant leadership foster employee learning, creativity, and innovation. This engagement leads to an increase in positive work attitudes, greater job satisfaction, and decreased turnover. Development of employees leads to expertise, which encourages knowledge sharing. Carmeli et al. (2013) determined organizations suffer when knowledge is withheld creating a loss in its ability to capitalize on employee expertise.

Leaders who encourage employee development and knowledge sharing cultivate frequent, effective problem-solving ideas from staff (Carmeli et al., 2013). The advantage, to organizations, is the diverse knowledge that each employee contributes to the organization. This relational capital, manifested by trust, contributes to improved performance, especially in knowledge intensive settings, such as health care. Leaders who support learning and development facilitate employee problem solving by creating conditions that produce quality interpersonal relationships and induce positive energy among staff (Carmeli et al., 2013).

Feeling Valued

Nei, Snyder, and Litwiller (2015) found that lack of recognition and respect experienced by nurses is cited as a few important reasons for leaving. Additionally, Nei et al. (2015) discussed how respect from supervisors is an important determinant of job

satisfaction. Anderson et al. (2010) found 64% of the respondents said that more respect from frontline managers would cause them to reconsider leaving their current position.

Nurses hesitate to voice concerns, potentially increasing negative outcomes when respect is not a tenet of the hospital culture. Hospitals are complex adaptive systems, and the relationship between leadership and nurse satisfaction requires a model on more than simple bivariate relationships. Paying close attention to interpersonal constructs and the quality of management relationships with staff are especially important in organizations in which collaboration, support, and service are essential for organizational effectiveness. Research studies demonstrated that the lack of collaboration, autonomy, and empowerment increased the reporting of low job satisfaction (Al Maqbali, 2015).

Environment of Freedom

Health care delivery requires collaboration between multiple professionals to achieve patient outcome goals and organizational expectations. Teams of nurses, doctors, para-professionals, and support staff contribute to the effort. Research on team effectiveness showed a strong correlation between the characteristics of the leader, leadership inclusiveness, and the task (Mitchell et al., 2015). With any team, however, individual considerations influenced the effectiveness of the team as a whole.

Person-focused behaviors require leaders to consider the influence each member's interactions have within the team's design. Leaders, who have an *other* focus, looked at the individual, and enabled each member to capitalize on personal strengths to contribute to the team's goals. Person-focused behaviors facilitate relational interactions, reasoning constructs, and establish relational mindsets for effective team dynamics. Tuckey,

Bakker, and Dollard (2012) determined that person-oriented leadership increased work engagement, team effectiveness, and optimized work conditions by strengthening work context. Tuckey et al. (2012) found managers created engaged work environments in which employees had higher levels of vigor, dedication, and absorption by influencing staff work characteristics, well-being, and empowerment.

Empowerment in the work environment presupposes that an employee has the freedom to construct a process that evaluates job situations, determine a course of action when problems arise, initiate best practices for a positive outcome without interference from management. Sun et al. (2012) described this as self-determination. Self-determination indicates perceptions of freedom to choose how to initiate and carry out tasks.

Empowerment, as proposed by Saufi, Kojuri, Badi, and Agheshlouei (2013), flourished, not by acting independently, but because there is a perception of both autonomy and interdependence. The perception is that any effort is a contribution to the implementation of organizational goals. The perception of freedom provides the courage for employees to act independently. To work autonomously, nurses must have the ability to make choices, be free of inappropriate interference from management, and to be able to reflect on self-directed decisions, thus gaining knowledge.

Sun et al. (2012) and Tuckey et al. (2012) found that empowering leadership includes behaviors that encourage critical thinking, self-leadership, participation in goal setting, and cohesive teamwork. Lorinkova, Pearsall, and Sims (2013) investigated the influence of empowering and performance and determined that sharing decision-making

power with employees enhances performance and work satisfaction. Organizational psychologists believe that preserving work-life quality is about improving employee satisfaction, furthering intrinsic motivation, and providing reasons to feel good about their vocation.

As discussed, these attributes describe relational leadership behaviors. When leaders engage in positive relational exchanges, it communicates a high degree of confidence, concern, and respect for the staff, which cultivates deeper trust in the manager. Employees reciprocate similar behaviors and exhibite a higher level of work performance because of psychological empowerment. Research suggestes relational behaviors of leaders play a vital role in providing staff a greater degree of intrinsic motivation, increased self-worth, and self-determination (Weinberg & Locander, 2014). Relational leadership behavior fosters psychological ownership of staff, intensify employees' senses of self-efficacy and self-discipline, and lessen staff's perception of powerlessness (Avey et al., 2012).

Nursing requires staff to be self-assured and confident. Research on confidence revealed the significance of considering self-efficacy. Avey, Wernsing, and Palanski (2012) found a strong relationship between study participants who report high self-efficacy and activities that require confidence. Behavioral plasticity hypothesis posited that individuals who report low self-esteem sought appropriate cues to validate or invalidate their sense of self-worth at a higher rate than those who report a high self-esteem (Thompson & Gomez, 2014). It may be advantageous for the nurse who has low self-esteem to have a leader who is more positive, and encourages greater self-efficacy,

as this relationship leads to a boost in empowerment and confidence. Individuals who had or developed self-worth were empirically found to engage in activities that were congruent with socially responsible behaviors.

Atmosphere of Safety

Liang, Tang, Wang, Lin, and Yu (2016) posited that successful leadership facilitated and educated for change, created a perception of a safe environment that fostered risk-taking and opportunism, and supported others to learn and adapt their behavior. Kessel et al. (2012) defined psychological safety as a shared belief between individuals and the consequences of interpersonal risk taking. Psychological safety is the freedom for individual self-expression, free of a social risk or harm, adverse consequences to self-respect, reputation, or profession (Kessel et al., 2012).

Psychological safety arises from mutual support, characterized by interpersonal trust, care, and concern for followers. Kessel, Kratzer, and Schultz (2012) posited individuals' engagement at work improved with high levels of psychological safety because individuals believe they could participate openly and actively, ask questions, seek information, and perform creatively without fear of suffering adverse personal consequences. As a result, staff is willing to share their knowledge and skills, identify, and utilize more effective performance strategies.

Engagement played a dominant role linking inclusive leadership and developing creative activities in employees. Robertson, Jansen Birch, and Cooper (2012) study contributed to the theory of leader inclusiveness related to the development of psychological safety by explaining how inclusive leadership was a sub-set of relational

leadership. Their findings contribute to the leadership processes by demonstrating how involvement in creative work tasks develops the psychological safety of employees. They also indicated that inclusiveness is essential in supporting employee creativity resulting in cultivating high-quality relationships that enhances the feelings of psychological safety.

Kim, Khan, Wood, and Mahmood (2016) reviewed literature that demonstrated the benefits of engaging employees and the positive financial results that occurred. Kim et al. (2016) concluded that a robust relationship exists between employee engagement and overall financial performance. Additionally, engaged employees show greater meaningful contributions to the organization engaged in corporate social responsibility behaviors leading to sustainable performance in the social, environmental, and governance areas, which is also associated with improved financial results.

Knowledgeable staff became more psychologically engaged in tasks when they perceived the work environment is psychologically safe resulting in improved goal achievement and financial sustainability (Gong, Cheung, Wang, & Huang, 2012). Psychological safety improves the capacity of followers to encourage coworkers to engage in care delivery by remaining open to the challenges of a dynamically changing health care environment.

Gittell et al. (2013) examined the relationship between shared goals, shared knowledge, and mutual respect, and their expression in high-quality relationships as these constructs related to psychological safety and interprofessional collaborative practice. They determined when staff engaged in learning opportunities; psychological safety facilitated the connection between high-quality relationships and organizational learning.

Process change and improvement occurred by increasing staff knowledge and sharing newly acquired information. Though much of Gittell et al.'s (2013) study focused on teamwork, they demonstrated that staff well-being is a critical factor for supporting organizational and individual learning. When staff feared there was any chance of repercussion from discussing failures and the root causes, the potential for learning decreased. Learning from a loss increases reliability and enhanced organizational outcomes, such as customer service, compliance with standards, and met production expectations (Chassin & Loeb, 2013).

Outcome measurements in non-health care organizations may not be transferable to health care organizations, as organizational and social goals are different, but the research is clear; by improving the psychological safety of staff, positive outcomes are possible. Any increase in the ability to learn from errors improves patient outcomes, standardizes nursing practices, and provides greater autonomy for nurses to make changes necessary to improve organizational sustainability.

Kessel et al. (2012) found psychological safety to be crucial for developing workplace-learning behaviors. The basis of psychological safety is on the positive or negative response from staff's questions, receiving feedback, reporting errors, or expressing an innovative thought. Individuals assess the consequences of speaking up or reporting a mistake.

Psychological safety is a different construct as compared to other relational concepts, such as trust and managerial support. Psychological safety and trust involves evaluating the degree of vulnerability a person is willing to experience and the choices

made to minimize negative consequences of voicing concerns. Vulnerability is treated differently between trust and psychological safety. Trust is giving another person the benefit of the doubt, while psychological safety is the degree of the benefit of the doubt that others give (Rothmann & Welsh, 2013).

Trust affected predictable and long-term consequences, while psychological safety focuses on short-term interpersonal actions (Rothmann & Welsh, 2013). Another concept is the perception of managerial support. Employees who receive managerial support develope stronger beliefs that their leaders value and appreciate staff contributions and cared about employee well-being (Caesens & Stinglhamber, 2014).

Psychological safety is about taking calculated risks and feeling confident to do so. Psychological safety is critical to empowering staff learning (Rothmann & Welsh, 2013) and critically thinking through challenging situations. When employees are psychologically safe, they embrace a healthy skepticism of traditional ideas and maintained an open mind about new ideas. Learning is a process in which members ask questions, seek feedback, and think critically before implementing new ideas. Being psychologically safe allows staff to reflect on results, and discuss unexpected outcomes. Rothmann and Welsh (2013) discoursed how the theoretical foundation for trust and perceived managerial support was a precursor of psychological safety.

Edmondson and Lei (2014) demonstrated the positive influence of a foundationally strong psychological safety climate in non-health care organizations and determined its role in enabling performance, mitigating interpersonal risks in learning, and showing that people with greater psychological safety were more willing to speak up.

Employees with mature psychological safety mental models are more likely to embrace failure as an occasion for learning and are less likely to blame others for failures. People acting positively toward each other are empowered to act through established norms, organizational cultures, and practices. High-quality relationships between leaders and followers create feelings of value, appreciation, the ability to engage in work activities, participate in decision-making, and feelings of safety when discussing difficult subjects.

Health care is a high-reliability industry because of the pressure to reduce errors and foster consistency, improve patient outcomes, and to achieve day-to-day operational efficiencies. System failures increase stress on employees and patients, resulting in an increasing number of nurses and patients experiencing dissatisfaction. The atmosphere, in many health care organizations, is more apt to blaming than to learning, resulting in a continued decrease in psychological safety.

Managers should understand that health care organizations should learn from failures. To do so, managers should establish an environment of psychological safety by developing processes that encourage shared goals, shared knowledge, and mutual respect among internal stakeholders (Gittell, Godfrey, & Thistlewaite, 2013). Knowledge-sharing mechanisms constituted a set of high-performance work practices that nurture relational behaviors among employees, resulting in improved quality and better outcomes. When leaders show respect, they signal that mutual respect is valued.

Hirak, Peng, Carmeli, and Schaubroeck (2012) determined a positive relationship between inclusive leadership and psychological safety. Leaders who embrace inclusion

stimulate employee involvement in work by inviting and appreciating input from others. These leadership behaviors help shape employees' beliefs that their voices are valued. Mitchell et al. (2015) posited that inclusive leadership is central to relational leadership.

When followers felt leaders are available, listen to staff, and are attentive to and concerned about their needs, the leader exhibited relational behaviors. Mitchell et al., (2015) determined that inclusive leadership creates an environment for employee creativity by fostering psychological safety constructs. Supportive peer relationships, encouraging participation, engaging in open communication, and cultivating trust all appear as important aspects of the climate that facilitated psychological safety and increased the desire to problem solve (Gong et al., 2012).

Behavioral Response

According to Paek, Schuckert, Kim, and Lee (2015), the psychological state of engagement mediates desirable behavioral responses of employees. Paek et al. (2015) found when the work environment is supportive, job demands minimized, and personal growth is encouraged, employees reciprocate the positive actions of leaders through extra-work behaviors that contribute to achieving organizational goals. As noted, employees respond to leaders they trust, have experienced a positive relationship with, felt empowered by; received open and honest communication, and who approached their role with humility. The reciprocal response to feeling empowered, valued by management, and knowing that their development is essential, is that employees expressed ideas in an environment that was safe, or experienced the psychological state of engagement (Jorge Correia de Sousa & van Dierendonck, 2014). Employees

responded, behaviorally, with increased motivation, an open mind to change, increased creativity, risk-taking, and job enthusiasm, thus increasing leader and organizational loyalty.

Loyalty/Commitment

Making a deliberate commitment to an employer, while sacrificing self-interest for the sake of organizational success, is the definition of employee loyalty. From an employer's perspective, having loyal employees contributes to organizational success through the employee's trustworthiness, and becoming more valuable to the organization. Additionally, loyal employees form stronger relationships, expand growth opportunities, improve performance, and contribute to the organization becoming a more valuable social institution (Elegido, 2013). Leadership style determined the quality of the relationship with employees. Employee turnover increases when the quality of the relationship is low if leaders could not be trusted, or employees felt unsupported. Ding, Lu, Song, and Lu (2012) conducted research on employee loyalty under the premise that loyalty is a combination of an employee's behavior and attitude. Ding et al. (2012) empirical study used structural equation model methodology, demonstrating that positive leadership correlated with employee loyalty. Ding et al. (2012) identified that employee satisfaction played a mediating role (77%) of the total effect between servant leadership and employee loyalty.

Employee commitment is an important factor in organizational success. Shahid and Azhar (2013) explored research literature and overall success of an organization and revealed significant factors that led to commitment of employees and employee

engagement. Leadership's relationship with employees and creating trust, a values-driven organization, continuous employee development, autonomy and satisfaction with supervision, were all positively related to commitment to the organization. Engaged employees directly affect retention, patient loyalty, and organizational profitability (Shahid & Azhar, 2013). Engaging employees increases their effort at work, creating extra value for the organization.

Autonomy

Autonomy is the degree in which a job provides freedom and discretion in determining the direction and actions necessary to perform the functions of the job (Sawa & Swift, 2013). The degree of autonomy prompts employees to take responsibility for work outcomes and relies on the efforts and decisions of individuals, rather than the supervisor providing instruction.

The degree of staff autonomy depends on the actions and beliefs of an empowering leader. Empowering leadership emphasizes employees' confidence on self-influence rather than a structured hierarchical process (Hopkin, Hoyle, & Toner, 2014). Leaders who provide autonomy and the ability to make decisions, independently and psychologically, empower followers. Management support of autonomy creates a more satisfying work environment for employees, greater trust in leaders, and an increase in positive work attitudes. Kindness, caring, consideration, and serving behavior models build up and enhance followers' well-being, especially when the leader is sincerely honest, humble, and selfless.

Discussion and Conclusions

The literature highlighted in Chapter 2 was a review of the contributions of studies for the constructs of servant leadership, the psychological state of employee engagement, employee behaviors, and the relationship of each construct on job satisfaction and turnover intention. Under the general construct headings, review of the literature detailed information on the sub-constructs that constituted the framework of the construct.

Proponents of a servant leadership suggest a multi-factorial approach is necessary when evaluating the effectiveness of leadership behaviors to job satisfaction. What is clear, in the study of servant leadership in nursing, is that desirable work environments are comprised of management behaviors and an emotionally safe environment that motivate employees to be engaged in their work.

The studies reviewed in Chapter 2 provide evidence of the significance of management behavior on engagement and the number of consequences including motivation, job satisfaction, and turnover intentions. It is evident that the type of behaviors exhibited by managers allows employees to develop their full potential in the job, which reflects in service to patients. The literature reinforces that a change in management focus from traditional leadership styles could nurture employees to become positively engaged, thus reducing, and reversing the current trend of high nursing turnover. Chapter 3 provides an overview about the quantitative research method and cross-sectional design used for this study.

Chapter 3: Research Methodology

Introduction

In the previous two chapters, relevant literature provided the importance of this study to the field of nursing leadership and the gap that exists in the research between nursing manager's servant leadership behavior and the job satisfaction of staff nurses. In the current research study, I determined whether the findings, related to the tested null hypothesis, are generalizable across multiple health care organizations. The results of this dissertation added to the body of knowledge supporting the positive relationship between nurse manager's servant leadership behaviors and job satisfaction of staff nurses. The research method and design, along with the instrumentation, population, strategy of inquiry, data collection, and analysis plans are included in this chapter.

Research Design and Rationale

This research was a quantitative, nonexperimental, cross-sectional correlation study and determined if, and to what extent, a relationship existed between four discrete independent variables that encompassed servant leadership characteristics (humility, empowerment, communication, and commitment) and the dependent variable job satisfaction and turnover intention.

Researchers use the nonexperimental design to observe and record situations found within a sample or groups of samples of a population, such that an inference can be made that the theory applies to the identified population and a conclusion is drawn from the results of the sample (Sánchez-Alagarra & Anguera, 2013). The choice of methodology, according to Venkatesh, Brown, and Bala (2013), relates to the research

questions, purpose, and context. In quantitative studies, researchers use standardized questions to garner opinions from large populations (Karanja, Zaveri, & Ahmed, 2013) making interviews and observations impractical.

Cross-sectional design is a research tool used to capture information based on data that is gathered for a specific period. Consideration was given to a quantitative longitudinal design for this research to determine the extent of nurse managers' leadership behaviors on staff nurses over a longer period. Alternatively, longitudinal studies involve taking multiple measures over an extended period providing a superior assessment of the phenomena (Shahar & Shahar, 2013). Cross-sectional design had identifiable advantages over longitudinal designs as it had little to no expense, avoided complicated data analysis drawn from multiple points in time, and avoided the assumption that the relationship between variables were stable over time. Incorporating a cross-sectional design, a researcher's record of the outcomes and characteristics are associated with the research, at a specific point. Additionally, the chosen design allowed the potential to provide to individuals who needed the information as soon as possible.

A correlation study provides the ability to assess variables, as they naturally occur, without altering the outcome with experimentation (Ingham-Broomfield, 2015). The application of the correlation research design chosen helped to determine the existence, direction, and magnitude of the correlation between servant leadership behaviors and job satisfaction at a given point in time, especially using surveys with high levels of external validity and dependency between variables (Withers & Nadarajh, 2013). Additionally, researchers can draw inferences from existing differences between

the relationships under study (Sedgwick, 2014). The disadvantage of correlational design is that the outcomes cannot be used to determine causality (Reinhart, Haring, Levin, Patall, & Robinson, 2013). The choice of this correlation design was appropriate to provide the prerequisite data to produce the information needed to fill the gap in the literature that was noted in Chapter 2. Additionally, the results provided nursing executives and other stakeholders who can influence nurse managers' behaviors with information that affects job satisfaction among staff nurses.

The application and outcome of this research design provided an advantage in measuring the relationship between the independent variables and the dependent variable, demonstrating the importance and strength of servant leadership characteristics of nurse managers to staff nurses job satisfaction.

Research Method

Yilmaz (2013) described the quantitative research method as one type of empirical research into a social or human problem explained through numerical data and analyzed using statistical methods to determine if a theory can be applied to predict a phenomenon of interest. By using the quantitative research approach, researchers attempt to explain social behaviors by emphasizing the measurement and analysis of causal relationships between variables in a logical framework (Arghode, 2013). Quantitative researchers can obtain large, representative samples (Fassinger & Morrow, 2013) for a measurable and reliably estimated phenomenon (Thamhain, 2014). Quantitative studies require numerical data (Ingham-Broomfield, 2015) generated from instruments that measure the outcome. The use of a quantitative research method was appropriate to

obtain broad, nonabstract, and generalizable findings and present the results succinctly (Hagan, 2014).

The quantitative method was appropriate for this research to apply a Likert-type survey instrument (see Appendix D) to measure participants' perspectives to identify a general pattern of reactions to closed-ended statements. Surveys are used in conducting quantitative research to count the frequency of occurrences of nurse's opinions and behaviors (Rowley, 2014). Participants' responses to a set of statements were measured, facilitating comparison and statistical aggregation of the data. The results of the internal consistency of the data show it is generalizable to the larger population.

After consideration, using a qualitative research method was not appropriate for this research. The purpose of the research was not to derive meaning from the participants regarding their experiences with the variables in the research. Qualitative researchers seek to examine the context that influences the meaning people ascribe to an experience. Using a qualitative method would attempt to understand the individual perspective of the variables as compared to determining relationships between the variables (Gioia, Corley, & Hamilton, 2013).

Instrumentation

In the data analysis process for this study, I employed a Likert-type survey instrument to determine the existence of a relationship, and to what extent, between four discrete independent variables that make up servant leadership characteristics (humility, empowering, communication, and commitment to development of employees) and the dependent variable job satisfaction. Survey methodology was used to produce numerical

descriptions about specific aspects of the study population (Stern, Bilgen, & Dillman, 2014). The primary way to gather this type of information was to provide well-designed statements, in which participants would indicate their degree of agreement or disagreement and derive data from the answers (Rowley, 2014). There was no one survey available that was applicable to this research for the data needed, thus extracting several statements from different surveys to provide a new survey containing 57 Likert-type statements. Survey statements were adapted from the surveys listed in Table 1.

The final survey was a Likert-type survey instrument (see Appendix F) designed to rate a nurse manager's servant leadership characteristics (humility, empowering, communication, and commitment to employee development) from a staff nurse's perspective. Participants were asked to rank the statements on a 7-point Likert-type scale (1 = *strongly disagree* to 7 = *strongly agree* with a midrange of a 4 = *neutral response*). Nurse managers were asked to also complete a Likert-type survey instrument (see Appendix I) designed to self-rate their servant leadership characteristics (humility, empowering, communication, and commitment to employee development). Once the data were collected, the results were tested for their internal consistency assuring Cronbach alpha exceeded .70 for all variables. Each survey was used with permission for noncommercial research and educational purposes without the need for written consent (see Appendix A). Each survey was extracted from the Walden University Library.

Table 1

Survey Question Source

Surveys used	Questions used from survey
van Dierendonck Servant Leadership Survey (2011)	2, 4, 5, 7, 9, 10, 11, 13, 21, 25, 29,
Liden, Waynes, Zhao, and Henderson Servant Leadership Scale (2008)	2, 3, 4, 10, 15, 16, 18, 20, 24, 26
Yang and Mossholder Trust in Leaders Instrument (2010)	1, 2,
Konczak Leader Empowering Behavior Questionnaire (2000)	1, 2, 3, 8, 9, 10, 11, 13, 15, 17
Qui, Bures, and Shehan Self-Perception of Job Autonomy Measure (2012)	1, 4, 6
Kouchaki, Oveis, and Gino Assimilation-Accommodation Appraisal Measurement (2014)	1, 3
Boyas, Wind, and Ruiz Communication Index (2015a)	2, 4
Chen, Tsui, and Farh Loyalty Scale (2002)	2, 4,
Hinshaw and Atwood Turnover Scale (1987)	1, 2, 3, 5, 6,
Warr, Cook, and Wall Job Satisfaction Scale (1979)	5, 8, 12, 14, 23, 25
Messersmith, Patel, and Gould-William Job Satisfaction Scale (2011)	1, 2
Reed, Vidaver-Cohen, and Colwell Executive Servant Leadership Survey (2011)	8, 37

Servant Leadership Survey

Van Dierendonck's (2011) multidimensional scale titled The Servant Leadership Survey: Development and Validation of a Multidimensional Measure was used to measure three dimensions of servant leadership humility (Statements 1, 2, 3, 4, 5, 6, 7), empowering (Statements 14, 16), commitment to growth (Statement 21). Hopkin et al. (2014) defined the conceptual aspect of humility as an appraisal of how one views one's place in society with a low self-focus, open-mindedness, valuing others, and being teachable. Van Dierendonck's survey consisted of 30 items across eight sub-scales: standing back, forgiveness, courage, empowering, accountability, authenticity, humility, and stewardship. The scales measured in van Dierendonck's study signified the willingness to support, to listen to, and to serve others. The reliability regarding internal consistency was good for all scales. Cronbach's alpha was .95 for humility (5 items) and .76 for authenticity (4 items).

According to van Dierendonck (2011), "The overall confirmatory factor analysis across different samples supported the predicted eight-factor structure and the inter-connectedness of the dimensions" (p. 264). A second-order factor analysis with transformational leadership confirmed the hypothesized stronger focus of servant leadership on an attitude characterized by service and on attending to the needs of followers. Operationally, humility subconstructs measured the respondent's belief to the extent of their manager's humility. Participants were asked to assess their agreement with statements such as "my manager does not center attention on his/her accomplishments"

(α = .71) and "my manager does not promote his/her self over my interests" (α = .65), on a seven-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Servant Leadership Scale

Liden et al.'s (2008) multidimensional research titled The Servant Leadership Scale was used to measure two dimensions of servant leadership. Liden et al.'s survey consisted of 28 questions across seven subscales: emotional healing, creating value for the community, conceptual skills, empowering, helping subordinates grow, putting subordinates first, and behaving ethically. A 7-point Likert-type scale was used to measure the constructs of humility (Statement 8), demonstrating commitment to growth (Statements 18, 19, 20), legitimized development (Statement 26), feeling valued (Statements 29, 30, 31), and environment of freedom (Statement 35) with scoring ranging from 1 (s*trongly disagree*) to 7 (s*trongly agree*). The resulting variable was calculated by averaging the response to all items. Each statement was positively worded and the highest score indicating a high perception of the construct measured.

When managers, supported by organizational decision makers, committed to developing the individual needs of employees through the creation of an environment that met his or her career needs and reinforced those needs through recognition of accomplishments, employee performance improved (Lancaster & Di Milia, 2014). Liden et al. (2008) described putting others first as an operational construct that represented a desire of the manager to assist in follower development. Liden et al. depicted this construct as "using actions and words to make it clear to others (especially immediate followers) that satisfying their success needs was a priority" (p. 162). They conducted an

exploratory factor analysis of a pilot study with results revealing the emergence of distinct dimensions of servant leadership. After a literature review of leadership, Liden et al. identified dimensions of servant leadership that focused on a commitment to followers. They collected data from 164 employees (response rate = 56.9%) and 25 supervisors (response rate = 86.2%) of a Midwestern production and distribution company.

An exploratory factor analysis resulted in the emergence of seven distinguishable factors, with scale reliabilities as follows: conceptual skills (α=.86), empowering (α=.90), helping subordinates grow and succeed (α=.90), putting subordinates first (α=.91), behaving ethically (α=.90), emotional healing (α=.89), and creating value for the community (α=.89). A confirmatory factor analysis of the seven servant leadership dimensions emerged from the pilot study. The scale reliabilities for the four-item scales of each dimension for this sample were as follows: conceptual skills (α=.81, confirmatory factor analysis sample; α=.80), empowering (α=.80, confirmatory factor analysis sample; α=.77), helping subordinates grow and succeed (α=.82, confirmatory factor analysis sample; α=.83), putting subordinates first (α=.86, confirmatory factor analysis sample; α=.86), behaving ethically (α=.83, confirmatory factor analysis sample; α=.82, HLM sample); emotional healing (α=.76, confirmatory factor analysis sample; α=.78), and creating value for the community (α=.83, confirmatory factor analysis sample; α=.84). Together, the results of both the exploratory factor analysis and the confirmatory factor analysis supported a multidimensional conceptualization of the servant leadership construct of commitment to others. Participants were asked to assess their agreement with

statements, such as “my manager is interested in making sure that I achieve my career goals” (α = .90) and “my manager provides me with work experiences that enable me to develop new skills” (α = .88) on a 7-point Likert-type scale, ranging from 1 (s*trongly disagree*) to 7 (*strongly agree*).

Another aspect of servant leadership was the concept of legitimized development that emphasized the effort by leaders to grow their followers, or at the very least allow self-development. Yoshida et al. (2014) discussed how employees who were actively engaged in learning and development were essential for organizational adaptability and competitiveness. Operationally, legitimized development subconstructs were measured by the respondent assessing the extent of their manager’s actions related to caring about the nurses’ personal and professional development.

Through confirmatory factor analyses, Yoshida et al. (2014) found that servant leadership was positively related to leader identification (γ = .70, *t* = 4.72, *p b* .01) and leader identification was positively related to employee development after controlling for servant leadership (γ = .21. *t* = 1.97, *p b* .05). Yoshida et al. determined that the influence of servant leadership on employee problem solving (creativity) through its leader identification occurred only when support was high, (simple slope: γ = .14, *t* = 1.91, *p b* .05; conditional indirect effect = .10; 95% confidence limits: .02 to .19). In their study, Yoshida et al. determined statements that evaluated this construct were “my manager encourages me to develop important work solutions to problems on my own” (α = .87) and “my manager seems to care about my success more than his/her success” (α = .90).

Participants were asked to assess their agreement with these and similar statements on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Trust in Leaders Instrument

Trust in Leaders Instrument was applied in this study to measure the construct of valuing others (Yang & Mossholder, 2010). Trust is significant for employee psychological engagement. Yang and Mossholder discussed how respect from supervisors was an important determinant of job satisfaction. Trust is important to nurses and includes feelings of believing in another person (Chippendale, 2013). An operational definition consisted of determining the trust arising from the actions of the manager toward the nurse.

Yang and Mossholder (2010) survey consisted of 20 statements across four subscales: cognitive trust in management, affective trust in management, cognitive trust in supervisor, and affective trust in supervisor. A 7-point Likert scale was used to measure trust (Statement 26) and (Statement 36) with scoring ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*). The resulting variable was calculated by averaging the response to all items. Each statement was positively worded.

Boyas, Wind, and Ruiz (2015b) conducted a study employing a cross-sectional research design and utilized a purposeful, statewide sample consisting of 313 employees of a public child welfare organization. Feeling valued is akin to having strong relational support. By using an 8-item scale, Boyas et al. assessed the extent to which employees perceived that their supervisors expressed sincere value. In Boyas et al.'s study supervisory support had moderately high internal consistency, with a Cronbach's alpha of

0.86. Operationally, statements assessed the extent of the respondent's belief of their manager's actions. Participants were asked to assess their agreement with statements, such as "my supervisor makes me feel valued" (α = .88) and "my manager shares information with me regularly" (α = .88) on a 7-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*).

Leader Empowering Behavior Questionnaire

Konczak, Shelly, and Trusty (2000) study titled Defining and Measuring Empowering Leader Behaviors: Development of an Upward Feedback Instrument was used to measure five dimensions of servant leadership. A manager's use of their discretionary power and ability to increase a follower's job autonomy defined the meaning of traditional empowering behavior (Cheung, Baum, & Wong, 2012). Konczak et al.'s survey consisted of 21 statements across seven subscales: delegation of authority, accountability, encouragement of self-directed decisions, information sharing, skill development, coaching for innovative performance, and psychological empowerment. A 7-point Likert-type scale was used to measure communication (Statements 9, 10), empowerment (Statement 17), legitimized development (Statements 22, 24), feeling valued (Statement 27), environment of freedom (Statements 32, 33), atmosphere of safety (Statement 37) with scoring ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*). The resulting variable was calculated by averaging the response to all items.

Konczak et al. (2000) collected data from 1,309 subordinates who rated 424 managers participating in a leadership-training program at a *Fortune 500* consumer products company. Alpha reliability coefficients were computed for the data and ranged

from .82 to .88. The results indicated that a six-factor model provided a good description of the relationships among the Leader Empowering Behavior Questionnaire items. With respect to leadership development, the Leader Empowering Behavior Questionnaire would appear to be a psychometrically sound instrument for providing managers with feedback on behavior relevant to employee empowerment.

Operationally, the empowering behavior was viewed as a psychological construct that reflected the follower's feelings of having self-control and self-efficacy. Arnold, Arad, Rhoads, and Drasgow (2000) discussed that a manager's empowering behavior encouraged the spirit of the relationship between the follower and the manager. In the Leader Empowering Behavior Questionnaire study, supervisory support had moderately high internal consistency, with a Cronbach's alpha of 0.86 demonstrating the measure of supervisory comfort with empowerment relative to employee feelings being valid. Questions derived from the survey instruments for the current research were found in research conducted by van Dierendonck (2011), Konczak et al. (2000), and Warr, Cook, and Wall (1979) which have shown similar consistency (.87, .86, and .74, respectively). Sample statements for empowerment were "my manager gives me the authority to make important decisions about my job" ($\alpha = .86$), and "my manager offers me opportunities to learn and try out new tasks" ($\alpha = .87$). Each response to the statement was measured on a seven-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Another aspect of empowerment in the work environment presupposes that employees have the freedom to construct processes that evaluated job situations, determined a course of action when problems arise, and initiated best practices for

positive outcomes without interference from management. Sun et al. (2012) described this as self-determination. Any noticeable increased employee effort was a contribution to the implementation of organizational goals. Mark and Smith (2012) conducted research on anxiety in 870 nurses who answered a random request for participation in a questionnaire assessing 27 items divided into four sub-scales: job demands, decision authority (control over decisions), levels of social support, and skill discretion. Nurses responded on how often they experienced autonomous situations at work. Mark and Smith converted the Likert-type scale scores to percentages and Cronbach's alpha scores were calculated as .85 for social support scale, .81 for decision authority, .68 for job demand, and .68 for skill discretion.

Self-Perception of Job Autonomy Measure

Three questions from the Self-Perception of Job Autonomy survey were applied to assess the degree of autonomy staff nurses felt their manager provided freedom to do their work and decision latitude (Qiu, Bures, & Shehan, 2012). Autonomy is the degree in which a job provided freedom and discretion in determining the direction and actions necessary to perform the functions of the job (Sawa & Swift, 2013). Statements assessing the respondent's belief in the manager's faith in staff nurse's ability to act independently measured the autonomy sub-constructs. A 7-point Likert-type scale was used to measure autonomy (Statements 44, 45, 46) with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Qiu, Bures, and Shehan (2012) analyzed stratified, unclustered, random probability sample of 2,470 respondents from the 2008 National Study of the Changing

Workforce to assess the self-perception of job autonomy in educated employees. Their research measured three items; work-family conflict, self-perception of job autonomy, and value of job challenge. For the item, self-perception of job autonomy, five statements taken from the Self-Perception of Job Autonomy Measure assessed the extent of freedom to do work and the degree of decision latitude. Cronbach's alpha for this scale was 0.79.

Operationally, autonomy was measured by questions assessing the respondent's degree of their manager's comfort in letting nurses act without significant oversite. Sample statements that captured this concept were; "I have the freedom to decide what I do on my job" ($\alpha = .77$), and "it is my responsibility to decide how my job is done" ($\alpha = .77$). The resulting variable was calculated by averaging the response to all items.

Perceiving support from one's supervisor demonstrated strong effects on individual enthusiasm and well-being. According to researchers, supervisor and coworker support tend to be significantly correlated with well-being and increased enthusiasm (Colbert, Bono, & Purvanova, 2016), with supervisor support correlations being stronger. Monnot and Beehr (2014) conducted research using two hedonic measure of self-well-being, previously validated by Warr (1990), to include contentment and enthusiasm. To assess enthusiasm, adjectives, such as cheerful and optimistic, were used. This scale displayed an internal reliability estimate of .80 (Warr, 1990). Response options for both contentment and enthusiasm were on a 6-point scale ranging from *never* to *all of the time*.

Subsequent research has shown that these scales correlated with theoretically related individual outcomes, such as intrinsic job satisfaction and engagement (Cooper-Thomas, Paterson, Stadler, & Saks, 2014). In the study conducted by Monnot and Beehr

(2014), showed enthusiasm, *M*=3.94; *SD*=.68; α=.877. Operationally, enthusiasm was measured by assessing the nurse's degree of excitement through statements that captured this concept. Sample statements that captured this concept were "my job provides that I can take pride in the work I have done" (α = .80), and "I look back on my day's work and feel fairly satisfied that I did my job well" (α = .80). A 7-point Likert-type scale was used to measure job autonomy (Items 36, 37, 38) with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

The most basic distinction of motivation was extrinsic motivation and intrinsic motivation. Intrinsic motivation was doing something because it was interesting and enjoyable while extrinsic motivation refers to doing something because it results in a specific outcome (Ma & Weng, 2015). Positive intrinsic motivation has shown to have a significant effect on employee attitude by increasing self-satisfaction and reducing turnover intention (Cho & Perry, 2012). Warr et al. (1979) constructed the Job Satisfaction Scale to measure work attitudes and aspects of employee psychological well-being. The instrument provided sufficient reliability (α = .91, ρ = .92) through a test-retest assessment conducted with a sample size of 381 participants (Heritage, Pollock, & Roberts, 2015).

This research utilized the intrinsic motivational aspects with an overall Cronbach's alpha scale of 0.807 for the Job Satisfaction Scale (Ma & Weng, 2015). Operationally, the survey assessed the extent of the manager's activities that created excitement for the respondent. Operational statements that represented this concept were "my manager pays attention to my success" (α = .80), and "I have the opportunity to use

my abilities" (α = .80). A 7-point Likert-type scale measured the responses with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Assimilation-Accommodation Appraisal Measurement

Kouchaki, Oveis, and Gino (2014) Assimilation-Accommodation Appraisal Measure assessed the degree of appropriate risk staff nurses felt they could take after identifying a problem to resolve, without manager oversite. One of the approaches taken with the Kouchaki et al.'s study was how the perceived control over outcomes explained the influence on risk-taking judgments, and whether an enhanced sense of control increased risk-taking behaviors. A 7-point Likert-type scale was used to measure environment of freedom (Statement 34) and atmosphere of safety (Statement 39) with scoring ranging from 1 (s*trongly disagree*) to 7 (*strongly agree*). The resulting variable was calculated by averaging the response to all items. Each statement was positively worded.

According to Kouchaki et al. (2014) certain emotions promoted adaptability of one's behavior to environmental changes (accommodation), whereas, other emotions promoted the tendency to behave according to internal traits (assimilation). Kouchaki et al. studied the effect of taking a risk to perform an activity was based on various elements. Assimilation/accommodation was assessed using four items resulting in an internal consistency rating of alpha = .58. These results dovetail with work from decision science demonstrating that appraisals of certainty and control were the two central dimensions governing decisions about risk.

In addition, individuals who perceived high personal control over their environment were more likely to engage in risk-taking behavior. Kouchaki et al. (2014) assessed participants' likelihood of engaging in risk-taking behaviors (α=.76) using three items. The emotion condition of the illusion of control had a statistically significant effect on the sense of control (*b*=.76, *SE*=.29, *p*=.01), which, in turn, significantly affected risk-taking (*b*=.24, *SE*=.10, *p*=.02). Operationally, risk-taking was measured by assessing the nurse's comfort in taking risks through sample statements that captured this concept. Examples were "I am able to take action, even if it means going against my manager or organizational goals" (α = .58) and "my manager motivates me to act to change situations" (α = .58). A 7-point Likert-type scale was used to measure the responses with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Taking risks requires an environment of safety. Psychological safety was defined as a shared belief between individuals and the consequences of interpersonal risk taking (Kessel et al., 2012). Specifically, safety was the freedom for individual self-expression that was free of a social risk or harm, adverse consequences to self-respect, reputation, or profession. Hirak et al. (2012) conducted research in a hospital environment examining whether leaders facilitated learning from failures resulting in better performance. One of the goals of Hirak et al. was to determine if learning from failures was an important mechanism that connected psychological safety with unit performance.

Hirak et al. (2012) surveyed 277 employees. Hirak et al. found a Cronbach's alpha for this measure was .90. Operationally, an atmosphere of safety construct assessed respondents' beliefs that their manager supported acceptable mistakes and an

environment existed that mistakes were learning experiences. Statements that represented this concept were “my manager is very forgiving when mistakes are made” (α = .80) and “my manager uses errors or mistakes as an opportunity to learn” (α = .79). A 7-point Likert-type scale was used to measure the responses with scoring ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*).

Communication Index

Boyas, Wind, and Ruiz (2015a) Communication Index contributed two statements to the current research for the construct of feeling valued. The statements were used to assess the extent respondents felt valued. Verčič, Verčič and Sriramesh (2012) defined communication as the exchange of information among members of an organization that created understanding and alignment of goals. To achieve this, relationship communication between manager and follower was essential. Operationally, managers share information and knowledge enabling employees to contribute optimally to organizational performance.

The Communication Index study employed a cross-sectional research design and utilized a purposeful, statewide sample to determine the impact communication has on job satisfaction. The Communication Index achieved a moderate internal consistency (Cronbach's alpha= 0.75). Boyas, Wind, and Ruiz (2015b) found, through analysis of variance and post-hoc testing, a significant group difference between employees who identified low communication with managers and employees who identified high communication in managers (*F*-test = 20.187, *p* = <.001). A 7-point Likert-type scale was used to measure communication (Statement 11) and feeling of being valued (Statement

28) with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The statements were positively worded and the highest score indicated a high perception of the construct measured. Communication and sharing was represented by the following examples, "my manager provides information that I need to ensure high-quality results" ($\alpha = .67$) and "my manager shares information with me regularly" ($\alpha = .88$).

Loyalty Scale

Two statements were used from Loyalty Scale to determine the concept of commitment to a supervisor (Chen, Tsui, & Farh, 2002). Chen, Tsui, and Farh used the term 'loyalty to supervisor' instead of commitment to supervisor in this study for two reasons: (1) loyalty was synonymous with commitment and (2) psychological attachment to a person was best described as personal loyalty rather than an impersonal form of commitment. Suharti and Suliyanto (2012) described one important factor in employee engagement as the relationship between the leader and the follower and the pattern of behaviors when interacting with those followers. Wu and Wang (2012) adopted Chen et al.'s Loyalty Scale to survey employee's relationship with their supervisor. The Loyalty Scale is classified into five general dimensions with 17 items. Cronbach's alpha is .86 for this scale. Operationally, loyalty subconstructs were measured by assessing the extent of staff nurses' loyalty to the manager, in consideration of the manager's leadership behavior. A 7-point Likert-type scale was used to measure loyalty (Statements 40, 42) with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The resulting variable was calculated by averaging the response to all items. Two statements that

represented this concept were, “if possible I would like to work for my manager for a long time” (α = .82), and “I am satisfied with my current manager” (α = .72).

Job Satisfaction Survey and Anticipated Turnover Scale

The influence a variable has on job satisfaction and turnover intention was the focus of the researchers referenced in this dissertation. Ultimately, the key to determining the factors that contributed to job dissatisfaction and reversing an employee’s turnover intention was to understand the variables that influenced the decision to remain committed and faithfully employed. Assessing the specific constructs, that factor into job satisfaction, was accomplished through questions asked in other areas of the survey.

Five statements from Hinshaw, Smeltzer, and Atwood (1987) Anticipated Turnover Scale were used to assess the extent that nurses intended to leave the organization (turnover intention). Hinshaw et al.’s survey consisted of 12 items measuring nurses’ intentions to stay or leave their job. Hudkins (2015) found Anticipated Turnover Scale had a Cronbach’s alpha = .83. A 7-point Likert-type scale was used to measure feelings about the job satisfaction (Statements 1, 2) and Turnover intention (Statements 52, 53, 54) with scoring ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*).

Job Satisfaction Survey

Additionally, Warr et al. (1979) Job Satisfaction Survey provided a wide range satisfaction scale, which permitted ratings of satisfaction from an individual’s perspective. The survey was a cognitive scale instrument that measured both intrinsic and extrinsic characteristics of the job and consisted of 15 items, seven measured intrinsic and

eight measured extrinsic characteristics. Five statements were used for the present research. A 7-point Likert scale was used to measure empowerment (Statement 12), legitimized development (Statement 23), loyalty (Statements 41, 43), job satisfaction (Statement 51) with scoring ranging from 1 (*strongly disagree*) to 7 (s*trongly agree*).

Job Satisfaction Score

Two statements adapted from Messersmith, Patel, Lepak, and Gould-Williams (2011) Job Satisfaction Score were used to determine the satisfaction of staff nurses with their job. Messersmith et al. explored the attitudinal and behavioral mediators aggregated at the unit level on performance. Messersmith et al. theorized that the relationship between high-performing work situations and behavior was mediated by three employee attitudes: organizational commitment, employee empowerment, and job satisfaction. As an indicator of discriminant validity, average variance extracted was above the recommended limit of 0.50. Messersmith et al. assessed discriminant validity by comparing the difference in chi-square values between constrained and unconstrained pairs of measures. The lowest change in chi-square was found to be 7.853 (*p* .001). The results of this analysis provided a model demonstrating satisfactory fit.

Messersmith et al. (2011) conducted a stratified sample with a purposeful oversampling of a targeted 6,625 front-line, non-managerial staff. Job satisfaction was measured with three items using a 7-point Likert-type scale. Two questions represented the operational aspect of their study and were adopted by the current research. The statements, “in general, I like working here” and “overall, I feel good about this job.” The Cronbach’s alpha was .83. A 7-point Likert-type scale was used to measure job

satisfaction (Statements 47, 48) with scoring ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The resulting variable was calculated by averaging the response to all items. Each statement was worded appropriately to elicit the necessary response. Two statements that represented this concept were "if I received another job offer, I would give it serious consideration" (.89), and "in general, I like working in my present position" (.83).

Population

Survey participants for this research study were staff nurses and nurse managers, employed at a Magnet certified, Level II trauma center located in Pennsylvania. The prospective frame of sampling of study participants derived from the hospital population of 719 staff nurses and nurse managers. Inclusion criteria for participation consisted of both male and female staff nurses who had successfully completed hospital orientation, had worked longer than 6 months for the manager being assessed, and were not in disciplinary action. Managers of nursing units were included in the survey regardless of length of employment.

Sampling Frame

There were approximately 719 nurses and nurse managers employed in the organization where consent had been provided to conduct this research. Approximately 701 nurses and 18 managers were eligible to participate. The appropriate number of nurses and nurse managers needed to participate in the survey that produced results at a 95% confidence interval with a margin of error of ± 5 was calculated by using the

formula $n = N / 1 + Ne^2$, resulting in requiring a minimum of 255 participants. The calculation is illustrated in Table 2.

Table 2

Sample Size Formula

$n = N / 1 + Ne^2$
$n = 701 / 1 + 701(0.05)^2$
$n = 701 / 1 + 701(0.0025)$
$n = 701 / 1 + 2.7525$
$n = 701 / 3.7525$
$n = 255$

The intention of this sample size was to maximize the value of information available from nurses who participated in the survey (Rose & Bliemer, 2013). To maximize the value of the information all 701 nurses and 18 nurse managers were sent a request to participate in the survey. To minimize participants from dropping out of the study, effecting the overall sample size, the survey was offered, available and completed in a limited time frame. The survey was made available on a Monday and ended on the following Sunday for a total of 13 days. To remind staff nurses and managers of nursing units to complete the survey, follow-up emails were sent on days 3, 7, and 11.

NonProbability Sample Design

In a non-probability sample design, sampling techniques utilized two forms of sampling methods; accidental or purposive (Tyrer & Heyman, 2016). For this research,

purposive sampling was selected because of the identification of one predefined group out of all the potential employees employed in the surveyed organization. This type of sampling design allowed for verification that the participants met certain criteria, participants could be targeted quickly, and proportionality was not the primary concern. The goal of this sampling design was not to determine the proportions of a particular audience, but rather the relationships between variables being tested.

Self-Selection Sampling Strategy

Self-selection sampling is a type of non-probability sampling that occurred when research participants chose to take part in research on their own accord; that is, the researcher does not approach participants directly (Greenacre, 2016). For this study, an online survey was provided through the organization's internal email system and all clinical staff nurses and nurse managers were invited to take part in the research. One advantage of self-selection was that participants were likely to take part in the study when they understood the importance to the profession. However, this advantage may have also served as a disadvantage as those who volunteered to participate had a degree of self-selection bias.

Strategy of Inquiry

Using a cross-sectional design, the study was a non-experimental strategy of inquiry. A web-based Internet design was used for data collection and a web link was provided to all potential participants. Respondents provided informed consent on the first screen of the web page and acknowledged their consent. Once consent was provided, the participants were directed to a link that opened the survey to complete. Participants who

did not provide consent were directed to exit the web page. Only completed surveys were considered valid for this study. Any incomplete surveys were excluded for the data analysis.

The use of a web-based survey offered versatility, cost savings, speed, user comfort/friendliness, and accessibility over the traditional paper-and-pencil questionnaires, providing some of the advantages of adopting this method (Dykema, Jones, Piché & Stevenson, 2013). Despite the threat of homogeneity with respect to characteristics, such as age and similar education, the advantages of a web-based survey design far outweighed the disadvantage; therefore, this approach was implemented. The hospital, where the research originated, utilized a web-based survey tool, REDCap® data system, providing accessibility to the survey by participants through the institution's internal email. Participants' response data collection was transferred to an Excel spreadsheet for aggregate analysis.

Procedures for Recruitment

The survey hospital's institutional review board was contacted and the project was discussed with the director and an assistant. Permission to conduct the research was tentatively approved and the design to collect data discussed. Collaborative designing of the process allowed for survey completion of the anonymous target sample via a web-based survey administration tool over a two-week period. The hospital's institutional review board was asked to provide access to all nursing staff and nursing unit managers through internally generated email accounts allowing the greatest opportunity to reach the target sample. The process for conducting the research at the hospital was established,

and all endorsements from the Director of Hospital Research and the Chief Nursing Officer were secured. Once the Chief Nursing Officer and the hospital's institutional review board granted permission, an email was sent to 719 nurses in the institution to solicit their participation. The email was directed to recruit all staff nurses who had completed hospital orientation, had worked at least 6 months, and were not in disciplinary action at the time of the study. The research study, the study's purpose, and directions for taking the survey, inclusion criteria, and a timeline for the survey were introduced. All nursing unit managers were asked to participate. A link to the survey was included in the email.

Procedures for Participation

Prior to completing the survey, the nurses who accessed the link for the survey read documents that explained the research purpose, the process of participating, benefits and risks of participation, confidentiality, ability to withdraw from the research, and who to contact with questions about the research. Participants were directed to access the survey link through their individual hospital log-on screen. Nurses, who willingly chose to participate, opened the link that described the research and the agreement to participate in the survey. After opening the link, the nurse viewed a screen that explained the directions for completing the survey. After reading the directions, the participants were directed to continue to the survey. Voluntarily clicking on the survey link implied informed consent and willingness to participate. Once the survey link was activated, the nurse became an anonymous participant and all responses were kept confidential. Participants were asked to complete all questions. Once questions were answered

completely or the nurse voluntarily exited the survey, the data collection was completed. No other communication with participants occurred.

Prior to the conclusion of the two-week time, on the 10th day, participation was evaluated and the total number of returned surveys reviewed. If the desired sample size of 308 eligible nurses was not reached, an email was sent to the targeted sample frame to remind them to complete the survey. At the end of the 2-week time, the survey was closed, and results analyzed.

Procedure for Data Collection

This method of sampling provided the greatest distribution of surveys to capture nurses' assessments of their nurse managers. Participant data were gathered using survey statements focusing on participants' perceptions of nurse managers' servant leadership behaviors and individual job satisfaction. Measured variables were correlated with the participants' perceptions of servant leadership within the organization and overall job satisfaction and turnover intention.

Reliability and Validity Value Relevant to the Study

Identifying and minimizing threats to validity were essential to concluding that a relationship between variables existed (Johnson, Rosen, Djurdevic, & Taing, 2012). Two types of threats existed; measurement and construct validity. The research was quantitative in nature, and thus relied on empirical data to determine the results. Assuring measurement validity of the proposed survey required that an initial Cronbach's alpha have a reliability coefficient above 0.70. Cronbach's alpha is the most widely used estimator of the reliability of tests and scales. Despite the empirical evidence that

demonstrated other alternatives, for example, composite reliability, the slight value difference between composite reliability (.86) and coefficient alpha value (.84), is inconsequential. Multiple regression analysis was used in this research (Peterson & Kim, 2013) to further delineate the results.

Statements that measured the specific constructs were garnered from previously validated surveys had a minimum alpha of .68 and high alpha of 0.96. Other studies utilizing the same survey instruments had demonstrated similar meaningful significance. In a like manner, the study provided the researcher a platform to perform similar analyses, and build upon the existing body of knowledge. The validity of the study was based on using valid instruments, similar research, and similar methods. Since the survey statements were used in previous research, to assess similar employee responses, construct validity was demonstrated.

Threats to Validity

Construct Validity

In research, the construct validity of an instrument is the accuracy and trustworthiness of instruments, data, and findings when no clear-cut criterion exists for validation purposes. If the instrument is not precise enough, researchers should build an accurate one to achieve validity (Bernard & Bernard, 2013). To achieve the desired objective, it was necessary to locate previous literature that validated the instrument used. In the current research, varieties of instruments were used to assess the constructs and sub-constructs. Research on the survey instruments demonstrated that the measuring instruments used were related to the general theoretical framework for each variable

measured. Each instrument had received peer-review evaluation and had demonstrated validity. Johnson, Rosen, Djurdevic, and Taing (2012) stated that an instrument should incorporate the whole concept by assessing the fit between the study constructs and the instrument under assessment. Each instrument's validity had been tested to assure best fit to the constructs tested.

Bernard and Bernard (2013) also argued that threat to construct validity emanated from internal and external sources. Threats to external validity included the timing of the administration of the survey, potential moderating variables, and representative sampling. Regarding the threats affecting the internal and external validity of the study, the benefit of a survey approach to research was the ability to survey a sample group of a population to make necessary inferences that can be applied to the general population concerning servant leadership behavior.

The potential threat of the timing and concern with the hiring cycle of new nurses may threaten construct validity. Timing relates to the degree in which participants can complete the survey while at work. To address the potential threat of not having enough time, participants were informed that the survey could be completed in 15 minutes or less. Since the study focused on the moderating variable of nurses, as it related to their perception of their manager's servant leadership, they were asked to view job satisfaction in context of the manager's servant leadership behaviors by using Messersmith et al. (2011) Job Satisfaction Score.

The second issue was the influx of newly hired nurses, who had recently completed orientation and had not experienced the full range of behaviors from the nurse

manager, potentially altering how the survey participant perceived the effect on their psychological state of engagement. To address this threat, participation criteria included successful completion of orientation and 6 months' employment on the nursing unit under the assessed nurse manager. Participants were asked to provide feedback on their current or previous managers with whom they had a longstanding work relationship.

To increase the external validity regarding proper sample selection, a hospital with 719 nurses and nurse managers was chosen. Specific surveys that explored real-world examples of behaviors encountered by nurses in a hospital organization were identified. External threats occur when researchers draw conclusions from the sample data and attempt to apply the results to other groups or settings. External threats can cause a researcher to draw incorrect conclusions.

One internal threat for this study was social desirability bias, in which research participants had a personal or professional familiarity with the researcher or the participants were aware of the desired response (Auchincloss et al., 2014). A second internal threat was the use of self-report measures, which are findings that did not accurately reflect the participants' current states of being. The third internal threat was concerned with participants with certain characteristics that might be more likely to complete the survey swaying the results in a particular direction (Auchincloss et al.)

Data Analysis Plan

Data collected through participant response were analyzed and summarized using descriptive statistics. A test for normality was performed to determine if the data were well modeled by a normal distribution. Ordinal scale data management and statistical

analysis was performed using Microsoft Excel version 15.25 and the Statistical Package for Social Sciences (SPSS) software, Version 23.0. The nature of the variables, the research questions, and prior research literature guided the study in terms of which statistical analysis was most appropriate. The servant leadership characteristics (humility, empowering, communication, and commitment) were the independent variables: job satisfaction and turnover intention were the dependent variables. The purpose of the data analysis was to look for a relationship between each of the four independent variables, and job satisfaction and turnover intention.

Pearson's product-moment correlation was employed to measure the strength of the correlation between variables. Pearson's product-moment correlation coefficient (Pearson's r) is a method to evaluate the linear relationship between two continuous variables. A relationship is linear when a change in one variable is associated with a proportional change in the other variable (Leech, Barrett, & Morgan, 2015).

With a multiple linear regression analysis, the researcher can use several independent variables to predict the dependent variable (Green & Salkind, 2013) by showing the degree of correlation between variables. Multiple regression was employed to determine the predictability of the criterion variables from the predictor variables.

Data Cleaning and Screening

The Statistical Package for Social Sciences program allowed for simple data cleaning identifying missing data values using frequencies or case processing summaries. For missing data values, this software also allowed for replacement of the missing values via series mean method. Any returned surveys with missing or incomplete data were

removed from consideration. Using this software, I was able to generate histograms and quantile-quantile (Q-Q) plots to assess normally distributed data.

Demographic Characteristics

Demographic characteristics were analyzed via nominal scale frequency distributions to identify the percentage of responses that fell into specific categories. The categories included the following: gender, length of employment status, age, education level, primary shift worked, and unit manager assessed. The data were used to provide a demographic profile of participants.

Descriptive Statistics

The data were analyzed for measures of central tendency. The mean for each variable was reported. Additionally, the standard deviation for each variable was reported to quantify the amount of dispersion.

Correlation Analysis

Correlation analysis was used to test the strength, direction, and type of relationship between each independent variable and the dependent variables. Specifically, Pearson's product-moment correlation (*r*) was used to measure the strength of the association between two variables. For this analysis, there were five theoretical assumptions: (a) the variables must be interval or ratio measurements, (b) the variables must be approximately normally distributed (tested for by using Shapiro-Wilk test), (c) there is a linear relationship between two variables (assessed via scatterplot examination), (d) outliers are kept to a minimum or are removed entirely (detected using case wise

diagnostics), and (e) there is homoscedasticity of the data (assessed via scatterplot of variances along the line of best fit).

Ethical Considerations

Data collection occurred upon obtaining Walden University IRB approval (01-06-17-0293864). Data collection occurred at a Magnet certified level II trauma center located in Pennsylvania. Nurse participants chose to complete the survey on a voluntary basis and could withdraw at any point.

Confidentiality

All nurses were informed to expect that the data collected from the survey would remain confidential at all times. Personally identifiable information was not collected. The study was designed to be voluntary and participants were not required to complete the study. No physical, psychological, economic, or legal harm resulted from the study. The option not to complete the survey was presented to all participants. The data obtained electronically was stored on a password-protected personal computer with limited access by outside persons.

Informed Consent

Ethical issues were an important consideration. Processes like getting consent from respondents were included under the category of researcher considerations. Some participants could perceive data collection as intrusive. In fact, simply identifying oneself as a researcher, conducting an investigation for academic purposes, could have negatively influenced any part of the research process. Ethical issues with informed consent might not only limit access to data, but it could also threaten to derail certain components of the

overall research project. So, at the very least, it was imperative to respect respondents' privacy and to protect the identity of participants by maintaining confidentiality and anonymity.

Additionally, nondiscriminatory language was used. Since the research was conducted within the context of Walden University, evidence was presented to the institutional review board and to the dissertation committee demonstrating that all respondents were protected from harm and that their privacy was respected. Copies of the data collection instruments (online surveys) and protocol stating that participation was voluntary, confidentiality was maintained, and respondents had the right to withdraw participation at any time was provided. This information was included on a consent form electronically provided to each respondent prior to participation.

Institutional Permissions

Another component of ethical consideration was generating an agreement to gain access to participants and respondents' data for analysis. Appendix C is the agreement by the hospital facility that permitted the research, once formal permission was provided. The permission was addressed to Walden University's institutional review board, to conduct research via the REDCap® platform.

Summary

This chapter contained the research study design and rationale, research method, measurements, instrumentation, population, strategy of inquiry, procedure for data collection, threats to validation, and statistical analysis. In summary, this research study was a cross-sectional, quantitative, non-experimental, study of servant leadership

behaviors of nurse managers and the effect these behaviors have on staff nurse's job satisfaction and turnover intention. The goal was to determine whether nurse managers' servant behaviors promoted the highest degree of staff nurse's job satisfaction and reduction in turnover intention. A Likert-type survey instrument was used to measure all variables and an online survey platform was used to collect data. Self-selection sampling, a type of non-probability sampling, was used to establish a sample of 308 nurses and managers from a Level II trauma, Magnet certified hospital. After cleaning and screening the data, the results were analyzed using Pearson's correlation. Ethical considerations included confidentiality, informed consent, and institutional permissions. In Chapter 4, I will review the data analysis and findings.

Chapter 4: Results

Introduction

The purpose of this quantitative, nonexperimental study was to examine the relationships between management's servant leadership behaviors (humility, communication, empowering, and commitment to employee growth) and job satisfaction and turnover intention in nursing staff. The moderating variables of psychological state of engagement and nursing behaviors were also examined. By evaluating the survey responses to the independent variable statements and the moderating variable statements, an assessment of the dependent variables was possible.

In this chapter, I present the results of the statistical analysis of the research hypotheses of this quantitative study. The analysis and interpretation of data were key components of the research process. A review of the data collected, details of the statistical techniques used to analyze the data, the steps used to test the hypotheses, characteristics of the respondents in a participant profile, procedures used to prepare the data for analysis, descriptive statistics of the measured variables, quality of the sample data, and the results of the statistical analyses are discussed.

The independent variable in this study was servant leadership behaviors (humility, communication, empowering, and commitment to employee growth). The moderating variables were a measure of the psychological state of engagement and nursing behaviors, and the dependent variables were job satisfaction and turnover intention.

Research Questions

The research questions were as follows:

RQ1: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting a positive psychological state of nurses and the dependent variable job satisfaction?

RQ2: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting positive behavioral responses of nurses and the dependent variable of job satisfaction?

RQ3: Do the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contribute to explaining and predicting nurses reporting greater job satisfaction and decreased turnover intention?

RQ4: Does positive job satisfaction in nurses correlate to a negative response to turnover intention?

The first three research questions investigated servant leadership behavior's effect on the psychological state of nurse engagement, behavioral response of nurses, and the reporting of job satisfaction. The fourth research question, addressed the possible correlation of positive job satisfaction to negative turnover intention.

Hypotheses

$H1_0$: There is no or a negative correlation among the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the psychological state of nurses.

*H*1a: There is a positive correlation among the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the psychological state of nurses.

$H2_0$: There is no or a negative correlation among servant leadership behaviors measured by the independent variables of humility, empowering, communication, and commitment to employee growth and the behavioral responses of nurses.

*H*2a: There is a positive correlation among servant leadership behaviors measured by the servant leadership behaviors of humility, empowering, communication, and commitment to employee growth and the behavioral responses of nurses.

$H3_0$: There is no or a negative correlation among servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contributing to nurses reporting greater job satisfaction.

*H*3a: There is a positive correlation among servant leadership behaviors of humility, empowering, communication, and commitment to employee growth contributing to nurses reporting greater job satisfaction.

$H4_0$: Job satisfaction does not correlate or positively correlates to turnover intention.

*H*4a: Job satisfaction negatively correlates to turnover intention.

Data Collection

Participant Profile

The timeframe for data collection was 2 weeks. A total of 701 nurses and 18 managers were eligible to complete the survey with 369 nurses returning the survey, for a response rate of 48%. Varying degrees of incompleteness eliminated 86 nurse responses, leaving 283 completed responses, exceeding the required number. As described in Chapter 3, the sampling frame of 255 nurse participants was needed to complete the survey; therefore, the sample size was large enough to identify statistically significant relationships in data analysis. Additionally, 18 managers received a management survey with six responses, for a response rate of 33%. Of all of the surveys that were completed, there were no discrepancies noted or outliers in the data collection process and no volunteers were excluded from the study.

Quantitative data were collected for this study through an in-hospital computer-administrated survey using REDCap®. Participants were invited to participate through personalized email accounts. Clicking on the survey link, participants chose to respond in private and completed the survey at their convenience, thus assuring confidentiality. Once the link was engaged, participants were provided with a unique identification number. Nurses were informed their participation was voluntary and if they chose to participate, responses were anonymous. In the sample, the participant profile was not diverse, as the sample contained more female respondents (85.2%) vs. males (14.8%), as the institution has a high number of females in nursing (Table 3). The mean age of nurses

was 34 years, with an age spread of a minimum of 21, and a maximum of 66 years (Table 4).

Table 3

Gender of Respondents

Gender	Frequency	Percent
Male	42	15
Female	241	85
Total	283	100.0

Table 4

Age of Respondents

Age	Minimum	Maximum	Mean	Std. Deviation
	21	66	34.74	11.19

Third shift nurses represented the highest number of responses at 42%, first shift at 40.3%, and second shift at 17.7% (Table 5). The low, second shift response can be attributed to nurses working 12-hour shifts, with the majority of their time on day shift or night shift.

Table 5

Shift Worked of Respondents

Shift worked	Frequency	Percent
First	114	40.3
Second	50	17.7
Third	119	42.0
Total	283	100.0

Nurses were asked to indicate the number of years they worked for the manager with the results indicating a minimum of 1 year and a maximum of 31 years with a mean of 2.95 years (Table 6). All nurses had a college degree with the majority having a Bachelor of Science (151), Associate in Nursing (120), and Master in Nursing (12) (Table 7).

Table 6

Years Worked for Manager

Years worked	Minimum	Maximum	Mean	Std. Deviation
	1	31	2.95	3.36

Table 7

Education Level of Respondents

Education	ADN	BSN	MSN	N
	120	151	12	283

Note. ADN-Associates in Nursing, BSN-Bachelor of Science in Nursing, MSN-Master of Science in Nursing

Data Analysis

The research questions were investigated using regression analysis, the analysis of variance, the *F*-test, the P (two-tail) test, and the *R*-squared statistic. The analysis of the research questions and hypothesis was performed by using the Statistical Package for the Social Sciences, Version 23.

Descriptive Statistics

The mean, standard deviation, and Cronbach alpha for servant leadership behaviors reliability, psychological state of engagement reliability, and nursing behaviors reliability are shown in Tables 8, 9, and 10, respectively. Table 11 indicates the

interreliability between job satisfaction and turnover intention. This Cronbach alpha coefficient of .70 or higher is considered acceptable in the social sciences (Bonett & Wright, 2014). The Cronbach alpha scores indicated all items had relatively high internal consistency.

Table 8

Servant Leadership Behaviors Reliability

SLB	α	*M*	SD	n
Humility	.97	4.83	1.81	8
Communication	.92	5.21	1.65	5
Empowering	.93	5.22	1.58	4
Commitment to Growth	.94	4.98	1.67	4

Note. Cronbach alpha scores indicated all items have relatively high internal consistency. SLB=Servant Leadership Behaviors. CI = 95%. *n* = number of questions.

Table 9

Psychological State of Engagement Reliability

PSE	α	*M*	SD	n
Legitimizing development	.95	5.08	1.55	5
Feeling valued	.96	4.98	1.77	6
Environment of freedom	.93	5.15	1.45	5
Atmosphere of safety[1]	.88	4.52	1.63	4

Note. Cronbach alpha scores indicated all items have relatively high internal consistency. Question 4 was removed from Atmosphere of safety. With Question 4 included, Cronbach's alpha = 0.678. PSE = Psychological Sate of Engagement. CI = 95%. *n* = number of questions

Table 10

Nursing Behaviors Reliability

NB	α	*M*	SD	n
Autonomy	.88	4.64	1.81	3
Loyalty[1]	.95	4.76	1.90	3

Note. Cronbach alpha scores indicated all items have relatively high internal consistency. Question 2 was removed from Loyalty. With Question 2 included, Cronbach's alpha = .22 NB = Nurse behaviors. CI = 95%. *n* = number of questions.

Table 11

Job Satisfaction/Turnover Intention Reliability

JS/TI	α	*M*	*SD*	*n*
Job satisfaction	.85	5.14	1.55	4
Turnover intention	.86	4.07	1.84	3

Note. Cronbach alpha scores indicated all items have relatively high internal consistency. Question 4 removed from Turnover Intention. With Question 4, the Cronbach's alpha = 0.607. JS/TI = Job satisfaction/Turnover intention. CI = 95%. *n* = number of questions.

The data were checked for missing variables. All participants who did not complete the survey were eliminated from the analysis. There were 283 nurses who responded to 57 questions for a total of 16,131 responses. Servant leadership variables were analyzed and were normally distributed. The variables for the state of psychological engagement were analyzed for approximate normal distribution and found to be normally distributed. Finally, the variables for the variables nursing behavior were analyzed and found to be normally distributed.

Evaluation of Data Quality and Data Preparation

Correlation analysis was used to test the strength and type of the relationship between each independent variable and the dependent variable. Specifically, Pearson’s

product-moment correlation (*r*) was used to measure the strength of the association between variables. Correlation strength was determined by

< .03 = weak correlation

.03-<.05 = moderate correlation

.05–1.0 = strong correlation

Study Results

A Pearson product-moment correlation was computed among four scales on the data for 283 participants to determine the relationships among the independent variable servant leadership behaviors (humility, communication, empowering, and commitment to employee growth), with the nurses' job satisfaction and turnover intention. Table 12 displays the results showing statistically significant, positive correlations between the independent variables of servant leadership. Humility and job satisfaction ($r = .44$, $p < .05$) and humility and turnover intention ($r = –.34$, $p < .01$), both indicating moderate strength. Communication and job satisfaction ($r = .42$, $p < .05$) and communication and turnover intention ($r = –.33$, $p < .05$), indicating moderate strength. Empowering and job satisfaction ($r = .40$, $p < .05$) and empowering and turnover intention ($r = -.29$, $p < .05$), both indicating moderate strength. Commitment to growth and job satisfaction ($r = .45$, $p < .05$) and commitment to growth and turnover intention ($r = -.33$, $p < .05$), indicating moderate strength.

Table 12

Correlation Matrix of Major Variables

	Hum	Comm	Emp	C to G	JS	TI
Humility	1					
Communication	.80	1				
Empowering	.80	.82	1			
Commitment to growth	.80	.77	.80	1		
Job satisfaction	.44	.42	.40	.45	1	
Turnover intention	-.34	-.33	-.29	-.33		1

Note. Hum = humility. Comm = communication, C to G = Commitment to Growth. JS = Job satisfaction. TI = Turnover Intention. CI = 95%.

In Table 13, the results of a Pearson's correlation analysis of the study grouped variables among participants with high internal tendencies (N = 283). Following row 4 of Table 14, the relationship between job satisfaction and servant leadership behaviors was positively, statistically significant (r = .44, p <.01), the relationship between job satisfaction and psychological state of engagement was positively, statistically significant (r = .50, p < .01), and the relationship between job satisfaction and nurse behaviors was positively, statistically significant (r = .51, p < .01). Similarly, following row 5 of Table 8, the relationship between turnover intention and servant leadership behaviors was negatively, statistically significant (r = -0.34, p <.01), the relationship between turnover intention and psychological state of engagement was negatively, statistically significant (r = -.30, p <.01), and the relationship between turnover intention and nurse behaviors was negatively, statistically significant (r = -0.36, p <.01).

Table 13

Correlation Matrix of Grouped Variables

	SLB	PSE	NB	JS	TI
Servant leadership behaviors	1				
Psychological state of engagement	.90*	1			
Nurse behaviors	.72*	.76*	1		
Job satisfaction	.44*	.50*	.51*	1	
Turnover intention	-0.34	-0.30	-0.36	-0.49	1

Note. *p < 0.01, two-tailed. SLB = Servant Leadership Behaviors, PSE = Psychological State of engagement. NB= Nurse Behaviors. JS = Job Satisfaction. TI = Turnover Intention.

Hypotheses Testing

Pearson product-moment correlation scores ranged from -1.00 to +1.00, with a +1.00 signifying a significant positive linear relationship and a value closer to -1.00 signifying a significant negative linear relationship (see Table 14). A value of 0 indicated a lack of relationship (Pavón-Dominguez, Jiménez-Hornero, & Ravé, 2013) with researchers using the resultant correlation to identify the degree observers would agree with one another concerning a relationship (Tang, Golam kibria, & Xie, 2013).

Table 14

Relationship Summary for Research Questions

Research Question	Variables	Values of correlation coefficient	Strength of correlation	Direction
RQ 1. Do the servant leadership behaviors contribute to explaining and predicting a positive psychological state of nurses and the dependent variable job satisfaction?	SLB → PSE	.90*	strong	positive
RQ 2. Do the servant leadership behaviors of contribute to explaining and predicting positive behavioral responses of nurses and the dependent variable of job satisfaction?	SLB → BR	.72*	strong	positive
RQ 3. Do the servant leadership behaviors contribute to explaining and predicting nurses reporting greater job satisfaction and decreased turnover intention?	SLB → JS	.44*	moderate	positive
RQ 4. Does positive job satisfaction in nurses, correlate to a negative response to turnover intention?	JS → TI	-.49	moderate	positive

Note. * = $p < 0.01$, two-tailed.

RQ1. Servant leadership behaviors is related to an individual nurse's level of Psychological Engagement. **$H1_0$:** Servant Leadership Behaviors and Psychological State of Engagement are not or have a negative correlation. **$H1_a$:** Servant Leadership Behaviors and Psychological State of Engagement are positively correlated.

The null hypothesis was rejected. There was sufficient evidence at the .01 level to conclude Servant Leadership Behaviors and Psychological State of Engagement positively correlated.

RQ2. Servant leadership behaviors is related to nurses' behavioral response. **$H2_0$:** Servant Leadership Behaviors and the behavioral response of the nurse are not or have a negative correlation. **$H2_a$:** Servant Leadership Behaviors and behavioral response of the nurse are positively correlated.

The null hypothesis was rejected. There was sufficient evidence at the .01 level to conclude Servant Leadership Behaviors and the behavioral response of the nurse was positively correlated.

RQ3. Servant leadership behaviors is related to nurses reporting greater job satisfaction. **$H3_0$:** Servant Leadership Behaviors and greater job satisfaction are not or have a negative correlation. **$H3_a$:** Servant Leadership Behaviors and job satisfaction are positively correlated.

The null hypothesis was rejected. There was sufficient evidence at the .01 level to conclude Servant Leadership Behaviors and nurses reporting greater job satisfaction was positively correlated.

RQ4. Job Satisfaction is negatively related to turnover intention. **$H4_0$:** Job satisfaction and turnover intention does not correlate or has a positive correlation. **$H4_a$:** Job satisfaction and turnover intention negatively correlates.

The null hypothesis was rejected. There was sufficient evidence at the .01 level to conclude Job satisfaction and turnover intention negatively correlates.

Predictability Testing

The use of multiple linear regression analysis helped test the hypothesis of the study. Multiple linear regression generated a linear model (Lazar, Mouzdahir, Badia, & Zahouily, 2014) and provided ease of implementation and accurate predictive results (Pavón-Dominguez et al., 2013). Data cleaning entailed detecting and correcting incomplete or inaccurate information from the dataset (Osborne, 2013). The dispersion of dataset frequencies was checked to identify incomplete or inaccurate areas and transform the reverse coded (turnover intention) statements. Once data entry was complete, the accuracy and validity of the data were checked to include outliers, as suggested by Osborne (2013). Unfinished surveys were removed from the analysis and further analysis determined there were no outliers, thus allowing the study power to remain high (Bertossi, Kolahi, & Lakshmanan, 2013). Statistical assumptions included linearity, homoscedasticity, and homogeneity of variances within data (Field, 2013).

An analysis of variance was the appropriate statistical procedure to provide the basis for significance testing (Field, 2013). The analysis of variance exhibits the F-test examines the hypothesis utilizing the entire coefficient estimates. Each F-test is a ratio of mean squares. A high F-test indicated a significant effect. If the F-test was greater in absolute value than the critical F, then the null hypothesis was rejected in that all of the coefficient estimates are zero. The P (two-tail) test, or significance test, checked for the probability of rejecting a true hypothesis. At the 95% confidence level, if the P value was less than a .05 significance level, the null hypothesis was rejected.

Homoscedasticity occurred when residuals were scattered randomly along the horizontal line of a scatterplot, which means the variance of errors was the same for all levels of the independent variables (Martinussen & Handegard, 2014). A homogeneity assumption tested the variance among populations was equal when identified by an *F*-test (Stevens, 2009). Normality was assumed when the difference between expected and predicted values created a normal distribution with zero skew or kurtosis, as assessed by a residual plot (Field, 2013). Stevens (2009) noted that measurement error assumptions, or reliability, occurred with an overestimation of effect sizes during multiple regression creating a Type I error.

Field (2013) stated checking for a variance inflation factor less than 10 and tolerance level above 0.2, would indicate no issues with collinearity. When the largest variance inflation factor was below 10, with an average around 1, and tolerance below 0.2, a researcher would not find multicollinearity (García, García, López Martin, & Salmerón, 2015). A variance inflation factor threshold of 5 and a tolerance of .02 to assess multicollinearity was chosen.

Inferential results were interpreted by observing the *p*-values for each of the hypotheses, with a low value indicating the null hypothesis had a low probability of being correct (Seaman, Seaman, & Allen, 2015). A *p* value of .05 was the threshold for whether to support or reject the null hypothesis and determine significance (Seaman et al., 2015). In this instance, the alternative hypothesis was determined to be correct and supported. Mathilde, Verdam, Oort, and Sprangers (2014) added informed judgment rather than a low *p* value alone, should guide a researcher.

Statistical Conclusion Validity

Statistical conclusion validity is the extent researchers can make accurate inferences from data analysis (Brutus, Aguinis, & Wassmer, 2013). Statistical conclusion validity threats occur when a researcher makes a wrong conclusion based on a violation of statistical premises or inadequate statistical power (Petter, Rai, & Straub, 2012). Statistical conclusion validity concerns include inflations of Type I, Type II errors and low accuracy (Heyvaert & Onghena, 2014). Type I errors comprise situations where no difference or correlation exists, but researchers make one exist. Type II errors exist when a researcher does not find a difference when it does exist (Kratochwill & Levin, 2014). Some of the principal threats to statistical conclusion validity of this study include (a) the reliability of the instrument, (b) data assumptions, and (c) sample size. A researcher can diminish threats through adequate sampling and employment of appropriate statistical test and measurement procedures (Kratochwill & Levin, 2014).

An internal consistency reliability check was conducted on the final instrument against the specific sample, and employed an effect size of 0.15, alpha of .05, and desired power of .80, with a large sample size of 284 participants to allow sufficient power. A power of .80 was useful with identifying the sample was sufficient to detect and reject a false null hypothesis and combat Type I and Type II errors (Cooper & Schindler, 2013; Dae Shik, 2015; Gaskin & Happell, 2014). Threats to statistical conclusion validity decreased by using sufficient power (Cooper & Schindler, 2013), detecting a true effect. A *p* value of .05 was the threshold for whether to support or reject the null hypothesis (Gaskin & Happell, 2014; Seaman et al., 2015). A *p* value of .05 conveys the probability

of inadvertently rejecting a null hypothesis when true. Issues with multicollinearity, normality, linearity, homoscedasticity, and independence of variables generated a regression model with biased, misleading, or inefficient confidence intervals, forecasts, or scientific insights (Tabachnick & Fidell, 2013). With the exception of outliers, researchers test the remainder of assumptions using normal probability plot (P-P) of the regression standardized or studentized residuals (Tabachnick & Fidell, 2013).

The Statistical Package for Social Sciences version 23.0 software provided the means to identify and test for errors (Field, 2013). These tests include variance inflation factor statistic, normality test, linearity assumption and transformations test, homoscedasticity assumption, and the Durbin-Watson Statistic (Field, 2013). Lastly, the data met the assumption of independence of residuals with a Durbin-Watson value of 1.976. With Durbin-Watson values close to 2, there were no serious violations noted (Field, 2013).

Servant Leadership and Job Satisfaction Predictability Analysis

Model Summary (Table 15) of servant leadership behaviors predictability of job satisfaction demonstrated an R^2 of .23 that indicated that 23% of the variability of Job Satisfaction was predicted by the independent variable of Servant Leadership.

Table 15

Servant Leadership and JS Model Summary

					Change Statistics					Durbin-Watson
Model	R	R^2	Adjusted R^2	SE	R^2 Change	F Change	df1	df2	Sig. F Change	
1	.48[a]	.23	.22	.92	.23	20.40	4	278	.00	1.98

Note. Dependent Variable: Job Satisfaction Question Average
a. Predictors: (Constant), Commitment to Growth Average, Communication Question Average, Humility Question Average, Empowering Question Average

Table 16 displays the result for the descriptive statistics for the constant job satisfaction. The mean value for empowering mean was the highest at 5.34, SD 1.45, while the humility mean value was the lowest at 4.87, SD 1.63

Table 16

Servant Leadership and JS Descriptive Statistics

	M	*SD*	*N*
Job satisfaction average	4.89	1.03	283
Humility average	4.87	1.63	283
Communication average	5.23	1.48	283
Empowering average	5.34	1.45	283
Commitment to growth average	5.00	1.55	283

Note. CI = 95%.

Results of analysis of variance testing for job satisfaction questions indicated that the variables of servant leadership were independent since there was significant variance between groups. Critical value for the F statistic at a significance level of .01 with degrees of freedom at 278 was approximately 3.39. The F statistic value (20.40) fell outside the critical value F. Formula: F(4, 278) = 20.40, p <.01, as indicated in Table 17.

Table 17

ANOVA

Model	*SS*	*df*	M^2	*f*	*Sig*
Regression	68.26	4	17.07	20.40	.00[a]
Residual	232.56	278	.84		
Total	300.83	282			

Note. Dependent variable: job satisfaction question average. $p < .01$.
a. Predictors: (Constant), Commitment to growth average, Communication question average, Humility questions average, Empowering question average

When evaluating the coefficients together, the significance is smaller when all servant leadership variables are combined as compared to the individual correlation. Humility, communication, and empowering exceeded p < .05. Tolerance for independent variables were unique and demonstrated that each was not predicated by the other independent variables. With a tolerance level value of 0.20 and a variance inflation factor threshold of 5, the variables did not exceed this threshold so there was little concern for multicollinearity (Table 18).

Table 18

Coefficients

	Unstandardized Coefficients		Standardized Coefficient			Correlations			Collinearity Statistics	
	b	*SE*	ß	*t*	Sig	Zero-order	Partial	Part	Toler	VIF
(Constant)	3.23	.22		14.98	.00					
Hum	.11	.07	.18	1.70	.09	.44	.10	.09	.26	3.81
Comm	.09	.07	.13	1.25	.21	.42	.08	.07	.27	3.77
Empow	-.03	.08	-.05	-.45	.66	.40	-.03	-.02	.25	4.09
C to G	.17	.07	.25	2.54	.01	.45	.15	.13	.28	3.57

Note. Dependent Variable: Job Satisfaction Question Average. Hum = Humility. Comm = Communication. Empow = Empowering. C to G = Commitment to growth. $p < .05$.

Outliers, normality, linearity, homoscedasticity, and independence of residuals. Outliers, normality, linearity, homoscedasticity, and independence of residuals were evaluated by examining the normal probability plots (P-P). The tendency of the points formed a reasonably straight line without major deviations. The points fell diagonally from bottom left to top right, supporting that no gross violations of the assumption of normality occurred (Boylan & Cho, 2012). The lack of a systematic pattern in the scatterplots also supported that there were no serious violations of assumptions.

Servant Leadership and Turnover Intention Predictability Analysis

Model Summary (Table 19) demonstrated an R^2 of .12 that indicated that 12% of the variability of turnover intention was predicted by the independent variable of servant leadership.

Table 19

Servant Leadership and TI Model Summary

					Change Statistics				
Model	R	R^2	Adjusted R^2	SE	R^2 Change	F Change	df1	df2	Sig. F Change
1	.36[a]	.12	.15	1.59	.13	10.11	4	278	.00

Note. Dependent Variable: Turnover Intention Question Average.
a. Predictors: (Constant), Commitment to growth average, Communication question average, Humility question average, Empowering question average

Table 20 displays the results for the descriptive statistics for the constant turnover intention. The mean value for empowering was the highest at 5.34, SD 1.45 while the humility mean value was the lowest at 4.87, SD 1.63.

Table 20

Servant Leadership and TI Descriptive Statistics

	M	*SD*	*N*
Turnover intention average	4.06	1.69	283
Humility average	4.87	1.63	283
Communication average	5.23	1.48	283
Empowering average	5.34	1.45	283
Commitment to growth average	5	1.55	283

Note. CI = 95%.

Results of analysis of variance testing for turnover intention questions indicated that the variables of servant leadership were independent since there was significant variance between groups. Critical value for the F statistic at a significance level of .01 with degrees of freedom at 278 was approximately 3.39 The F statistic value (10.11) fell beyond the critical value F. The formula for the affect servant leadership had on turnover intention was $F(4, 278) = 10.11$, $p < .01$ (Table 21).

Table 21

ANOVA

Model	*SS*	*df*	M^2	*f*	*Sig*
Regression	101.71	4	25.43	10.11	.00[a]
Residual	699.38	278		2.52	
Total	801.10	282			

Note. Dependent variable: turnover intention average. $p < .01$.
a. Predictors: (Constant), Commitment to growth average, Communication average, Humility average, Empowering average

When evaluating the coefficients together, the significance was smaller when all servant leadership variables were combined as compared to the individual correlation. All variables exceeded $p < .05$ had a negative correlation except for empowering. Tolerance for independent variables were unique and demonstrated that each was not predicated by the other independent variables. With a tolerance level value of 0.20 and a variance inflation factor threshold of 5, the variables did not exceed this threshold, so there was little concern for multicollinearity. Table 22 displays the coefficient results.

Outliers, normality, linearity, homoscedasticity, and independence of residuals. Outliers, normality, linearity, homoscedasticity, and independence of residuals were evaluated by examining the normal probability plots (P-P). The tendency of the points formed a reasonably straight line without major deviations. The points fell diagonally from bottom left to top right, supporting that no gross violations of the assumption of normality occurred (Boylan & Cho, 2012). The lack of a systematic pattern in the scatterplots also supported that there were no serious violations of assumptions.

Table 22

Coefficients

	Unstandardized Coefficients		Standardized Coefficient			Correlations			Collinearity Statistics	
	b	*SE*	ß	*t*	Sig	Zero-order	Partial	Part	Toler	VIF
(Constant)	6.04	.37		16.16	.00					
Hum	-.18	.11	-.18	-1.62	.11	-.34	-.10	-.09	.26	3.81
Comm	-.16	.12	-.14	-1.26	.21	-.32	-.08	-.07	.27	3.77
Empow	.10	.13	.08	.74	.46	-.29	.05	.04	.25	4.09
C to G	-.16	.12	-.15	-1.38	.17	-.33	-.08	-.08	.28	3.57

Note. Dependent Variable: Turnover Intention Question Average. Hum = Humility. Comm = Communication. Empow = Empowering. C to G = Commitment to growth. $p < .05$.

Psychological State of Engagement and Job Satisfaction Predictability Analysis

Model Summary (Table 23) of the psychological state of engagement behaviors predictability of job satisfaction demonstrated an R^2 of .26 that indicated 26% of the variability of Job Satisfaction was predicted by the independent variable of psychological state of engagement.

Table 23

Psychological State of Engagement and JS Model Summary

					Change Statistics				
Model	R	R^2	Adjusted R^2	SE	R^2 Change	F Change	df 1	df2	Sig. F Change
1	.51[a]	.26	.25	.89	.26	24.56	4	278	.00

Note. Dependent Variable: Job Satisfaction Question Average
a. Predictors: (Constant), Atmosphere of safety question average, Legitimized development average, Environment of freedom question average, Value question average

Table 24 displays the results for the descriptive statistics of the constant job satisfaction. The mean value for environment of freedom mean was the highest at 5.16, SD 1.35, while the safety mean value was the lowest at 4.55, SD 1.14.

Results of analysis of variance testing for job satisfaction questions indicated that the variables of the state of psychological engagement were independent since there was significant variance between groups. Table 25 indicates the results of analysis of variance testing. Critical value for the F statistic at a significance level of .01 with degrees of freedom at 278 is approximately 3.39 The F statistic value (24.56) fell beyond the critical value F. The formula for the effect of the psychological state of engagement on job satisfaction was $F(4, 278) = 24.56$, $p < .01$.

Table 24

Psychological State of Engagement and JS Descriptive Statistics

	M	SD	N
Job satisfaction average	4.89	1.03	283
Legitimized development average	5.10	1.44	283
Value average	5.05	1.62	283
Environment of freedom average	5.16	1.35	283
Atmosphere of safety average	4.55	1.14	283

Note. CI = 95%.

Table 25

ANOVA

Model		*SS*	*df*	M^2	*F*	*Sig*
1	Regression	78.54	4	19.64	24.56	.00[a]
	Residual	222.28	278	.80		
	Total	300.82	282			

Note. Dependent Variable: Job Satisfaction Question Average. $p < .01$.
a. Predictors: (Constant), Atmosphere of safety average, Legitimized development average, Environment of freedom average, Value average

When evaluating the coefficients together, the significance was smaller when all psychological state of engagement variables was combined as compared to the individual correlation. Legitimized development environment of freedom and atmosphere of safety exceeded p < .05. Tolerance for independent variables were unique and demonstrated that each was not predicated by the other independent variables. With a tolerance level value of 0.20 and a variance inflation factor threshold of 5, the variables did not exceed this threshold so there was little concern for multicollinearity (Table 26).

Table 26

Coefficients

		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
Model		*b*	*SE*	ß	*t*	Sig	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	2.98	.24		12.45	.00					
	LD	.12	.07	.17	1.72	.09	.47	.10	.09	.29	3.45
	Value	.19	.07	.29	2.85	.01	.47	.17	.15	.25	3.96
	E of F	.04	.07	.06	.62	.54	.43	.04	.03	.33	3.06
	A of S	.03	.07	.04	.45	.66	.40	.03	.02	.41	2.46

Note. Dependent Variable: Job Satisfaction Question Average. LD = Legitimized Development. E of F = Environment of freedom. A of S = Atmosphere of safety.

Outliers, normality, linearity, homoscedasticity, and independence of residuals. Outliers, normality, linearity, homoscedasticity, and independence of residuals were evaluated by examining the normal probability plots (P-P). The points fell diagonally from bottom left to top right, supporting that no gross violations of the assumption of normality occurred (Boylan & Cho, 2012).

Psychological State of Engagement and Turnover Intention Predictability Analysis

Model Summary (Table 27) of the psychological state of engagement behaviors predictability of turnover intention demonstrated an R^2 of .13 that indicated that 13% of the variability of turnover intention was predicted by the independent variable of psychological state of engagement.

Table 27

Psychological State of Engagement and TI Model Summary

					Change Statistics				
Model	R	R^2	Adjusted R^2	SE	R^2 Change	F Change	df1	df2	Sig. F Change
1	.36[a]	.13	.12	1.59	.13	10.20	4	278	.00

Note. Dependent Variable: Turnover Intention Question Average.
a. Predictors: (Constant), Atmosphere of safety question average, Legitimized development average, Environment of freedom question average, Value question average

Table 28 displays the results for the descriptive statistics for the constant turnover intention. The mean value for environment of freedom mean was the highest at 5.16, SD 1.35, while the safety mean value was the lowest at 4.55, SD 1.14. Engagement on turnover intention was $F(4, 278) = 10.20$, $p < .01$ (Table 29).

Table 28

Psychological State of Engagement and TI Descriptive Statistics

	M	*SD*	*N*
TI	4.06	1.69	283
LD	5.1	1.44	283
Value	5.05	1.62	283
E of F	5.16	1.35	283
A of S	4.55	1.14	283

Note. TI = Turnover intention. LD = Legitimized development. E of F = Environment of freedom. A of S = Atmosphere of safety.

Table 29

ANOVA

Model		*SS*	*df*	M^2	*F*	*Sig.*
1	Regression	102.53	4	25.63	10.20	.00[a]
	Residual	698.56	278	2.51		
	Total	801.10	282			

Note. Dependent Variable: Turnover Intention Question Average. $p < .01$.
a. Predictors: (Constant), Atmosphere of safety average, Legitimized development average, Environment of freedom average, Value average

When evaluating the coefficients together, the significance was smaller when all psychological state of engagement variables was combined, as compared to the individual correlation. The variables legitimized development, environment of freedom, and atmosphere of safety exceeded $p < .05$ with legitimized development and value showing a negative correlation. Tolerance for independent variables were unique and demonstrated that each was not predicated by the other independent variables. With a tolerance level value of 0.20 and a variance inflation factor threshold of 5, the variables did not exceed this threshold so there was little concern for multicollinearity (Table 30).

Table 30

Coefficients

		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
	Model	*b*	*SE*	ß	*t*	Sig	Zero-order	Partial	Part	T	VIF
1	(Constant)	5.83	0.42		13.75	0					
	LD	-0.19	0.12	-0.16	-1.52	0.13	-0.32	-0.09	-0.09	0.29	3.45
	Value	-0.33	0.12	-0.31	-2.81	0.01	-0.35	-0.17	-0.16	0.25	3.96
	E of F	0.08	0.12	0.07	0.67	0.5	-0.26	0.04	0.04	0.33	3.06
	A of S	0.09	0.13	0.06	0.67	0.5	-0.24	0.04	0.04	0.41	2.46

Note. Dependent Variable: Turnover intention question average. LD = Legitimized development. E of F = Environment of freedom. A of S = Atmosphere of safety.

Outliers, normality, linearity, homoscedasticity, and independence of residuals. Outliers, normality, linearity, homoscedasticity, and independence of residuals were evaluated by examining the normal probability plots (P-P). The tendency of the points formed a reasonably straight line without major deviations. The points fell diagonally from bottom left to top right, supporting that no gross violations of the assumption of normality occurred (Boylan & Cho, 2012).

Summary of Correlation Analysis and Results

The purpose of this study was to examine the strength of the relationship between (a) servant leadership, (b) psychological state of engagement of managers relative to the (c) job satisfaction and (d) turnover intention of nurses in Magnet Certified Level II trauma center in Pennsylvania. According to the correlation analyses, servant leadership behaviors, psychological engagement and nurse behaviors all have positive, linear

relationships with job satisfaction and turnover intention; therefore, all four alternative hypotheses were supported.

Standard multiple linear regression and Pearson's product-moment correlation were applied to examine the servant leadership to predict employee job satisfaction and turnover intention. Assumptions surrounding multiple regression were assessed with no serious violations noted. The job satisfaction model moderately predicted employee turnover, $F(4, 278) = 20.40$, $p<.01$ $R2 = .23$. The $R2$ (.23) value indicated approximately 23% of the variance in employee job satisfaction was uniquely accounted for by servant leadership. The turnover intention model was able to predict employee turnover, $F(4, 278) = (4, 278) = 25.43$, $p <.01$ $R2 = .13$. The $R2$ (.13) value indicated approximately 13% of the variance in employee turnover intention was uniquely accounted for by servant leadership.

Based on prior research, it was determined that servant leadership would have an effect on job satisfaction and turnover intention. The considerations were the servant leader behaviors of humility, communication, empowering, and commitment to employee growth. The belief was that manager's servant leadership behaviors would have an effect on the mediating psychological state of employee engagement, leading to specific nurse behaviors resulting in an identifiable relationship between with job satisfaction and turnover intention. The implications of these findings for future research and also for professional practice were discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative, nonexperimental, study was to examine the relationships between the independent variables, managers' servant leadership behaviors (humility, communication, empowering, and commitment to growth), and the dependent variables, the degree of job satisfaction and turnover intention. The quantitative, cross-sectional study was deductive in nature and was conducted to identify behaviors that were successful in promoting a psychological state of engagement, leading to greater job satisfaction and a decrease in turnover intention. Chapter 5 covers five main topics: an overall discussion and interpretation of findings; limitations of the study; recommendations for future research; implications for academic research, pragmatic use, and positive social change; and conclusions.

Interpretation of Findings

Servant Leadership Behaviors

The original model of servant leadership theory was based on social exchange theory, which proposed that a connection exists in the relationship between followers and their leader (Greenleaf, 1970). Greenleaf (1970) identified behavioral characteristics of listening, empathy, awareness, healing, foresight, stewardship, persuasion, conceptualization, commitment to growth, and community building, which, when embraced by the leader, would create an environment that leads to individual growth, mutual trust, and empowering. Additional research on nursing's role found that communication, commitment to growth, humility, and empowering, have foundations in

both servant leadership and nursing practice (Benner, 2004). The findings for this study supported previous evidence of this theory. The results signified a modest, positive relationship between the servant leadership behaviors of humility, communication, empowering, and commitment to employee growth and the effect these behaviors have on the psychological state of engagement of nurses, the resultant behavior, and job satisfaction.

Outcome of Research

Many studies (Bambale, 2014; Bobbio & Manganelli, 2015; McAlearney & Robbins, 2014; Parris & Peachey, 2013) determined that servant leadership helped develop learning organizations, generated superior organizational performance, created a stronger serving culture, and motivated employees to perform above expectations. To date, very few research studies were conducted that directly examined the relationship between servant leadership in nurse managers and employee job satisfaction and turnover intention.

The outcome of this study identified management behaviors that resonated with staff nurses by assessing an increase in job satisfaction and reduction in turnover intention. The results from this study demonstrated a moderate correlation between the behaviors of servant leadership (humility, communication, empowering, and commitment to employee growth), job satisfaction and turnover intention. I also found a strong correlation between the individual psychological state of engagement responses of nurses (legitimized development, feeling valued, an environment of freedom, an atmosphere of safety), job satisfaction and turnover intention. Additionally, there is a strong correlation

between nurses' responses (loyalty/commitment, autonomy), job satisfaction, and turnover intention. Finally, there was a moderate, inverse correlation between job satisfaction and turnover intention.

Further examination using analysis of variance and linear regression demonstrated the model was able to predict employee job satisfaction $F(4, 278) = 20.399$, $p < .01$, $R^2 = .227$. The R^2 (.227) value indicated approximately 23% of the variance in nurse job satisfaction was uniquely accounted for by servant leadership. The model was able to predict employee turnover intention $F(4, 278) = 25.428$, $p < .01$, $R^2 = .127$. The R^2 (.127) value indicated approximately 13% of the variance in nurse turnover intention was uniquely accounted for by servant leadership.

Another result of the study was the examination of the relationship between the psychological state of engagement and job satisfaction. The model was able to predict employee job satisfaction $F(4, 278) = 24.557$, $p < .01$, $R^2 = .261$. The R^2 (.261) value indicated approximately 26% of the variance in nurse job satisfaction was uniquely accounted for by the feelings of psychological engagement. The model was able to predict employee turnover intention $F(4, 278) = 10.201$, $p < .01$,$R^2 = .128$. The R^2 (.128) value indicated approximately 13% of the variance in nurse turnover intention was uniquely accounted for by the feelings of psychological engagement.

Despite a low R^2, the results do not mean a negative outcome is evident (Frost, 2013). In some fields, especially those that attempt to predict human behavior, may typically have a low *R*-squared value (<50%) because humans are harder to predict (Frost, 2013). If the results demonstrated a statistically significant predictor and the *R*-

squared was low, a researcher can draw valuable conclusions about how a change in the predictor value corresponds to a change in response value (Frost, 2013).

The results demonstrated that nurse managers who embrace servant leadership behaviors positively influence the psychological state of staff nurse engagement with positive nursing responses that lead to greater job satisfaction and a decrease in turnover intention. Transformational leadership is considered the primary style for nurse leaders, though much research has shown that transformational leadership may not be as effective as once thought. Alternative theories have influenced current leadership in many organizations, outside health care (Al-Sawai, 2013), and with careful consideration, adopting other theories may improve the current nursing shortage. Implementing the needed changes will help to retain experienced nurses, improve quality outcomes, and reduce operational costs for organizations.

Health care is changing, and leaders who recognize that staff nurses are essential for identifying problems can work independently to solve issues and seek to be valued for their contribution; this will concentrate attention and resources on developing the nurses. By embracing servant leadership behaviors, nurse managers can focus on the dynamic relationship between what nurses experience versus what nurses desire of their leaders. Embracing servant leadership has resulted in an increase in organizational stewardship (Beck, 2014). As an antecedent of servant leadership, organizational stewardship prepares a health care organization to build a positive legacy, based on the moral role it plays in society.

Based on the theory of corporate social responsibility, any improvement in the organization can result in enhanced performance without any tradeoffs between the synergy of the other aspects of corporate social responsibility (Cavaco & Crifo, 2014).

Transformational leadership influences behaviors that advance organizational goals (von Knippenberg, & Sitkin, 2013). Nurses desire leaders who demonstrate the ability to act morally (Hoch, Bommer, Dulebohn, & Wu, 2016), actively share and seek feedback (Johansson, Miller, & Hamrin, 2014), improve the work environment to ensure quality (McAlearney & Robbins, 2014), and do not exhibit dominant patriarchal behaviors that devalue their contributions (Hesselgreaves & Scholarios, 2014). The crossroad in health care occurs when nursing continues to embrace traditional models of leadership without serious consideration of models that can better adjust to the uncertainty of health care.

Limitations of the Study

This research contributed to the literature and the influence of servant leadership behavior on employee job satisfaction and turnover intention and was subject to the following limitations:

1. Data collection included only self-reported measures. Self-reporting was considered a disadvantage and a potential threat to validity because participants gave the manager the benefit of the doubt or the responses were not reflective of their true feelings.
2. The independent variables were measured by nurses' responses to their manager's behavior. These responses could be influenced by job-related

stressors or constraints and not be representative of the actual manager's influence.

3. The restricted period for data collection did not allow for a longitudinal study.

4. The cross-sectional research design was not appropriate for inferring causal relationships. Longitudinal research may have mitigated this problem.

Recommendations for Further Research

The results produced in this study indicate that servant leadership behaviors influence the psychological state of engagement and nursing response, leading to an increase in job satisfaction and lower turnover intention in a healthcare setting. Furthermore, a manager who embraces servant leadership behaviors resonates with nurses and creates within the nurses a higher level of engagement, greater loyalty, and autonomy. Further research on this topic is necessary, as very few empirical studies explore servant leadership and its effect on job satisfaction through mediating factors.

Conducting additional research could help to uncover how nurse managers learn, adopt, and subsequently apply leadership knowledge. Current leadership focuses on transformational, yet this has not stemmed the loss of nurses from the profession. In this research, I demonstrated that servant leadership was effective in improving job satisfaction and reducing turnover intention, yet the consideration for servant leadership style in formal education and adoption by professional organizations continues to go unheeded.

A third area of research relates to determining the relationship between turnover intention and actual turnover. Nurses indicated a correlation between low job satisfaction and a higher turnover intention. I did not include the turnover of nurses out of the institution. Future researchers could explore the statistical probability of psychologically considering leaving a manager or organization and actively separating from the manager or organization.

Finally, research on the cost differential between current leadership styles (related to nursing loss) and the improvement in actual turnover related to servant leadership would validate the economic benefit of investing in servant leadership education. By establishing a net positive financial improvement in overall human capital costs, organizations could not only plan for specific education but also justify the investment with a higher return on the investment.

Implications

For healthcare organizations to survive, it is essential that leaders, educators, and nurse administrators grasp this rapid change and prepare leaders who are ready to handle the changes. The results of this study offer suggestions to researchers, practitioners, and health care leaders in understanding the benefits of servant leadership. Servant leaders can positively influence change in a health care organization to meet the expectations of nurses and prepare the business for the demands of an ever-changing environment. By flipping the leadership hierarchy, health care organizations can profit from making necessary adjustments to their current health care processes and leadership styles leading to a more engaged, loyal, and creative nursing staff.

Researchers may use this study as a springboard for further investigation into the influence of servant leadership. Practicing managers may either perceive this study as a purely academic exercise or apply the results to current and future leadership initiatives. Nurse managers may elect to capitalize on employee efforts by exploiting new opportunities for employees to make self-directed changes to the job so that employees can make impactful contributions to the health care agenda, organizationally, locally, regionally, or nationally.

The findings from this study identified a gap in current research regarding the relationships between servant leadership behaviors, the psychological state of engagement, nurse response, job satisfaction, and turnover intention. Specifically, the study highlighted the importance of adopting servant leadership behaviors, which had a stronger relationship with the psychological state of engagement and job satisfaction. Future researchers could validate and expand this knowledge.

Implications for Practicing Managers

The results of this study indicated nurse managers have a significant effect on nurses' job satisfaction. For practicing managers, this insight may be the impetus for assessing or redirecting their efforts by embracing behaviors that resonate with staff nurses and leads to greater psychological engagement. With so many traditional, organizational-focused activities, the relationship between nurse managers and staff nurses have deteriorated over time as represented by the increasing nursing shortage. Conventional leadership centers more on manager's efforts and capabilities while neglecting the nurses' self-initiated creativity and problem solving. The results of this

study clearly indicate organizations should encourage servant leadership behaviors if the desire is to improve nursing's job satisfaction.

Implications for Positive Social Change

While the motivation for this research was to understand the relationships between servant leadership and nursing job satisfaction, results of the study suggest servant leadership activities positive influence the psychological state of engagement in nursing, resulting in positive responses of loyalty and autonomy. These positive responses empower nurses' creativity, improving job satisfaction. Positive social change may result in better patient outcomes as nurses are more engaged in their jobs as demonstrated by creative problem solving, autonomous decision-making, and better teamwork.

Organizationally, staff engagement results in better patient outcomes as nurses solve problems by responding quickly to patient events or creatively adopting new methods of care during rapid changes to the environment, thus reducing negative outcomes that result in greater organizational financial success. When hospital administrators increase the revenue/expense gap, investment in new equipment, community health programs, and social concerns such as the uninsured are more likely, resulting in positive social changes.

As societies become healthier, social growth occurs. A heathier population experiences greater employment, contributes to the local economy though greater purchasing power, or becomes involved in the immediate community. Becoming connected increases opportunities to influence social change by developing leaders and

mentors.

Concluding Remarks

Nursing, nursing leadership, and health care organizations have faced many obstacles and changes throughout the years. The results of this study revealed ways a leader can influence the course using servant leadership. The purpose of this study was to investigate the relationship between servant leadership behaviors, the psychological state of engagement, nursing response, job satisfaction, and turnover intention. Empirical results demonstrate significant, positive relationships between the independent variables of servant leadership behavior and the moderating variables of the psychological state of engagement and nurse response with job satisfaction and turnover intention. Therefore, efforts to improve nurses' job satisfaction should include reeducating nurse managers on leadership styles, particularly servant leadership, that resonates with staff nurses.

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Appendix A: Permission for the Following Surveys

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Warr, P. (1990). No permission is required; this instrument is open for individual use. This instrument is copyrighted. (Worldcat.org, 2012)

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Appendix B: Permission for Hinshaw Survey

Dennis Mitterer
To: XXX@usuhs.edu
Permission for use of Anticipated Turnover Scale

Dr. Hinshaw

Good evening. I am currently working on my Ph.D. dissertation at Walden University and was made aware of your survey instrument. After review of the questions, I determined that your survey would be beneficial in gathering the needed information for my research. I am requesting permission to use your survey instrument in my study of managerial behaviors on the job satisfaction and turnover intention of health care workers.

Thank you in advance for your time and consideration.

Best regards,

Dennis Mitterer
XXX@aol.com

XXX@umich.edu
To: Dennis Mitterer Cc: XXX@comcast.net XXX@umich.edu

Anticipated Turnover Scale

Dr. Atwood and I would be pleased for you to use the Anticipated Turnover Scale. I need to warn you that the reliability estimates are dated. Best of success with your research.

Dennis Mitterer
To: XXX@umich.edu
Re: Anticipated Turnover Scale

Dr. Hinshaw,

Thank you for your permission and alerting me to the reliability. I have found some peer-review articles that have confirmed your findings so I feel confident your instrument will work in my study.
Sent from my iPhone

Appendix C: Letter of Permission from Hospital Institutional Review Board for Conducting of Research Study

INSTITUTIONAL REVIEW BOARD

November 10, 2016

Dennis Mitterer, BSN
Nursing Administration

RE: Leadership Behavior and Its Effect on Employee Job Satisfaction and Turnover Intent
Protocol Number: 2016-61

Dear Mr. Mitterer:

On November 7, 2016, a designee, representing the Chair of the Institutional Review Board of XXXX conducted an expedited review of the above-mentioned protocol, the designee further reviewed an Implied consent form and a staff survey, Pursuant to 21 CFR 56,1 10 and 45 CFR 46.1 10, Category 7 this review revealed no more than minimal risk to subjects, Therefore, expedited approval of the research project was granted pending modifications to the protocol and the Implied consent form incorporating recommendations made by the designee. The revised protocol and Implied consent form, modified as requested, were received and approved on November 10, 2016, Based on review of this project, the designee assigned the research project a minimal risk level, The IRB approval Is effective for the period of November 10, 2016 through November 6, 2017

Continuing review of the protocol will be conducted at Intervals commensurate to the degree of risk but not less than once a year. Based on the risk level assigned to the protocol, continuing review will occur once a year, As the principal investigator you will be required to submit a request for continuing review at least 60 days prior to the expiration of the current approval.

This project is to be conducted in accordance with all federal regulations governing human subject research, as well as the policies of institution.

If you have any questions regarding this letter or the IRB, please contact me at XXX-5091

Sincerely,

Chair, Institutional Review Board

Appendix D: Letter to Participate for Staff Nurse

Dear XXX General Nurse,

You are being asked to participate in an anonymous online survey about the leadership behaviors of your current or past nurse manager and how these behaviors influence job satisfaction. The purpose of this study is to identify the relationship of nurse manager's behaviors on registered nurses and the effects of these behaviors on job satisfaction. This survey is being administered to all inpatient registered nurses (RN) who have successfully completed hospital orientation, have been off orientation for more than 6 months, and are not in disciplinary action. The total number of participants is dependent on the number of nurses employed at the time of study. Currently this number is 1,350 nurses employed. The anticipated number of completed responses needed for data analysis is 308 nurses. This study is being conducted to complete the requirements for a Ph.D. dissertation research project through Walden University. Dennis Mitterer M.Mgmt, BSN is the primary investigator and as such, I am requesting your consideration and participation in this project.

Completion of this survey is your decision and your participation is voluntary. The survey will take approximately 15-20 minutes to complete. Your decision whether or not to participate in the survey will not affect your employment or your relationship with the XXX General, administrators, physicians, etc. Your merit, job performance, etc. will in no way be affected by your decision to complete this survey. You do have the ability to skip any question. You may discontinue the survey at any time. The survey does not collect any identifiable information, so Dennis Mitterer will not be able to trace your responses back to you individually. The survey is administered via REDCap®. Dennis Mitterer will receive responses via REDCap®. Your response will not come to Dennis Mitterer via your XXX General email account. These safeguards are in place to protect your anonymity, and although very unlikely, there is a minimal potential risk of loss of anonymity resulting from participation in the study.

Survey responses will only be accessible by Dennis Mitterer. If you have questions about the study or your rights as a research participant, please feel free to contact me at 717-XXX-X322 or XXX@waldenu.edu. If I am not available or you want to talk to someone other than myself, you may contact the Office of Research with any questions, concerns or complaints at XXX General. The Human Research Protection Program provides oversight of all research activities involving human subjects at XXX General Health. If you have any questions about your rights as a research participant, or if you have complaints or concerns, you may send an email to the (SM-HRPP@XXX.org). You may also call the Chair of the Institutional Review Board at XXX General Hospital at 717-XXX-X091.

By completing the survey, you are providing your informed consent to participate in this research study. Please click on link to begin survey.

Appendix E: Demographic Characteristics

Responses to the following questions will be used to describe general characteristics of survey participants. This information will not be used to identify you.

What is your gender? ☐ Male ☐ Female

I am: _____ years of age.

The unit I currently work on is _____

I will be assessing my: ☐ current manager ☐ past manager

If assessing a past manager, indicate the unit they work/worked on _____

I worked for the assessed manager for: _____ years

My highest level of nursing education is: ☐ ADN ☐ BSN ☐ MSN

Appendix F: Opinion Survey on Leadership Behaviors

This survey is an anonymous questionnaire to collect data for research and academic purposes. You will not be identified during the collection and analysis of the data gathered. Please do not include any identifiable information on the survey.

Please select either your current manager or one who managed a unit that you were employed, and evaluate him/her with respect to the following statements. Use the same manager throughout the survey.

Choose one of the following options that best describe the manager and write your numerical response in the space provided for each statement.

(1) Strongly Disagree (2) Disagree (3) Slightly Disagree (4) Neutral (5) Slightly Agree (6) Agree (7) Strongly Agree

(Humility)
Regarding your manager's ability to balance the needs of self and others, my manager:

1. ____ does not get defensive when given constructive feedback
2. ____ is willing to learn from staff
3. ____ admits his/her mistakes
4. ____ recognizes his/her limitations
5. ____ does not seek personal recognition
6. ____ does not promote his/her self over my interests
7. ____ places the needs of others before his/her own needs
8. ____ sacrifices personal benefit to meet employee needs

(Communication)
Regarding your manager's skill in sharing information, my manager:

9. ____ shares information with me regularly
10. ____ provides information that I need to ensure high-quality results
11. ____ provides me with timely feedback and implications about decisions
12. ____ promotes open communication and sharing of information
13. ____ listens carefully to others

(Empowering)
Regarding your manager's behavior and consistency in enhancing others, my manager:

14. ____ encourages me to express my ideas fully and frankly
15. ____ pays attention to my suggestions
16. ____ encourages me to be creative with new ideas
17. ____ gives me authority to make important decisions about my job

(Commitment to Growth)

Regarding your manager's desire to help you grow professionally, my manager:

18. ____ makes my career development a priority
19. ____ seems to care about my success more than his/her success
20. ____ is interested in making sure I achieve my career goals
21. ____ derives satisfaction when others excel

(Legitimizing Development)

Regarding your manager's effort to develop you as a nurse, my manager:

22. ____ offers me opportunities to try out new tasks
23. ____ provides me with a lot of variety in my job
24. ____ provides me with work experiences that enable me to develop new skills
25. ____ provides opportunities to use my abilities
26. ____ does what he/she can to make my job easier

(Valued)

Regarding your manager's behavior and ability to demonstrate sincere concern for others, my manager:

27. ____ is open to hearing my feelings and concerns
28. ____ believes I have the ability to make decisions
29. ____ makes me feel valued
30. ____ takes time to talk to me on a personal level
31. ____ cares about my personal well-being
32. ____ values relationships more than task completion

(Environment of Freedom)

Regarding your manager's trust in you, my manager:

33. ____ encourages me to develop important work solutions to problems on my own
34. ____ allows me to make my own decisions in my area of work
35. ____ motivates me to act to change situations
36. ____ gives me the freedom to handle difficulty situations in a way I feel is best
37. ____ when I have to make an important decision, I do not have to ask my manager

(Atmosphere of Safety)

Regarding your manager's behavior in providing a safe work environment, my manager:

38. ____ will sincerely respond with care to my problems
39. ____ will risk mistakes on my part if I will learn and develop
40. ____ is very forgiving when mistakes are made
41. ____ is quick to point out the mistakes of staff
42. ____ is accepting of me when I take action, for a positive patient outcome, even if it means going against my manager.

(Loyalty)

Regarding your feelings about the relationship you have with your manager

43. ____ If possible I would like to work for my manager for a long time
44. ____ I totally dislike my manager

45. ____ I am satisfied with my current manager
46. ____ My manager provides an environment where I can take pride in the work I have done

(Autonomy)
Regarding your feelings about your job
47. ____ I have the freedom to decide what I do on my job
48. ____ It is my responsibility to decide how my job is done
49. ____ I have a lot of say about what happens on my job

(Job satisfaction)
Regarding your feelings about your job position
50. ____ In general, I like working in my present position
51. ____ All things considered, I feel good about working here
52. ____ Deciding to stay in my position is not a critical issue for me now
53. ____ I have been in my position about as long as I want to
54. ____ I look back on my day's work and feel fairly satisfied that I did my job well

(Turnover intention)
Regarding your feelings about your job transitioning from your job
55. ____ If I received another job offer, I would give it serious consideration
56. ____ I plan to leave this position shortly
57. ____ I do not intend to leave my present position

Appendix G: Letter to Participate for Nurse Managers

Dear XXX General Nurse Manager,

You are being asked to participate in an anonymous online survey about your leadership behaviors and how these behaviors influence job satisfaction. The purpose of this study is to identify the relationship of nurse manager's behaviors on registered nurses and the effects of leadership behaviors on job satisfaction. This survey is being administered to all inpatient registered nurses (RN) who have successfully completed hospital orientation, have been off orientation for more than 6 months, and are not in disciplinary action. The total number of participants is dependent on the number of nurses employed at the time of study. Currently this number is 1,350 nurses employed. The anticipated number of completed responses needed for data analysis is 308 nurses. This study is being conducted to complete the requirements for a Ph.D. dissertation research project through Walden University. Dennis Mitterer M.Mgmt, BSN is the primary investigator and as such, I am requesting your consideration and participation in this project.

Completion of this survey is your decision and your participation is voluntary. The survey will take approximately 15-20 minutes to complete. Your decision whether or not to participate in the survey will not affect your employment or your relationship with the XXX General, administrators, physicians, etc. Your merit, job performance, etc. will in no way be affected by your decision to complete this survey. You do have the ability to skip any question. You may discontinue the survey at any time. The survey does not collect any identifiable information, so Dennis Mitterer will not be able to trace your responses back to you individually. The survey is administered via REDCap®. Dennis Mitterer will receive responses via REDCap®. Your response will not come to Dennis Mitterer via your XXX General email account. These safeguards are in place to protect your anonymity, and although very unlikely, there is a minimal potential risk of loss of anonymity resulting from participation in the study.

Survey responses will only be accessible by Dennis Mitterer. If you have questions about the study or your rights as a research participant, please feel free to contact me at 717-XXX-X322 or XXX@waldenu.edu. If I am not available or you want to talk to someone other than myself, you may contact the Office of Research with any questions, concerns or complaints at XXX General. The Human Research Protection Program provides oversight of all research activities involving human subjects at XXX General Health. If you have any questions about your rights as a research participant, or if you have complaints or concerns, you may send an email to the (SM-HRPP@XXX.org). You may also call the Chair of the Institutional Review Board at XXX General Hospital at 717-XXX-X091.

By completing the survey, you are providing your informed consent to participate in this research study. Please click on link to begin survey.

Appendix H: Opinion Survey for Evaluating Nurse Managers' Leadership Behaviors

Principal Investigator: **Dennis Mitterer**
Walden Institutional Review Board No: **01-0617-0293864**
Date: **2017**

Study Title: Leadership and Its Effect on Employee Job Satisfaction and Turnover Intent

You are being asked to be in a research study. This form provides you with information about the study.

Why is this study being done?
This study will help us learn more about how manager's behaviors influence staff engagement and behavioral response. You are invited to be in this research study because your participation will help organizations and managers better understand the role and importance of relationships at work. Up to 1,350 people will participate in this study.

What happens if I join this study?
If you join the study, you will be asked to complete one survey, which will take about 10-15 minutes to complete.

What are the possible discomforts or risks?
Discomforts you may experience include sitting at a computer terminal for an extended period of time (i.e., 10-15 minutes), and rating statements that ask about your personal beliefs.

Will I be paid for being in the study? Will I have to pay for anything?
You will not receive any monetary benefit from participating in the study. It will not cost you anything to be in this study.

What are the possible benefits of the study?
There are no potential or direct benefits to you if you participate in this study.

Is my participation voluntary?
Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you choose to take part, you have the right to stop at any time. If you refuse or decide to withdraw later, there will be no negative outcomes of your decision.

Who do I contact if I have questions?
The researcher carrying out this study is Dennis Mitterer. If you have questions, you may contact him at XXX@waldenu.edu. Or you can contact may send an email to the HRPP

(SM-HRPP@XXX.org). You may also call the Chair of the Institutional Review Board at XXX General Hospital at 717-XXX-X091.

Who will see my research information?
We will do everything we can to keep your responses confidential. It cannot be guaranteed. However, since no identifiable information is collected the items submitted by you may be looked at by those who are involved with monitoring the safety of human subjects and others, for example:

- Federal agencies that monitor human subject research
- Human Subject Research Committee
- The person doing the study
- Regulatory officials from the institution where the research is being conducted who want to make sure the research is safe

The results from the research may be shared at a meeting. The results from the research may also be in published articles. However, only aggregate data will ever be presented or published.

Agreement to be in this study
I have read the above details or they were read to me. I understand the possible risks and benefits of this study. I know that being in this study is voluntary. I choose to be in this study. I may also print a copy of this consent form.

By completing and submitting this survey, you are voluntarily agreeing to take part in this study. Completing the survey indicates that you have read this consent form and have had all of your questions answered, and that you are 18 years of age or older.

Thank you!

IF YOU AGREE TO PARTICIPATE IN THIS STUDY, PLEASE CLICK THE ">>" BUTTON BELOW TO BE TAKEN TO THE SURVEY.

Appendix I: Demographic Characteristics

Responses to the following questions will be used to describe general characteristics of survey participants. This information will not be used to identify you.

What is your gender? ☐ Male ☐ Female

I am: _____ years of age.

The unit I currently work on is _____

I managed this unit for: _____ years

My highest level of nursing education is: ☐ ADN ☐ BSN ☐ MSN

Appendix J: Opinion Survey for Nurse Managers on Leadership Behaviors

This survey is an anonymous questionnaire to collect data for research and academic purposes. You will not be identified during the collection and analysis of the data gathered. Please do not include any identifiable information on the survey.

Choose one of the following options that best describe your beliefs and write your numerical response in the space provided for each statement.

(1) Strongly Disagree (2) Disagree (3) Slightly Disagree (4) Neutral (5) Slightly Agree (6) Agree (7) Strongly Agree

(Humility)
Regarding my ability to balance the needs of self and others through an accurate view of self and others, I generally:

1. ____ do not get defensive when given constructive feedback
2. ____ am willing to learn from staff
3. ____ admit my mistakes
4. ____ recognizes my limitations
5. ____ do not seek personal recognition
6. ____ do not promote myself over the interest of my staff
7. ____ place the needs of others before my own needs
8. ____ sacrifice personal benefit to meet employee needs

(Communication)
Regarding my skill in sharing information, I generally:

9. ____ share information with my staff regularly
10. ____ provide information that my staff needs to ensure high-quality results
11. ____ provide my staff with timely feedback and implications about decisions
12. ____ promote open communication and sharing of information
13. ____ listen carefully to others

(Empowering)
Regarding my behavior and consistency in enhancing others, I generally:

14. ____ encourage my staff to express their ideas fully and frankly
15. ____ pay attention to suggestions made by my staff
16. ____ encourage my staff to be creative with new ideas
17. ____ give authority to my staff to make important decisions about their job

(Commitment to Growth)
Regarding my behavior in helping your staff to grow professionally, I generally:

18. ____ make the career development of my staff a priority
19. ____ care about my staff's success more than my success

20. ____ am interested in making sure my staff achieves their career goals
21. ____ derive satisfaction when others excel

(Legitimizing Development)
Regarding my behavior regarding efforts to develop your staff as a nurse, I generally:
22. ____ offer staff opportunities to try out new tasks
23. ____ provide staff with a lot of variety in their job
24. ____ provide staff with work experiences that enable them to develop new skills
25. ____ provide opportunities to use their abilities
26. ____ do what I can to make their job easier

(Valued)
Regarding my behavior and ability to demonstrate sincere concern for others, I generally:
27. ____ am open to hearing staff's feelings and concerns
28. ____ believe my staff has the ability to make decisions
29. ____ make the staff valued
30. ____ take time to talk to all staff on a personal level
31. ____ care about my staff's personal well-being
32. ____ value relationships more than task completion

(Environment of Freedom)
Regarding your trust in your staff, I generally:
33. ____ encourage staff to develop important work solutions to problems without my input
34. ____ allow staff to make their own decisions on the unit
35. ____ motivate staff to act to change situations
36. ____ give staff the freedom to handle difficulty situations in a way they feel is best
37. ____ allow staff to make important decisions without asking me

(Atmosphere of Safety)
Regarding my behavior in providing a safe work environment, I generally:
38. ____ will sincerely respond with care to staff's problems
39. ____ will risk mistakes made by staff if they will learn and develop
40. ____ am very forgiving when mistakes are made
41. ____ am quick to point out the mistakes of staff
42. ____ am accepting of staff when they take action, for a positive patient outcome, even if it means going against me.

(Loyalty)
Regarding my behavior about the relationship I have with my staff, I believe:
43. ____ my staff would like to work for me for a long time
44. ____ some staff totally dislikes me as a manager
45. ____ most staff is satisfied with me as their manager
46. ____ I provide an environment where staff can take pride in the work they have done

(Autonomy)
Regarding my behavior about your staff's job, I believe:
47. ____ I give my staff the freedom to decide what they can do while on job
48. ____ It is their responsibility to decide how their job is done
49. ____ the staff has a lot of say about what happens on their job

(Job satisfaction)
Regarding your feelings about your job position
50. ____ my staff like working in their present position
51. ____ my staff feel good about working here
52. ____ staying in their position is not a critical issue for them
53. ____ some of my staff believe they have been in my position about as long as they want to
54. ____ my staff look back on the day's work and feel fairly satisfied that did well

Turnover intention)
Regarding your feelings about your staff's desire to stay, in general, I believe
55. ____ if many of my staff received another job offer, they would give it serious consideration
56. ____ many of my staff are planning to leave this position shortly
57. ____ most of my staff do not intend to leave their present position

Regarding your feelings about your overall leadership, I generally:
58. ____ desire to be successful in my career
59. ____ look to be promoted
60. ____ make my career development a priority
61. ____ am interested in making sure that I achieve my career goals
62. ____ seek ways to utilize staff's differences to advance the goals of the unit
63. ____ value everyone on the unit
64. ____ am not interested in self-advancement
65. ____ look for ways to make others successful
66. ____ see my role as a position of authority
67. ____ am accountable to my superior
68. ____ am interested in how my superior views me and my efforts
69. ____ communicate with a select group of individuals on my unit
70. ____ focus on task completion and fulfilling nursing activities
71. ____ focus on inspiring staff to accomplish organizational goals
72. ____ recognize my position as a source of power
73. ____ need to impress my superiors to get noticed
74. ____ spend more time in meetings than developing staff
75. ____ do what my superiors tell me to do
76. ____ promote staff learning to fulfill regulatory requirements or organizational goals

77. ____ unquestionably expects staff to obey my authority
78. ____ believe to be a strong leader, I need to keep my staff under control
79. ____ believe it is important that I am seen as the leader to my staff
80. ____ believe that staff must be told what they do wrong

(1) Strongly Disagree (2) Disagree (3) Slightly Disagree (4) Neutral (5) Slightly Agree (6) Agree (7) Strongly Agree

Regarding your feelings about GENERAL topics about your management style and beliefs
I generally:

81. ____ emphasize the need to get things done
82. ____ base my decisions on the needs of the organization
83. ____ receive direction from my superiors
84. ____ get the respect I deserve from my staff
84. ____ believe my staff trust me and my work
86. ____ feel like I am a mentor to my staff
87. ____ feel I am well liked by my staff
88. ____ believe my staff respect and admire my leadership style (T)
89. ____ believe I am attentive to my staff's individual needs and concerns (T)
90. ____ believe I lead by example (T)

Choose one response that best represents your style of leadership

____ Transactional
____ Authentic
____ Transformational
____ Dictatorial
____ Servant
____ Charismatic
____ Resonant