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### Evaluation of Leadership Changes in Adult Primary Care

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Evaluation of Leadership Changes in Adult Primary Care

Dierdre A. Gilliam

Submitted as Partial Fulfillment for the Doctor of Nursing Practice Degree

Regis University

December 1, 2015

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## **Executive Summary**

### **Evaluation of Leadership Changes in Adult Primary Care**

#### **Problem**

This project examines the abilities of Charge Nurses and administrative leaders in the outpatient clinic setting during a time of tremendous growth and change, after the implementation of the Patient Protection & Affordable Care Act. The inability of the Charge Nurses to participate in quality improvement efforts, or the implementation of changing work flows, caused the practice administration to re-evaluate the types of leaders necessary to lead teams forward in a changing health care environment, choosing to trial non-clinical administrative Unit Managers as operational leaders. The project evaluates the perception of the staff at two separate facilities, one with a Unit Manager, and one with Charge Nurses, as pertains to the Full Range Leadership theory of Bruce Avolio and Bernard Bass (1995). The research question addressed was: What are the perceived differences in staff perception of leadership ability between the charge nurse and the non-clinical Service Unit Manager in Adult and Family Medicine?

#### **Purpose**

The purpose of this program evaluation project was to analyze the differences in staff perception of leadership ability of a Charge Nurse versus an administrative manager in an Adult & Family Medicine clinic.

#### **Goals**

The goal of this project is to evaluate staff perception and observations of leaders' engagement in 32 leadership behaviors, and identify their current abilities in Transformational, Transactional and Passive-Avoidant

#### **Objectives**

MLQ scores will indicate areas of leadership development needed by the Unit Managers or Charge Nurses, as well as identifying developmental issues that may be limiting effective leadership practices, which will be used at a future date to develop educational opportunities to assist them in learning to lead successful teams through times of intense change.

#### **Plan**

This was an experimental quantitative design, using survey methodology to measure characteristics of a static group of support staff within a two primary care clinics. Data analyzed using the Excel 2013 Data Analysis ToolPack.

#### **Outcomes and Results**

Survey results showed that, although the staff at the control clinic indicated that they had more trust for the Charge Nurses, they also perceived them as practicing much more passive-avoidant, or non-leadership, behaviors than those in the clinic with the administrative leader. ( $p < 0.05$  at 0.02). This project provides a framework for leadership training, as well as broader testing of staff at other facilities in the system.

## **Acknowledgements**

I dedicate this to my husband, Larry, who has stood by me through this effort, as I became the first in my family to accomplish the monumental fete of completing a doctoral degree. Thank you for your support, for cooking and cleaning and doing laundry while I spent hours in the office working on papers and discussion questions.

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I would also like to remember the ancestors who went before me, especially, my grandmother, Sylvia Eversley, who always encouraged me to further my education, because when she was a young woman, she was told that Black women didn't go to college. She never got to see me get my nursing degree, but her love and encouragement are what have kept me moving forward in my career. Also, to my uncle, Edward Eversley, who left us this year shortly after the loss of his son. I know how proud he was of me, and what I have accomplished. I submit this knowing that they both are smiling down on me.

Lastly, I give thanks to the Creator of us all, who gave me the intelligence, and the drive, to accomplish more than I ever expected. To Him be the glory!

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The Institute of Medicine's (IOM) seminal report, "The Future of Nursing: Leading Change, Advancing Health," dedicates an entire chapter to the subject of leadership in nursing, stating:

"Strong leadership is critical if the vision of a transformed health care system is to be realized. Yet not all nurses begin their career with thoughts of becoming a leader. The nursing profession must produce leaders throughout the health care system, from the bedside to the boardroom, who can serve as full partners with other health professionals and be accountable for their own contributions to delivering high-quality care while working collaboratively with leaders from other health professions" (Institute of Medicine, 2011, p. 222).

However, by nature of the profession, and their position as the frontline of the healthcare system, all nurses need to be able to participate in the design, implementation, and evaluation of the reforms that are looming before the industry. Nurses also need to be the advocates of the receivers of service, or the patients, that they serve.

This report came out at a time of great stress in healthcare, as the industry waited to see what the impact of the implementation of the Patient Protection and Affordable Care Act of 2010, also referred to as the Affordable Care Act (ACA), would be. It was estimated 32 million previously uninsured Americans would enter the system upon implementation of the ACA. Many of those are community members who were previously uninsured and live at 133% or less of the Federal poverty level. Although there are incentives to support innovation in care delivery and temporary increases in payments to primary care providers (PCPs), the nursing and support staff were impacted by the increased patient population and changing demographic, as well as by the changes in practice required by the ACA (Kaiser Family Foundation, 2011). Locally,

approximately 14,000 new enrollees have joined the health plan associated with the physicians group since 2014, the majority of which are empaneled to medical providers in the Sacramento region (E. Bermudez, M. D., personal communication, 2014).

It is this report that helped to identify the issues that currently exist in nursing leadership in Adult & Family Medicine (AFM) in the Greater Sacramento Metropolitan Area. Initially, this Doctor of Nursing Practice capstone project was a proposal to develop a transformational leadership educational program for the charge nurses of AFM, however, in December 2012, the decision was made by administration to start negotiations with the nurses' union to eliminate the charge nurse position for all North Valley service area primary care clinics including AFM, women's health and pediatrics (P. Maydahl personal communication, 2012). This necessitated a change in the focus of the project. It was decided at that time to develop a program evaluation of the new leadership-staffing matrix proposed, comparing staff perceptions of the leadership skills of charge nurses versus the leadership skills of non-clinical managers.

### **Purpose Statement**

The purpose of this project is to analyze the differences in staff perception of leadership ability in a clinic led by a charge nurse versus a clinic led by a non-clinical unit manager. The study used the Multifactor Leadership Questionnaire Rater Form (5x short) (Appendix A).

### **Problem Recognition and Definition**

The organization consists of a pre-paid, integrated managed care company, with its headquarters in Northern California, with an associated multi-specialty, physician-owned and operated group practice with over 7,000 physicians providing care to 3.3 million members throughout Northern and Central California (Kaiser Permanente, 2013). It is an integrated health care delivery model, in which the physicians partner with the health insurance plan division, and

the hospital system to provide patient-centered care to its members (Kaiser Permanente, 2013). Each year, regional physician leadership develops a series of strategic imperatives for the group, communicated not only to the physicians within the group, but also to the Medical Group Administrators in each service area. This necessitates that strategic planning take place in each of the service areas in order to align local operations with the organizations strategic imperatives. The strategic imperatives identified by organizational leadership for the past five years based on initial preparation for and subsequent impact of full implementation of the Affordable Care Act, starting in January 2014.

In the spring of 2012, the AFM management team for the North Valley service area started the process of investigating what changes could be made to the current model of care delivery for the primary care clinics. The model, at that point, differed from other primary care practices in the community in that there were two Registered Nurses (RN) in each clinic, a charge nurse and a staff RN, in addition to the Medical Assistants (MA). This is an extremely expensive staffing model, especially when comparing the salaries of RNS to MA's or Licensed Vocational Nurses (LVN). One of the issues identified was that, generally speaking, the charge nurses were not proving to be effective leaders. Because of collective bargaining agreements, promotion to charge nurse is determined by seniority, regardless of whether the candidate can demonstrate any type of leadership ability. In essence, if a nurse applying for a charge nurse position meets the time in practice requirements, the manager has to choose the most senior applicant, regardless of whether that nurse has had any leadership experience (P. Maydahl, personal communication, 2012). This lack of leadership ability was exposed by the fact that, with 22 operating clinics providing the same services for the same organization, there was little consistency in how services were provided to the patients or the doctors. Even clinics in the

same facility with the same department RN Manager operated differently, depending on the personality and leadership abilities of the charge nurse. Customer service was suffering, there was evidence that patient care was delayed and there were many complaints from internal and external stakeholders. One of the strategic goals of the organization was to increase patient satisfaction scores (D. Rios & P. Maydahl, personal communication, 2012).

The changes looming from the implementation of healthcare reform created competition in the local market, with another health system making it public at the time they had every intention of luring members away from the organization by implementing integrated care services, providing insurance premiums that 8-12% less than the current health plan premiums, and providing stellar customer service (Robertson, 2011). In an increasingly competitive environment, this leaves the organization at risk for loss of membership, thus threatening the livelihood of all of the staff.

The need to change patient care delivery in the clinic operation to meet the external threats of competitors combined with the unknowns related to full implementation of the Affordable Care Act, and the inability of those serving in Charge Nurse roles to act as champions of change, led the administration to the decision a more cost effective and efficient practice staffing model was necessary. The AFM management team looked at what administrative duties the Charge Nurses were performing and which ones did not require a license to perform. Added to this formula were the job duties outlined in the Charge Nurse job description that they were not performing, such as implementing change and oversight of the MAs to ensure new interventions were actually enacted. Feedback from the Associate Medical Group Administrator informed the team there was a position being utilized in other service areas, the non-RN Service



Unit Manager, which met the administrative functional need for the clinics (P. Maydahl, D.

Miller, 2012). Excerpts from the job descriptions for the two positions are outlined in Table 1:

<b>Comparison of Essential Functions Staff Charge Nurse II vs. Service Unit Non-RN Manager II (as related to project)</b>	
<b>Staff Charge Nurse II</b>	<b>Service Unit Non-RN Manager II</b>
<b>Job Summary:</b> As leader of the health care team, directs shift-to-shift departmental operations and provides professional nursing care, including utilizing the nursing process in accordance with established standards of care, policies and procedures.	<b>Job Summary:</b> Manages, or assists in managing one or more units providing ambulatory services. Ensures staff provides high quality, accessible, cost effective care, and patient focused services to members across the continuums, which comply with local, state, and federal requirements. Develops and maintains budgets and on-going staff development.
<b>Major Responsibilities/Essential Functions (in order of importance:</b> <ul style="list-style-type: none"> <li>• Uphold organizational policies</li> <li>• Must be in charge over five or more employees, of which at least one must be another RN</li> <li>• Demonstrates a professional, supportive attitude, including mentoring, orienting and coaching staff as needed; leads and directs others through the change process</li> <li>• Supports and ensures teamwork with all internal and external departments and agencies involved in the provision of care</li> <li>• Participates in required staff development</li> </ul>	<b>Major Responsibilities/Essential Functions (in order of importance:</b> <ul style="list-style-type: none"> <li>• Ensures assistants and staff provide the highest quality of care and are in compliance with federal, state and local requirements</li> <li>• Collaborates with physicians and other health care providers in establishing, implementing, and maintaining patient care and quality service standards to meet members and internal clients expectations</li> <li>• Designs and evaluates processes to improve systems and patient care results across the continuum of care</li> <li>• Provides ongoing staff development</li> </ul>

Table 1. Excerpted from Organizational Job Descriptions.

The management team analyzed the budget implications of eliminating the Charge Nurse position, as well as eliminating one nursing position on each unit and replacing with an LVN.

The rationale for these changes included the reduction in salary costs for both the non-RN Service Unit Manager, and the LVN positions; compared to the RN, as well as the fact the

Service Unit Manager would be able to perform all of the administrative duties of the Charge

Nurse; and the LVN would be able to perform duties independently in the primary care setting delegated by the RN for which the MA's required RN oversight. In both cases it was determined that these changes would have a positive effect by reducing overhead salary and benefit costs, and freeing up nursing time for more direct care duties. It was anticipated that another benefit would be the improvement of the efficiency of the Nurse Manager by reducing the number of direct reports, increasing the ability of the managers at each facility to monitor the successful implementation of changes, which support the organizational strategic imperatives.

### **Problem Statement**

There is a need for evaluation of the new leadership structure to compare staff perceptions of the leadership skills of charge nurses versus the leadership skills of non-clinical manager. The outcome of that evaluation will determine whether administrative leaders with management experience demonstrate full range leadership abilities more effectively than charge nurses who lack management or supervisory experience or training.

### **PICO Statement**

The population, intervention, comparison and outcome (PICO) question for this project was as follows:

**P** - Charge and non-clinical Unit Managers in AFM

**I** – Determine differences in staff perception of leadership skills of Charge Nurses vs. administrative Unit Managers

**C** – Current staffing patterns remain in place

**O** – Survey results will show if there is a difference in perception of leadership skills between the two types of leaders

Thus, yielding the PICO question: What are the perceived differences in staff perception of full range leadership ability between the charge nurse and the non-clinical unit manager in AFM?

The PICO question originates from and specifically relates to the role of the Doctor of Nursing Practice (DNP) role as an advanced health care leader with the ability to integrate objective data with the knowledge gained from a groups subjective experience, as well as, the ability to apply scientific knowledge to the processes of program development, management and evaluation (Chism, 2010).

### **Theoretical Foundations**

Zaccagnini and White describe the Doctor of Nursing Practice project as one that should “address a complex practice, process or systems problem within the student’s field of expertise” or practice setting (2011). The nursing theory applied is Betty Neuman’s Systems Model, with its focus on the wellness of the client system. The theoretical foundation for this project includes application of theories of leadership and management, in particular, the Full Range Leadership model and change model designed by Ronald Lippitt (Mitchell, 2013).

### **Nursing Theory Application: Neuman’s Systems Model**

The Neuman’s Systems Model is a holistic system, which views the client as an open system responding to stressors (Fawcett, 2000). This includes, as related to this project, the metaparadigm concepts of central core which consists of basic survival factors; the flexible line of defense, which protects the normal state and prevents stressors from invading the system; the normal line of defense, where the client is currently; lines of resistance, which support a return to the wellness state; internal and external environment forces, which are all interactions external to the client system; intra-, inter- and extra-personal stressors on the system; optimal system

stability, and; reconstitution, the degree of reaction to the stressor, and the return to stability following treatment for the stressor (Fawcett, 2000).

Viewing the primary care clinic system as the client, it becomes easy to see how the metaparadigms of Neuman's Systems Model would apply in the case of a change of management structure to the support staff. The proposed change was perceived as a threat to the staff, a change from their normal state of the Nurse Manager being rarely present, and the Charge Nurses being expected to supervise the operations. This perceived threat – a person they did not know coming in to “oversee” the operation, and who was expected to be constantly present in the clinic to ensure workflows were followed, created stressors on the clinic operational system. It became necessary for this Nurse Manager/Researcher to assess the staff perceptions of the basic structure, the lines of resistance and defense, and determine the effect of the newly created environment (Fawcett, 2000). At this point, the decision was to apply Ronald Lippitt's Change Theory to this project.

### **Lippitt's Change Theory**

Ronald O. Lippitt's Change Theory uses language similar to the nursing process: assessment, planning, implementation, and evaluation (Mitchell, 2013). These elements are further broken down into phases:

Nursing Process Elements	Lippitt's Change Theory Phases
<b>Assessment</b>	Phase 1: Diagnosing the problem Phase 2: Assessing the motivation and capacity for change Phase 3: Assess the change agents motivations and resources
<b>Planning</b>	Phase 4: Selecting progressive change objectives Phase 5: Choosing the appropriate role of the change agent
<b>Implementation</b>	Phase 6: Maintaining the change
<b>Evaluation</b>	Phase 7: Terminating the helping relationship

Table 2: Lippitt's Change Theory (Roussel, L., 2011)

The change in management structure to the non-RN unit manager is a new, and untested, model for AFM. Whether this structural change would prove to be effective was an unknown. In assessing the necessity for this project, the RN Manager/researchers utilized Lippitt's first three phases, diagnosing the problem, assessing the motivation and capacity for change, and assessing change agents motivations, by identifying the need for a method to determine the leadership abilities of the unit manager. The motivations for the change to this model have been described previously. The capacity to make the change involved recruiting and hiring applicants for the position. The persons responsible for integrating the unit manager position into the operating structure of the clinic were the RN managers, making them the change agents. As part of the management team, the RN Manager/researcher for this project understood the motivation behind making the change, and agreed.

During the planning phase, a training program was developed for the UMs, focused on teaching them the various tasks of the support staff, most specifically, the Medical Assistants. It was determined they would be able to oversee the operational aspects of the registered nurses in the clinics, however, the Nurse Managers would continue to have clinical oversight and

evaluation of nursing practice. Metrics to determine the effectiveness of the UMs were based on the performance of the MAs, rather than on the abilities of the UM themselves (P. Maydahl, 2013). The assumption was made that, if the outcomes expected of the MAs were within target, then the UM were performing well. This set up the environment and impetus for this project, with its focus on the performance of the UM as leaders who would inspire the staff to do well, rather than autocrats directing the staff to perform specific tasks in return for either monetary reward if successful, or disciplinary action if unsuccessful.

As mentioned previously, the original plan for the capstone was to evaluate the staffs' perception of the unit manager as a full range leader, as compared to the charge nurse, then utilizing that data to determine the need for a Leadership Training Program. For this iteration of the project, the focus is on what leadership skills would be necessary for the UMs to possess in order to lead a team to successfully implement, and sustain the patient care delivery changes necessary to meet the goals of the organization. The planning phase of Lippitts' change theory includes selecting the change objectives, and choosing the appropriate role of the change agent. After a thorough literature search, it was determined that the Full Range Leadership theory of Avolio & Bass would be the best fit for the project as the change objective.

### **Full Range Leadership Theory**

Bernard Bass first proposed the concept of Full Range Leadership (FRL) theory in 1985 (Antonakis & House, 2002). Bass looked at the transactional leadership style, that where the leader rewards employees for performing well by recognition, pay raises, and advancement, and punishes those who do not perform to standard with discipline and dismissal (Bass, 1990). Transactional leadership, combined with passive management-by-exception, or intervening only when standards were not met, is, according to Bass, a prescription for mediocrity. He theorized

that a leader who generates awareness of the purpose and mission of the organization, and is able to inspire employees to look beyond their own self-interests for the good of the group, that leader demonstrated superior – or transformational – leadership behavior (Bass, 1990). Those who they lead may see transformational leaders as charismatic, or they have demonstrated that they are concerned about the emotional needs of their staff. They may intellectually stimulate the imaginations of the staff, engaging them in identifying and resolving process issues within the organization (Bass, 1990). A comparison of transactional and transformational leadership characteristics found in Figure 2.

Bass theorized that the transformational leader enabled followers to see beyond themselves and their own self-interests. Charismatic leaders wield power and influence, and their followers have a high degree of trust and confidence in them. This type of leader is considerate of the individual, paying close attention to the particular differences between employees, mentoring those who seek to grow and advance (Bass, 1990). A transformation leader practices management-by-walking-around, talking to staff and finding out how they view things from their perspective. Transformational leader encourages employees to perform beyond standard expectations because they can see the sacrifices the leader makes to achieve the mission. The employees identify with the mission and feel supported in achieving it (Bass & Avolio, 2004).

Transformational leaders may find it necessary to utilize transactional leadership characteristics at times. These include possessing an understanding of the roles and tasks required to meet organizational objectives, and knowing how to clarify those objectives and how to meet them. Transformational leaders also recognize the needs and desires of their staff, and can clarify how those needs and desires will be met if the objectives are met. Transformational

leadership in achieving the goals and objectives of the organization (Bass & Avolio, 2004) augments transactional leadership.

There is a third leadership style, Passive Avoidant, which is also considered by Bass to be non-leadership. One subscale of this leadership practice is Management-by-exception: passive. It is characterized by only responding to a problem after it has festered and become a true problem, rather than monitoring for errors. The other subscale is Laissez-faire, or avoidance of intervention or leadership (Bass & Avolio, 2010).



<b>Transactional versus Transformational Leadership Characteristics</b>	
<b>Transactional Leadership</b>	<b>Transformational Leadership</b>
Contingent Reward (CR): <ul style="list-style-type: none"> <li>• Rewards achievement</li> <li>• Specifies who is responsible for achieving performance targets</li> <li>• Clarifies what can be expected when goals are met</li> </ul>	Idealized Attributes (IIA) <ul style="list-style-type: none"> <li>• Builds trust</li> <li>• Displays a sense of power and confidence</li> <li>• Instill pride in others for being associated</li> <li>• Acts in ways that build others respect</li> </ul>
Management-By-Exception: Active <ul style="list-style-type: none"> <li>• Monitors deviations and mistakes</li> </ul>	Idealized Behaviors (IIB) <ul style="list-style-type: none"> <li>• Acts with integrity</li> <li>• Discusses values and beliefs</li> <li>• Discusses the importance of a strong sense of purpose</li> <li>• Considers the moral and ethical consequences of decisions</li> <li>• Emphasizes the importance of a collective sense of mission</li> </ul>
	Individual Consideration (IC) <ul style="list-style-type: none"> <li>• Coaches and develops</li> <li>• Treats others as individuals</li> <li>• Considers each individual as having different needs, abilities and aspirations</li> <li>• Helps followers to develop their strengths</li> </ul>
	Inspirational Motivation (IM) <ul style="list-style-type: none"> <li>• Encourages others</li> <li>• Talks optimistically about the future</li> <li>• Is enthusiastic about what needs to be accomplished</li> <li>• Articulates a compelling vision of the future</li> <li>• Expresses confidence that goals will be achieved</li> </ul>
	Intellectual stimulation (IS) <ul style="list-style-type: none"> <li>• Encourages innovative thinking</li> <li>• Questions critical assumptions for appropriateness</li> <li>• Seeks differing perspectives for solving problems</li> <li>• Encourages others to look at problems from different angles</li> <li>• Suggests new ways to complete assignments</li> </ul>

Table 3. Transactional vs. Transformational Leadership Characteristics. (Bass & Avolio, 2004).

## **Systematic Review of the Literature**

A systematic review of the evidence (SRE) was conducted initially to identify peer-reviewed journal articles which discuss charge nurse leadership competencies, or studies conducted to analyze the leadership abilities of charge nurses or nurse managers (see Appendix B). The search was conducted using the Ovid Nursing, EBSCOhost, and Cumulative Index to Nursing and Applied Health (CINAHL) databases, and sometimes a simple Google search for articles listed in article references that could not be accessed through the other databases. Key words utilized included: charge nurse (764 results), transformational leadership (483 results), multifactor leadership questionnaire (62 results), ambulatory care nurse (1374 results), clinic manager (1492 results), primary care charge nurse (41 results), primary care clinic manager (225 results) and primary care manager (3123 results). Position statements from expert committees, such as organizational leadership, and the IOM, were also included in the review. Later literature searches and reviews were conducted after the focus of the project changed in late 2012. Studies chosen included research that was quantitative, qualitative, and systematic review of the literature. Very little was found in the literature regarding primary care management that is not focused on nurse practitioners or physicians, and nothing was located discussing non-clinical managers to date, indicating that there is a gap in the literature. There is a lack of quantitative or qualitative studies in primary or ambulatory care management in general. Selected articles ranged in time from 1985 to 2015, with the majority between 2005 and 2014. Four tiered levels of evidence were utilized as described by Houser and Oman, Ia, Ib, IIa, IIb, III, and IV (Houser and Oman, 2011). Table 4 provides a breakdown of the articles chosen for use in this project by Level of Evidence.

Four Tiered Levels of Evidence		
Level	Description	Number of articles found
Ia	Evidence obtained from meta-analysis or systematic review of randomized controlled trials	1
Ib	Evidence obtained from at least one randomized controlled trial	3
IIa	Evidence obtained from at least one well-designed controlled study without randomization	0
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study	0
III	Evidence obtained from well-designed nonexperimental descriptive studies, such as comparative studies, correlation studies, and case studies	18
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	1

Table 4. Four Tiered Levels of Evidence. (Houser & Oman, 2011)

Several of the articles found during the SRE identified the lack of leadership education for charge nurses, thus putting them at risk for role burnout and job dissatisfaction. A study by Dugulay and Jublay (2010) evaluated the outcomes of a transformational leadership educational program for charge nurses in acute care facilities in Turkey, concluding there was a need for development of similar programs to improve the leadership skills of charge nurses, as well as the need for such programs made mandatory for anyone assigned to the position.

In a study of the relationship between quality focus of the front line nurse manager and patient satisfaction, unit effectiveness and staff perception of quality, Lageson (2004) conducted a study based on Donabedian's description of quality as structure, process, and outcome. The study was a descriptive, cross-sectional survey design of inpatient nursing units in the American Midwest. She concluded nurse managers need to provide significant leadership on their units and should have a quality focus that reflects the need for a stable and productive workforce able to provide high quality and cost-effective care. Wojciechowski, Rize-Cullen and Tyrrell (2011)

conducted a nonexperimental qualitative survey design study at a 160-bed facility in the Midwest for the purpose of understanding the educational needs of charge nurses, identifying barriers to functioning as charge nurses, and identify what their perceptions were of their educational needs to be able to function in their roles.

Role overload was also identified, due to multiple demands from all sources, including staff, peers, patients, families, and the organization as a whole (McCallin & Frankson, 2010). They expressed feelings of being overwhelmed, as the demands of the role exceeded their resources. Increased role stress was caused by the inability to find solutions for problems. The recommendations from one study included new approaches to charge nurse development were needed, including role preparation for future nurse leaders, succession planning, and postgraduate management education prior to a nurse assuming a management position (McCallin & Frankson, 2010).

Connelly, Yoder & Miner-Williams (2003) conducted an exploratory, qualitative research study in a military hospital with the research question, “what do nurses at various levels perceive to be the competencies needed to effectively carry out the role of charge nurse in a military medical center?” (p. 299). The results were grouped into four categories: clinical/technical, critical thinking, organizational and human relations skills. The conclusion was that a Charge Nurse Development Program was needed, as the role is complex and is considered first-line management (Connelly, Yoder, & Miner-Williams, 2003). A subsequent study by two of the same researchers in the same practice setting looked at the specific barriers and facilitators of the charge nurse role. As part of the larger study, this was a stratified purposive sampling using data derived from the original study. The outcome was 24 barriers or facilitator grouped into three categories: personal, or internal which influenced their ability to

perform as charge nurse; interpersonal, or factors involving interactions with others, and; organizational barriers and facilitators, or factors in the organizational environment, which influenced their ability to perform the charge, nurse role (Connelly & Yoder, 2003).

The only major quantitative study of charge nurse leadership development was conducted by Krugman & Smith (2003) at the University of Colorado Hospital (UCH). The literature search conducted during this study yielded very few articles about how the charge nurse role was developed, its structure, or the relationship of the charge nurse to other nurse leaders, such as nurse managers and directors. In 1995-96, the nursing leadership of UCH formed a task force for the purposes of initiating a permanent Charge Nurse Leadership Position. The project was grounded on Kouzes and Posner's Leadership Model, which uses five domains representing the dimensions of outstanding leadership behaviors: Challenging the Process; Inspiring Shared Vision; Enabling Others to Act; Modeling the Way, and; Encouraging the Heart (Krugman & Smith, 2003). The project design was as a research study with the objectives of improving charge nurse leadership, improving unit functioning, maintaining patient satisfaction, and measuring nurse job satisfaction. The tools utilized included the Kouzes and Posner's Leadership Practice Inventory to measure charge nurse leadership after the educational offerings; the review of shift reports utilizing a tool developed collaboratively by one of the authors and the Charge Nurse Task Force. The researchers were not able to obtain consistent measures of patient satisfaction due to a change in the tool used over the course of the four-year study, therefore, chose not to report this data. The last objective, nurse job satisfaction, was measured since 1992 using the McCloskey Mueller Satisfaction Survey. The outcomes as measured by the various tools helped to drive improvements to the charge nurse educational program over the years,

eventually creating a promotional opportunity within the clinical ladder program and a system for management succession planning (Krugman & Smith, 2003).

Studies were found by Muenjohn and Armstrong (2008), as well as Kanste, Miettunen, and Kyngas, (2006), which validated the use of the Multifactor Leadership Questionnaire (5x short) (MLQ) for capturing full-range transformational leadership abilities. Muenjohn and Armstrong (2008) examined the structural validity of the MLQ utilizing Confirmatory Factor Analysis (CFA) to measure the factor structure and determine how well the measurement model fits. Muenjohn and Armstrong, who tested the English versus the Thai version of the tool, indicating the Cronbach alpha = 0.86 for the English version, and alpha = 0.87 for the Thai version, with reliability values >0.70, indicating that the testing level was adequate (Muenjohn & Armstrong, 2008). The English and Thai versions were used to conduct a reliability check and to provide evidence that the MLQ would produce the data for which it was designed. The findings implied the MLQ was reliable in small studies such as this one (n = 138) or larger studies, such as one conducted by the developers of the tool (n = 1,394) (Muenjohn & Armstrong, (2008).

A study conducted in Finland with 601 nurses and nurse leaders examined the psychometric properties of the MLQ (Finnish version) among nurses (Kanste, Miettunen, & Kyngas, (2006). Psychometrics defined by Merriam-Webster (2013) as the measurement of psychological trends using quantitative devices. The study was designed as a nationwide postal survey mailed to a stratified random sampling of nurses from the university, central and district hospitals, health centers, psychiatric hospitals, and private hospitals. Both nurses and head nurses evaluated the leadership behaviors of their immediate supervisor. The results of this study indicated support for the internal consistency of the MLQ. Independent, though

interrelated, leadership dimensions identified were charisma, intellectual stimulation, individualized consideration, contingent reward, active management-by exception, and passive laissez-faire leadership (Kanste, Miettunen, & Kyngas, (2006). They concluded leadership is a multidimensional construct as measured by the MLQ, and that the MLQ is a suitable tool for measuring the full-range of leadership ability (Kanste, Miettunen, & Kyngas, (2006).

### **Research Study Objectives**

Initially, three UMs were hired and a trial of the position began in October, 2012 in three AFM clinics in the Sacramento area. The goal of this project was to evaluate the effectiveness of the change from a leadership perspective through comparing staff perceptions of leadership differences between one clinic module with a UM, compared to a charge nurse at two separate sites, with two different nurse managers.

The investigator for this project is a Masters-prepared DNP student, certified by the State of California Board of Registered Nursing as a Public Health Nurse, and currently practicing as a Department Manager/Leader for three Adult and Family Medicine clinics. The outcomes chosen for this project are based on the identified program, or operational changes currently trialed in one of the AFM clinics. After discussion with the North Valley *Lean* team, also known as the *North Valley Way*, Masters-prepared mentors and department leadership, the proposal was developed to perform an evaluation of the trialed unit manager position.

The outcomes for the project are the comparison of staff perceptions of leadership abilities of the Charge Nurse versus the non-clinical Unit Manager, as measured by the responses to the Multifactor Leadership Questionnaire Rate (5x short) (MLQ). This was utilized to measure the effectiveness of the change of frontline clinic operations from licensed to unlicensed personnel.

## **Goals**

One of the six steps of program evaluation is the gathering of credible evidence which strengthens the evaluation judgments and the resulting recommendations. Gathering credible evidence means compiling data stakeholders perceive as trustworthy and relevant. Credible evidence provides valid, reliable, and systematic information as the basis of the effective evaluation. The activities involved in collecting credible evidence include choosing indicators that address evaluation questions in a meaningful manner; provide a full description of the attributes of information sources, and the rationale for selection; establishing clear procedures for data collection, and; safeguarding the confidentiality of information and sources (CDC, nd).

For this project, the goal was to evaluate the staff perceptions of leaders engagement in the 32 specific leadership behaviors of Avolio & Bass's Full Range Leadership theory (1995), as measured by the MLQ. In addition, MLQ scores indicated areas of leadership development needed by the UMs or Charge Nurses, as well as identifying developmental issues limiting effective leadership practices. The research question was: What are the perceived differences in staff perception of leadership ability between the charge nurse and the non-clinical unit manager in Adult and Family Medicine? The hypothesis tests the organizations leadership theory that administrative leaders with management experience will demonstrate the Full Range Leadership abilities more effectively than Charge Nurses who lack management or supervisory experience. The null hypothesis was there would be no difference.

## **Project Plan and Evaluation**

### **Market/Risk Analyses**

An analysis of the strengths, weaknesses opportunities and threats (SWOT) is typically used as a component of organizational strategic planning, illustrating impacts on financial



planning and management decisions, and allows for a more comprehensive analysis (Morrison, 2011). This process focuses on issues with the most potential impact and is useful when time is limited. It is a way of reducing the volume of information to provide concise and precise meaning for decision makers (Whonderjohn, 2009).

The SWOT analysis for this project is illustrated in Table 5. Issues that threatened the timely completion of this project included the efforts to implement a redesign on all 22 clinics of Adult and Family Medicine, the influx of new patients into the system, causing a strain on the operation, resulting in multiple changes to the system, presenting obstacle to the project's completion.

<b>SWOT Analysis</b>	
<b>Strengths</b>	<ul style="list-style-type: none"> <li>• Support of administration</li> <li>• Peer input included</li> <li>• Practice setting (clinic)</li> <li>• No funding required</li> <li>• Stakeholders include: fellow nurse managers, department director, unit managers, charge nurses, physicians</li> <li>• Project team includes: DNP student, clinical mentors, DNP capstone chair, DNP faculty advisor, DNP course faculty</li> <li>• Outcomes could improve program management</li> </ul>
<b>Weaknesses</b> <ul style="list-style-type: none"> <li>• Limited to two clinics out of six possible</li> <li>• Time limitations for intervention</li> <li>• Occurs during time of operational redesign</li> <li>• Existing culture on FUMs</li> <li>• Investigator is a nurse manager in Sacramento Adult Primary Care</li> </ul>	<b>Strategies to Overcome Weaknesses</b> <ul style="list-style-type: none"> <li>• Educate staff in purpose of project</li> <li>• Provide assurances to staff that results of study will not threatened employability</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>• Knowledge gained from the project will inform the DNP student/nurse manager of future training needs for nurses and administrative unit managers</li> </ul>
<b>Threats</b> <ul style="list-style-type: none"> <li>• The nurses' union</li> <li>• Limited staff participation</li> </ul>	<b>Strategies to Overcome Threats</b> <ul style="list-style-type: none"> <li>• Inform staff of project during staff meetings</li> </ul>

Table 5. SWOT analysis.

### Driving and Restraining Forces

Kurt Lewin's Force Field Analysis is a method of systematically analyzing complex problems and solutions. Problems are framed in terms of pressures supporting change (driving forces), and those resisting change (restraining forces). Driving Forces are forces that push in a direction that causes change to occur, creating a shift toward change. Restraining forces oppose change. It is essential driving and restraining forces be analyzed prior to implementing a planned change (Kaminsky, 2011)

For this project, the identified driving forces internal to the organization were the need for support staff work flows to be consistently implemented. These work flows are the tools needed to meet regulatory quality outcomes and improve patient satisfaction. This, in turn, would improve the organizations standing against competitors in the local marketplace (P. Maydahl, 2013). Restraining forces are internal, such as the resistance of the staff to the change to another level of management, and the elimination of the charge nurse position, which required negotiation with the nurses' labor union.

### **Needs, Resources and Sustainability**

As mentioned previously, the change to the Service Unit non-RN Manager was a decision made by organizational administration based on the need to meet the challenges presented by customer growth due to ACA enrollment in the health plan, and to mitigate the impact of competition in the marketplace. This was a Management Staffing model already in place in other service areas, therefore, implementing it in the North Valley seen as a feasible choice to meet the challenges, and has been sustained by AFM leadership (P. Maydahl, personal communication, 2014).

### **Feasibility, Risks and Unintended Consequences**

The objective of the capstone project was to establish the feasibility of this change to the unit manager as a more effective leader compared to the charge nurses. There were no risks identified with the change to the unit manager position. A previous cost-benefit analysis conducted by Administration demonstrated significant salary savings, in some cases 30-45%, when comparing the unit manager salary to that of the charge nurse.

Planned change can lead to unintended consequences, which can be either positive or negative, and are the unforeseen results of change (Tiffany & Johnson, 1998). During the course of this project, the only unintended consequence realized involved the management structure of the reception staff, which was not included in this study. The interconnectedness of the operation caused a shift from having clerical supervisors working in tandem with the department managers, to an evaluation of the supervisor's position and change to a management position, which is the operational equivalent of the unit manager, but without a raise in wages (P. Maydahl, personal communication, 2014).

### **Stakeholders and Project Team**

The stakeholders were everyone (staff and leadership) involved in the operation of Adult and Family Medicine and patients. Although this study was a very small scale, there was the potential for outcomes that would help focus the learning needs in leadership practice of the unit managers.

### **Cost/Benefit Analysis**

A cost-benefit analysis (CBA) quantifies all costs and consequences, including benefits and harms, related to an intervention, with the difference between the two indicating whether that intervention is advisable (Reh, nd). CBA includes theories that address inequity, such as the distribution of potential benefits and the costs of economic policies, identifying what group or individual bears the costs and benefits of a particular project or program. It also includes all costs and all benefits of a policy measured in true dollar amounts, and is used to evaluate whether the maximum output is achieved relative to a given level of inputs (CDC, nd). A cost-benefit analysis helps to determine whether a program is worth implementing, comparing the costs of alternatives in achieving a specific outcome (Shi & Singh, 2011).

Costs associated with this project were minimal and included the license to utilize the MLQ, and the use of Mind Garden, Inc.'s Transform™ system, to analyze the results of the survey. Organizational assets employed were the space for the staff meeting, and designated time for staff completion of the survey. Staff completed the survey during their normal work hours, for which they received their normal rate of pay. The budget and resources for this project can be viewed in Appendix C.

## **Risk/Benefit Analysis**

### **Risks**

There was a possibility of perception of risk for the staff because of the investigators position within the organization. These included concerns regarding the use of the results of the MLQ, and whether the results will affect participants job standing. To ensure the staffs right to self-determination, and anonymity, confidentiality and privacy was protected via the administration of the survey through the proprietary third-party site of Mind Garden, Inc., licensor of the MLQ. No protected data was collected during the project.

In their position statement on nursing research, the American Association of Colleges of Nursing (AACN) describe scientific integrity and the ethics of investigation as transcending all nursing research ventures (American Association of Colleges of Nursing, (2012). Survey results were collected anonymously. Informed consent was implied through the participants' willingness to go to the web site housing the survey, opening and answering the survey questions. Pre-survey meetings were held at each site to explain the project and the process, and included written definitions of the various types of leadership, and the link to the website. Institutional Review Board approval was obtained from Regis University (Appendix D) and the organizations' nursing research program (Appendix E).

## **Benefits**

The 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, emphasized the need for a fundamental redesign of systems of care in the health care system to achieve safer, high-quality care. Although many attempts were made to achieve these changes, few were successful due in part to the lack of support by the culture and structure of the larger organization (Lukas, Holmes, Cohen, Restuccia, Cramer, Shwartz & Charns (2007). Organizational structure was one of the problems that led to the development of this capstone project. Previous attempts to implement quality improvement initiatives in AFM clinics had failed due to the inability of department managers to reinforce workflow changes because of the number of direct reports to each manager, which ranged from 30 to 60, depending on the number of physicians or mid-level practitioners at each practice site. The charge nurse role was initially implemented to help move change forward on each clinic, however, the inability of the charge nurses to perform as change leaders was a primary reason the decision was made to hire administrative unit managers to support the department managers.

## **Research Methods and Procedures**

This project was internal to the organization, with the goal of providing base line information regarding the effectiveness of changes in front line leadership structure. A convenience sample included two sites chosen out of seven in the Greater Sacramento Metropolitan Area, with one site being the only site that never had a Unit Manager. The project outline follows:

1. This was a quasi-experimental quantitative design, using survey methodology to measure characteristics of a static group of support staff within two primary care clinics.

2. 26 Medical Assistants at Site 1, and 24 at Site 2 were invited to participate in the study. Education regarding the study was provided during staff huddles, or brief meetings, at each site. Staff was provided with handouts explaining the leadership model being tested, and the web site address for the Mind Garden, Inc. website. (Appendix B)
3. A Collaborative Institutional Training Initiative (CITI) trained nurse researcher conducted the study (Appendix C). Institutional Review Board approval was obtained from Regis University (Appendix D), as well as the organization's research department (Appendix A).
4. Participants were by chance through choice to participate from the individual sites, as well as through the anonymity of participation.
5. The Multifactor Leadership Questionnaire 5X (short) survey (Appendix A) was administered through the Mind Garden, Inc. Transform™ system, and data retrieved through the same site. The contract for use of the site discusses the use of non-person-specific data, which does not contain any linked data to an identifiable person. The contract specifies that Mind Garden will not use any identifiable information, if collected however; it does reserve the right to aggregate any non-person specific data, such as age range, for research, product development or statistical purposes.
6. There was no funding requested from the organization during this project. The nurse researcher conducted the study during regular work hours, and as part of completion requirements for the Doctor of Nursing Practice through Regis University. Staff participation was voluntary and were paid for their time as a part of their regular work schedules.

## **Protection of Human Rights**

In their position statement on nursing research, the American Association of Colleges of Nursing (AACN) states, “scientific integrity and the ethics of investigation transcend and are part of all nursing research ventures” (American Association of Colleges of Nursing, (2012). The study investigator completed the Collaborative Institutional Training Initiative (CITI) human research curriculum in September 2012 (Appendix F).

The target population for this project could be considered a vulnerable population based on the fact the researcher is a manager at one of the AFM facilities. Every effort was made to assure those who chose to participate; their responses will not be connected in any way with their employability. Data collected during this project was used only for the purposes of this study. Responses were transmitted directly to the Mind Garden, Inc. Transform™ website once the respondent selected “done” on the survey. The link to the survey was distributed to potential participants manually during staff meetings via an educational handout, which included the link to the survey (Appendix G). Administering the survey in this manner allowed for complete anonymity. No identifying information was collected in this process.

A license was purchased from Mind Garden, Inc. for the use of the MLQ Rater for research only for 50 administrations. The survey received approval of the IRB application. Because of the anonymity of the survey, there was minimum risk to the participants of this study. Other risks identified were discomfort with answering certain questions, or not understanding certain questions.

## **Provision for Informed Consent**

From both the legal and professional perspectives, the power of decision-making for participation in any type of research is protected by placing that power in the hands of actual and potential project subjects. The process of informed consent protects the autonomy of participants



through provision of sufficient information prior to making the decision to participate (Cassidy & Oddi, 1986). For the purposes of this project, consent was implied by participation in the project.

### **Data Collection Plan**

The initial plan for data collection was to give participating support staff two weeks to complete the survey, which opened on the Mind Garden, Inc. Transform™ website in December of 2013. The initial response was very low, with one participant at the site with the Unit Manager, and none at the other site. In addition, during this period, the Department RN Manager at the site without a Unit Manager chose to retire abruptly. During the following four months, two other Department Managers alternated at that site. The decision was to leave the survey open, and wait until a new manager was in place, which occurred in April 2014. In June 2014, staff at both sites were re-educated regarding the project. There was little to no turnover at both sites, so the staff remembered the project. Potential participants knew that the survey would remain open for an additional four weeks. Survey data was exported from the Transform™ site into Microsoft Excel 2013 format, and was analyzed using the Excel 2013 Data Analysis Toolpack.

### **Data Analysis Plan**

The MLQ 5X (short) is designed as a nine-factor model with 45 questions, which identify nine distinct leadership factors and three leadership outcomes. Eight of the factors identify transformational leadership characteristics: Idealized influence – attributed; Idealized influence – behavior, Inspirational motivation; Individual consideration; Extra effort; Effectiveness; Satisfaction and Intellectual stimulation. Three scales described as characteristic of transactional leadership: Contingent reward, and Management-by-exception – active.

Management-by-exception – passive and Laissez-faire are the two scales associated with Passive Avoidant leadership, or non-leadership. This combination is what defined as “full range leadership” (Muenjohn & Armstrong, 2008, 265).

The rating scale for scoring the MLQ is a Likert-type scale ranging from zero (not at all) to four (frequently, if not always). A scoring key is used to measure the responses. Originally designed in 1985, the MLQ has been challenged, tested, and redesigned to increase its validity. Most of the criticism of earlier versions was concerned with high correlations among the transformational scales, and between the transformation leadership and contingent reward scales.

Since its initial development, research studies conducted in a variety of environments to bolster the use of the MLQ as an effective tool in determining leadership styles (Bass & Avolio, 2010). Kantse, Miettunen & Kyngas (2007), studied the psychometric properties of the tool among nurses in Finland, concluding that leadership, as measured by the MLQ, is a multidimensional construct, and that the MLQ is a suitable instrument as a 360-degree evaluation tool for leadership both from the manager and subordinate level. Muehjohn & Armstrong (2008) found the instrument to successfully captured the full range leadership constructs, providing researchers with confidence in using the MLQ to measure the factors represented in transformational, transactional and passive-avoidant behaviors.

The DNP anticipated that there would be potential threats to the validity of this study. During the period of data collection, there were changes made to the work-flows of the Medical Assistants. The RN Manager/investigator was new to the facility and staff. Additionally, there was the addition of the unit manager position, communicated to the staff as adding an additional layer of oversight to the operation. The elimination of the charge nurse position was public.

There was also the anticipation of a small sample size, which was the case. This increases the possibility of a Type II error, where the researcher decides that there is no significant difference between the samples when one actually exists (Burns & Grove, 2001). The small sample size also presents a threat to generalizability of study findings.

<b>Potential Threats to Validity</b>	
<b><u>Internal</u></b>	<b><u>External</u></b>
History	Generalizability (small sample size)
Low statistical power	Time

Table 6. Potential Threats to Validity

### **Timeframe and Budget/Resources**

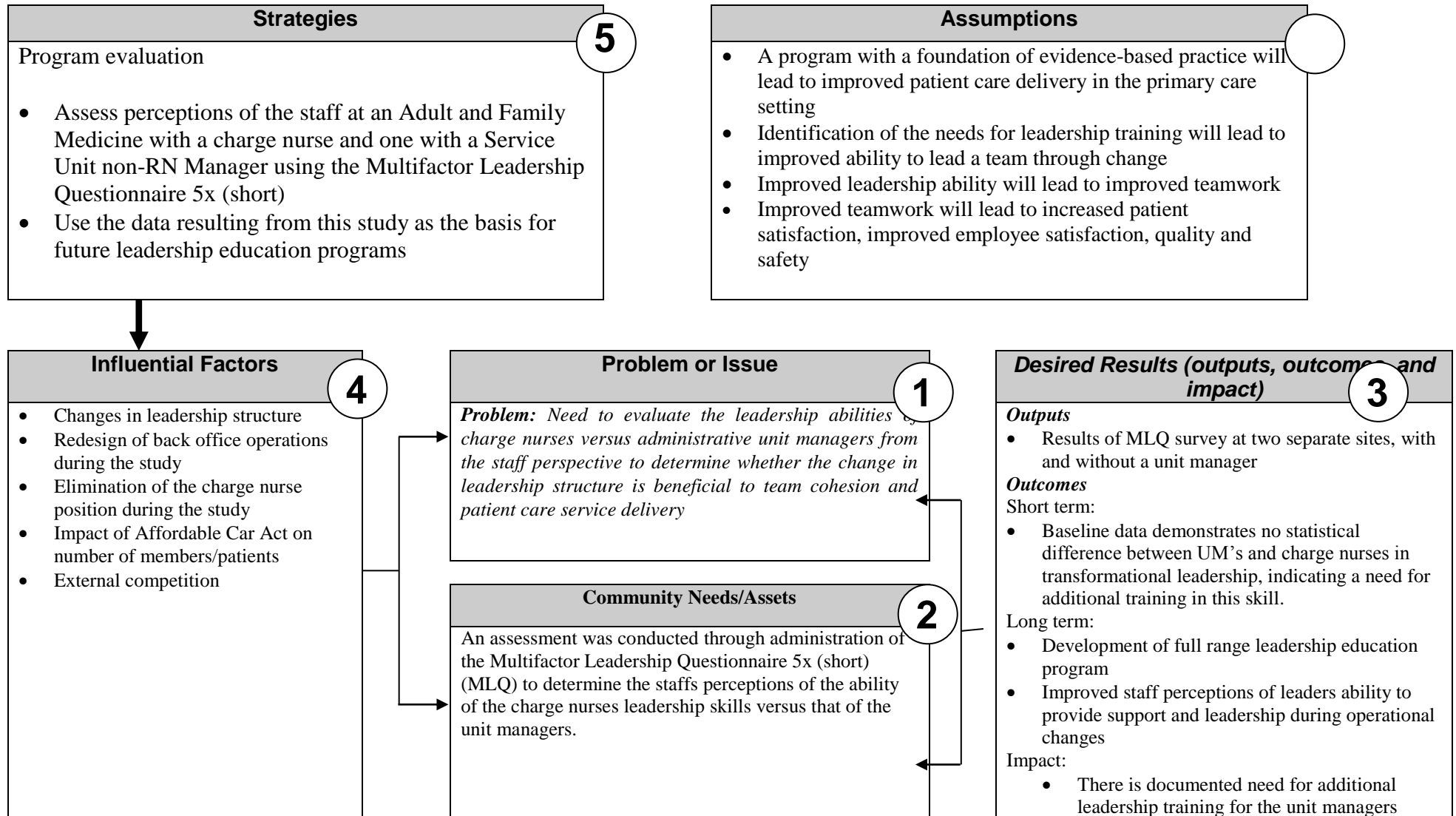
#### **Logic Model**

A logic model creates a picture of the project plan, as seen by the developer. It provides a visual method of presenting and sharing the relationships between the resources available for program planning, short and long-term goals, and projected impacts (Kellogg Foundation, 2004). Several different models were needed for various parts of the project. The most basic logic model provides a picture that describes the sequence of activities needed to affect change, and how those activities link to the results the program expects to achieve. The logic model used for this project was adapted from the W. K. Kellogg Foundation (2004), and developed for program planning (Figure 1).

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Figure 1. Project Logic Model



The logic model starts with a statement of the problem or issue addressed. This theory points toward the effectiveness of the program. The next step is a needs assessment: what led the researcher to address the issue (W. K. Kellogg Foundation, 2004). The need identified for this project was to obtain a baseline measurement of the staff perception of the full range leadership skills of the charge nurses and unit managers.

Box three illustrates the desired outcomes of the program in both the short and long term (W. K. Kellogg Foundation, 2004). In this case, the outcome of the survey would provide the baseline data needed to justify the development of a training program based on full range leadership theory. Box four of the logic model lists the factors that influence change. Box five, describes the strategy, conducting the MLQ survey of staff. Box six, states the assumptions, explaining how and why the researcher believed that this strategy would work (W. K. Kellogg Foundation, 2004).

### **Study Timeline**

Since the beginning of the DNP program in 2012, the capstone project for this investigator has changed twice, once due to a change in job, and the second time because of the decision of the organizations' administration to eliminate the Charge Nurse position, and ensuing labor negotiations. Planning and collaboration for this third iteration of the capstone project started in January, 2013. The timeframe also had to be altered due to the unexpected retirement of the Department RN Manager at the control site. IRB approval was received from Regis University in September 2013, and from the organizations nursing research department in July, 2013. Figure 2 depicts the timeline.



Figure 2. Study Timeline

### Budget and Resources

The investigator is a full time Department RN Manager, with responsibility for three separate clinics, one of which participated in this project. All meetings took place during regular work hours, and during regular staff meetings. There was a cost associated with purchasing the license for use of the MLQ, and for utilization of Mind Garden, Inc.'s Transform™ system, both of which were funded by the investigator. Otherwise there was no additional funding needed.

Budget and Resources		
Item	Cost	Source of Funding
MLQ User's Manual	\$ 50.00	Researcher
MLQ Transform™ Survey Hosting	\$120.00	Researcher
Space for staff meeting	\$0	Organization
Paid time for staff to complete survey 11 staff at two sites @ 28.05/hr each; approximately 45 minutes to complete survey	\$231.41	Organization

Table 7. Budget and Resources

### Research Study Findings and Results

## **Demographic Data**

Because of the anonymity of this study, there was no demographic information collected. The pool of volunteer participants are all Medical Assistants, most of which have been employed within the organization for many years. According to the United States Bureau of Labor Statistics (2014), entry-level educations for a Medical Assistant is a postsecondary, non-degree award, with some learning through on-the-job training and have only a high school diploma. The respondents to the survey come from within this demographic grouping.

## **Study Findings**

The research question for this study was:

What are the perceived differences in staff perception of full range leadership ability between the charge nurse and the non-clinical Service Unit Manager in AFM?

The data analyzed were the responses to the 45 questions included in the Multifactor Leadership Questionnaire. Mind Garden, Inc.'s Transform™. The MLQ design is to test, described by the developers Avolio and Bass (2002), as the full range of leadership styles as measured through responses to 45 questions. Nine subscales measure the three leadership characteristics of Transformational, Transactional and Passive-Avoidant. The nine subscales within each scale are:

1. Transformational: Idealized Influence, Behavioral (IIB) ; Idealized Influence, Attributed (IIA); Inspirational motivation (IM); Intellectual Stimulation (IS), and; Individual Consideration (IC)
2. Transactional: Contingent Reward (CR); Management by Exception – Active (MBEA)

3. Passive-Avoidant: Management by Exception – Passive (MBEA); Laissez-Faire (LF)

The data for each clinic site was analyzed using descriptive statistics. This data is illustrated in Table 3. The rating scale for scoring the MLQ is a Likert-type scale ranging from zero (not at all) to four (frequently, if not always).



Table 8.

	Site 1 – Unit Manager (n=5)					Site 2 – Charge Nurse (n=6)			
	Min	Max	M	SD		Min	Max	M	SD
Acts with Integrity (IIB)	0	3.5	0.7	0.7		0	3	1	1.26
Builds Trust (IIA)	0	2.8	0.56	1.25		0	3	2	1.26
Coaches & Develops People (IC)	0	3.5	2.22	1.41		0	2	2	1.03
Encourages Others (IM)	0	2.5	0.96	1.31		0	3	1.33	1.36
Encourages Innovative Thinking (IS)	0	3	0.66	1.31		0	2	0.66	1.03
Rewards Achievement (CR)	0.5	3.8	2.72	1.33		1	4	2.33	1.21
Monitors Deviations & Mistakes (MBEA)	0	3.5	2.12	1.33		0	3	1.66	1.5
Fights Fires (MBEP)	0	3	0.6	1.34		0	4	1.33	1.5
Avoids Involvement (LF)	0	0.8	0.36	0.35		0	4	1	1.55

Table 8. Descriptive Statistics,

Multifactor Leadership

Questionnaire, two primary care clinics

Table 8 represents the first step of the data analysis, the calculation of descriptive statistics for the variables of interest, the nine subscales of the Multifactor Leadership Questionnaire, for each of the two clinic sites. Variation in

responses measures the standard deviation of the frequency ratings for the subscales. A smaller standard deviation (sd) would mean higher agreement among the raters' ratings (Bass & Avolio, 2003). Since most of the sd's were greater than 1.0, it can be assumed that there was wide variety in the participant's answers.

In addition to the descriptive statistics, a series of *t* tests, paired two sample for means, were run to compare the results of the two

clinic sites, illustrated by leadership scale in tables 4 through 6. The universal norms represent data from over 27,000 raters who previously completed the MLQ (Bass & Avolio, 2003)

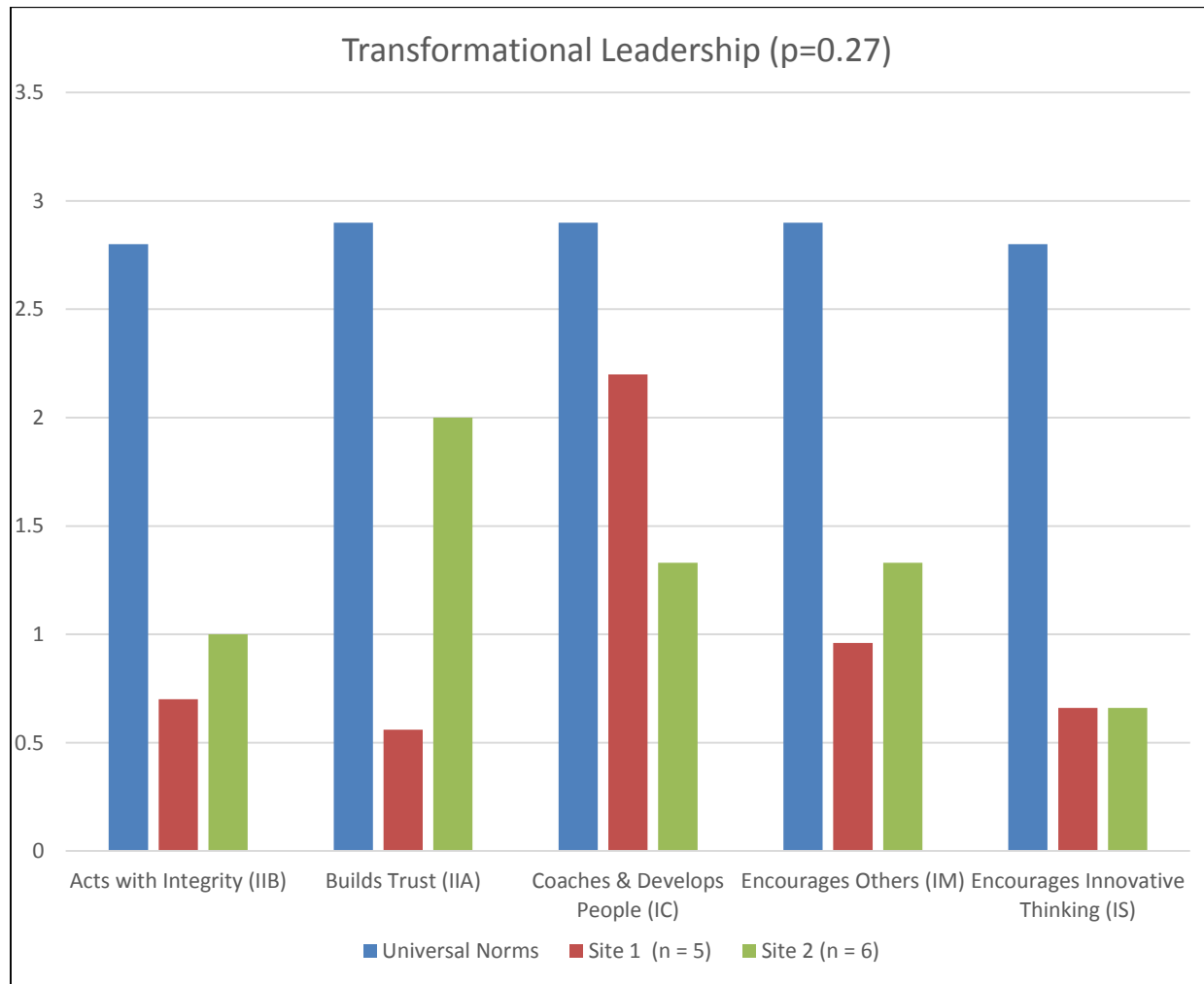


Table 9. *t*-Test: Paired Two Sample for Means, Transformational Leadership

Transformational Leadership is described as a process, which motivates followers through the leaders' ability to persuade and motivate them to act in a way that focuses efforts on the greater good, rather than focusing on their own self-interests (Doody & Doody, 2012). For the attribute of Transformational Leadership, there was no significant difference in the perception of the staff between the two sites, as indicated by the p-score of 0.27, therefore, the hypothesis that the Unit Manager would demonstrate the characteristics of a transformational leader more than the Charge Nurse had to be rejected. Of note, on the subscale *Builds Trust*, Site 2 scored higher than Site 1. This could be an indicator that the staff perceives the Charge Nurse as more trustworthy because they are not as directive as the Unit Manager. The subscale of Coaches and Develops lends some credence to this theory, as Site 1 scored the Unit Manager higher in this area. Follow-up studies would be required to determine if that continues to be the case over time.

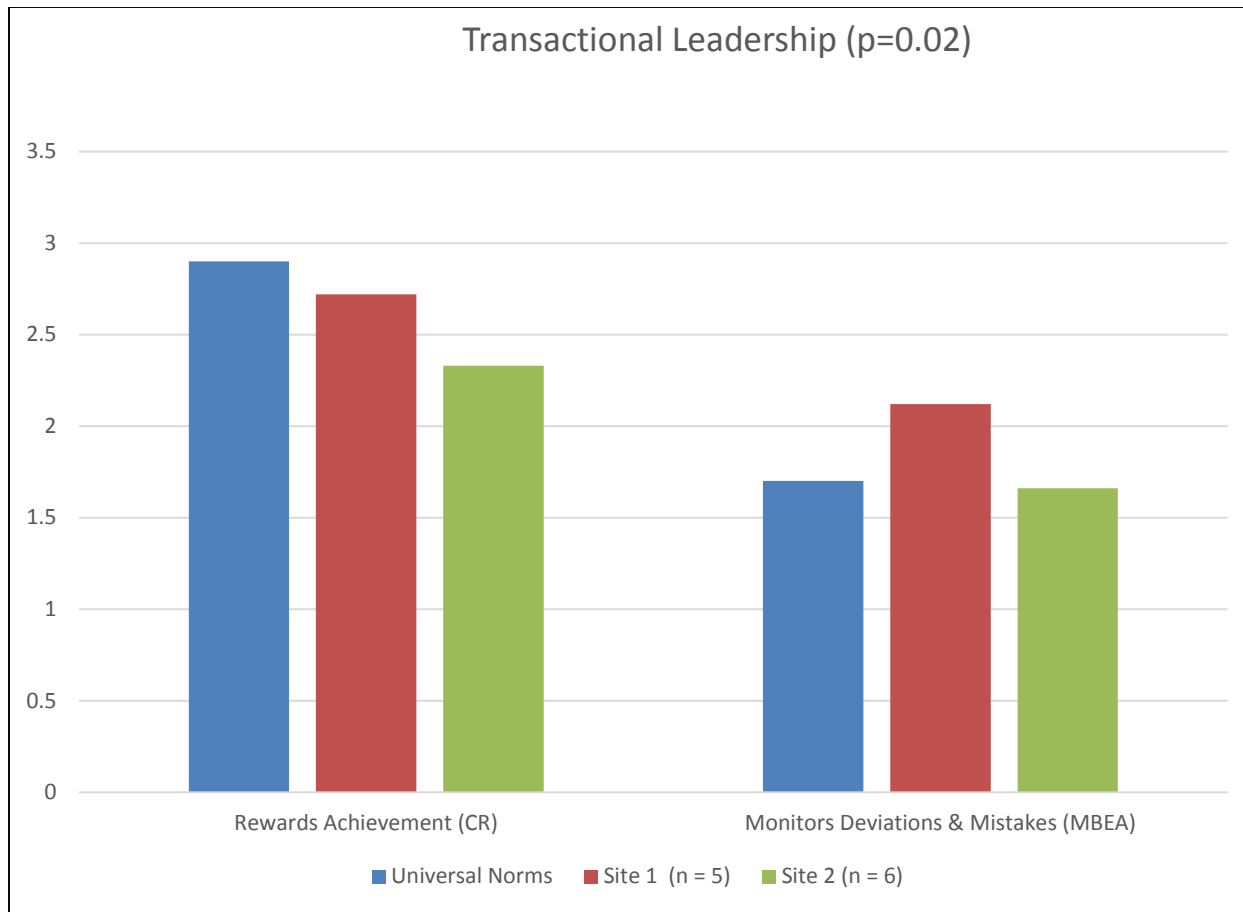


Table 10. *t-Test: Paired Two Sample for Means*, Transactional Leadership

Transactional leaders focus on the tasks required to reach desired outcomes, clarifying these for subordinates, as well as what staff need to achieve those outcomes, at times, for a reward (contingent reward). This motivation to perform provides a sense of direction and energy. This approach has historically been stressed in leadership training programs (Avolio & Bass, 1995).

The results of the MLQ for this study demonstrate that the staff at Site 1 perceive the Unit Managers as demonstrating more transactional leadership characteristics than the Charge Nurses at Site 2, as indicated by the p score ( $p < 0.05$ ).

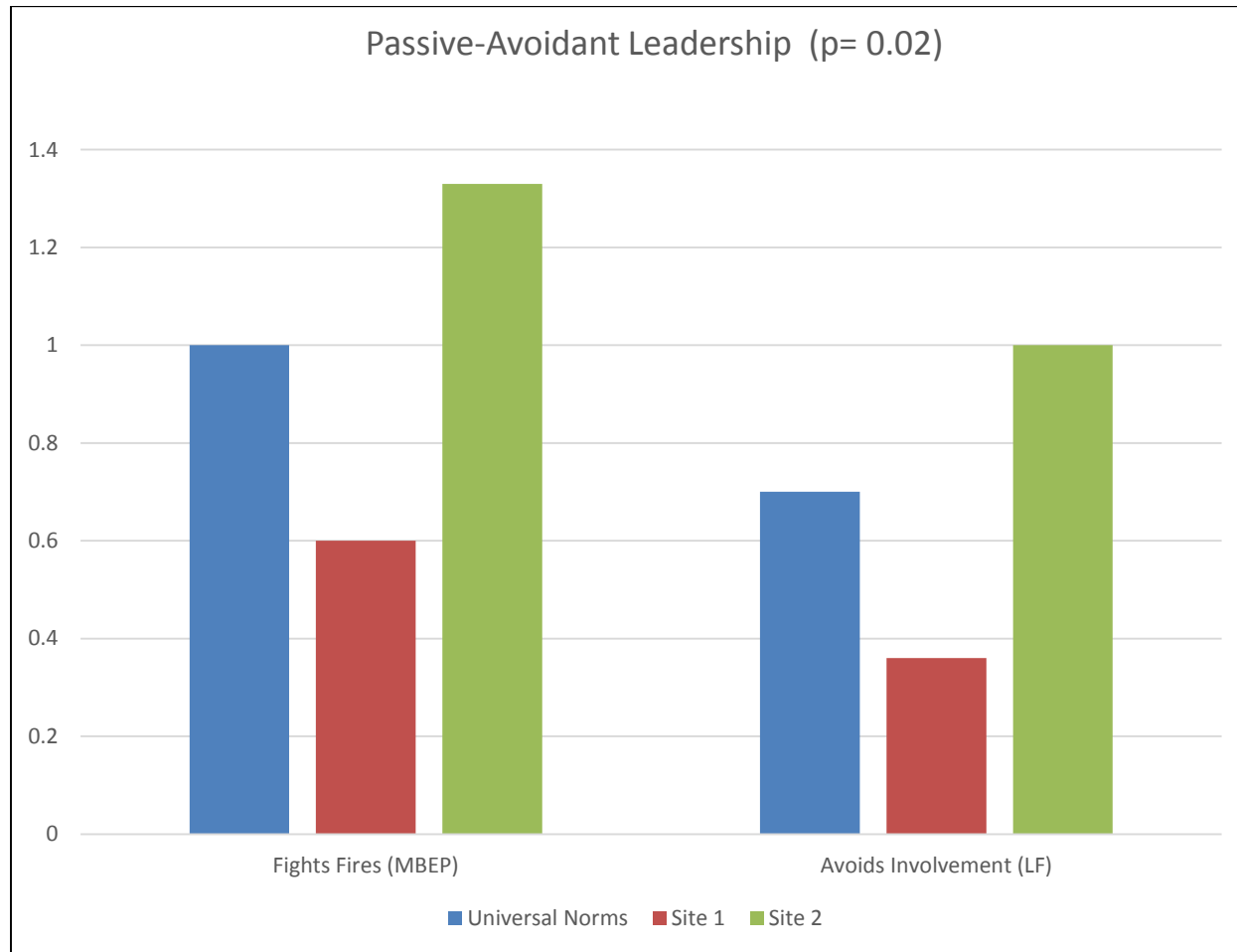


Table 11. *t-Test: Paired Two Sample for Means*, Passive-Avoidant Leadership

Passive-Avoidant leadership is described as more passive and reactive, with no systemic response to situations. This style usually demonstrates corrective actions only when mistakes occur, or Management by Exception – Passive. This has a negative effect on the desired outcomes. The other subscale in this leadership style is Laissez-Faire, also described as the “no leadership” style. Table 4 demonstrates these subscales are most dominant in the clinic where the Charge Nurse is considered the leader ( $p < 0.05$ ), confirming the hypothesis of the administrators that the Charge Nurses are not effective at leading their team in meeting organizational objectives.

### **Discussion**

The purpose of this research was to explore how support staff in the primary care setting perceived the leadership skills of non-clinical unit managers versus the leadership skills of charge nurses. Historically, it was the charge nurses who staff was used to working with. The unit manager role was one that was new to the staff, and was rolled out quickly across almost all primary care clinical sites of the organization, even though there was not a clear understanding of what the role would do, or how to measure success. The null hypotheses were two-fold: first, there would be difference in the full range leadership abilities of the two types of leaders, and second, there would be no difference in the staff perceptions between the two types of leaders.

The findings propose there is a difference in staff perception when viewed through the lens of full range leadership. In the scale of transformational leadership, there was a difference noted in the subscales Builds Trust, and Coaches and Develops People. In the former subscale, the staff at Site 2, the site with the charge nurses, had long-term relationships with the charge nurses. All had worked together for many years, with little turnover. This was actually the standard in the organization: staff are hired into positions, and rarely change departments. Relationships become intimate, and may, at times, transcend the professional relationship to one that is

more personal. Under these circumstances, it would be reasonable to assume the staff views the relationship as trusting, although there may not be much effort at leadership. Conversely, the perception of the staff at Site 1, with the unit manager, scored higher in the subscale for coaching and development. This would reflect the efforts of the unit managers to teach the staff new workflows and ensure they are followed consistently. To accomplish this requires a combination of transformational and transactional leadership. Unit managers would benefit from a Leadership Training Program based on the full range leadership scales and subscales. The organization also benefit through the development of a cadre of leaders who have the experience and the training to lead front line staff through the types of operational changes that are needed for the organization to remain a viable competitor in the healthcare market, both locally and regionally. Follow-up evaluation of the unit managers utilizing the MLQ would provide data to prove the efficacy of the training program.

### **Limitations, Recommendations, Implications for Change**

#### **Limitations**

The main limitation of this study is the very small sample size within a large integrated care system, which decreases reliability and eliminates generalization of the results to other health care systems and organizations (Malloy & Penprase, 2010). This might have been reduced if a power analysis had been run prior to the study, described as the long-term probability that the null hypothesis will be rejected when it is false, or the likelihood that an effect will be statistically significant (Gaskin & Happell, 2014). This is the process that, when planning the study design, calculates how many participants would need to be recruited for an effect of sufficient

magnitude to be statistically significant (Gaskin & Happell, 2014). This should be taken into consideration for future research on this topic.

Other limitations include the short time frame for the study, given the delay of four months due to managerial change, and the study design itself. Kane and Radosevich (2011) discuss the limitations of randomization, especially when restricted to a tightly targeted group of participants, describing it as a way of trading tightness of comparisons, or internal validity, for generalizability, or external validity. The sample in this study was very tightly restricted due to the exposure of all sites except one prior experience and exposure to the unit manager model.

Lastly, the fact that this was a self-report study could be considered a limitation. The perceptions of leadership can be subjective, depending on the environment at the time the survey administered. If the survey is administered during a time of uncertainty within the organization, as it was during this study, the responses could be skewed because of the anxiety the staff may have been feeling at the time.

### **Implications for Practice and Future Research**

This study serves as a foundation for further research and education in effective leadership practices not only for charge nurses and unit managers, but also for all who serve in leadership positions within the organization. The MLQ can be used for 360-degree evaluations of leaders, with responses from the leader, their peers, subordinates, or higher-level associates (Bass & Avolio, 2004). Since the organization has moved to full implementation of the Service Unit non-RN Manager across all sites, and as it moves ahead with further operational changes, it would be of great benefit to assess full range leadership abilities, and develop a comprehensive



leadership development program. Further examination of the relationship between staff and leaders should be repeated after implementation of further training, to determine whether The benefits to the organization would be improved staff job satisfaction, and improved patient care delivery and satisfaction.

### **Conclusion**

The principal goal of this project was to establish a baseline of how the staff perceives the leadership ability of the charge nurses and unit managers of Adult and Family Medicine. To accomplish this required an examination of the theoretical basis, and the empirical data to answer the research question: What are the perceived differences in staff perception of full range leadership ability between the charge nurse and the non-clinical Service Unit Manager in AFM?

The lack of charge nurses or other leaders possessing the necessary leadership skills to navigate the changes needed to meet a transforming patient care delivery service results in difficulty meeting clinical outcomes, and job dissatisfaction. The dearth of studies focusing on leadership in the ambulatory care setting points to a need for further research in this area. The studies, which do exist, have focused on transformational leadership alone, even though studies of full range leadership in other disciplines have demonstrated its effectiveness as a model. Rewarding and charismatic leadership qualities are successful in leading effective teams; however, there is still a need for the more traditional reward for performance found in transactional leadership (Kantse, Kaariainen & Kyngas, 2009). Full range leadership allows for the flexibility needed to guide teams through change.

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*Appendix A Multifactor Leadership Questionnaire 5x (short) Rater*

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4
1.	Provides me with assistance in exchange for my efforts			0 1 2 3 4
2.	Re-examines critical assumptions to question whether they are appropriate			0 1 2 3 4
3.	Fails to interfere until problems become serious			0 1 2 3 4
4.	Focuses attention on irregularities, mistakes, exceptions, and deviation from standards			0 1 2 3 4
5.	Avoids getting involved when important issues arise			0 1 2 3 4
6.	Talks about their most important values and beliefs			0 1 2 3 4
7.	Is absent when needed			0 1 2 3 4
8.	Seeks differing perspectives when solving problems			0 1 2 3 4
9.	Talks optimistically about the future			0 1 2 3 4
10.	Instills pride in others for being associated with him/her			0 1 2 3 4
11.	Discusses in specific terms who is responsible for achieving performance targets			0 1 2 3 4
12.	Waits for things to go wrong before taking action			0 1 2 3 4
13.	Talks enthusiastically about what needs to be accomplished			0 1 2 3 4
14.	Specifies the importance of having a strong sense of purpose			0 1 2 3 4
15.	Spends time teaching and coaching			0 1 2 3 4
16.	Makes clear what one can expect to receive when performance goals are achieved			0 1 2 3 4
17.	Shows that he/she is a firm believer in "If it ain't broke, don't fix it"			0 1 2 3 4

18.	Goes beyond self-interest for the good of the group	0	1	2	3	4
19.	Treats others as individuals rather than just as a member of a group	0	1	2	3	4
20.	Demonstrates that problems must become chronic before taking action	0	1	2	3	4
21.	Acts in ways that build others' respect for him/her	0	1	2	3	4
22.	Concentrates full attention on dealing with mistakes, complaints, and failures	0	1	2	3	4
23.	Considers the moral and ethical consequences of decisions	0	1	2	3	4
24.	Keeps track of all mistakes	0	1	2	3	4
25.	Displays a sense of power and confidence	0	1	2	3	4
26.	Articulates a compelling vision of the future	0	1	2	3	4
27.	Directs my attention toward failures to meet standards	0	1	2	3	4
28.	Avoids making decisions	0	1	2	3	4
29.	Considers an individual as having different needs, abilities, and aspirations from others	0	1	2	3	4
30.	Gets others to look at problems from many different angles	0	1	2	3	4
31.	Helps others to develop their strengths	0	1	2	3	4
32.	Suggests new ways of looking at how to complete assignments	0	1	2	3	4
33.	Delays responding to urgent questions	0	1	2	3	4
34.	Emphasizes the importance of having a collective sense of mission	0	1	2	3	4
35.	Expresses satisfaction when others meet expectations	0	1	2	3	4
36.	Expresses confidence that goals will be achieved	0	1	2	3	4
37.	Effective in meeting others' job-related needs	0	1	2	3	4
38.	Uses methods of leadership that are satisfying	0	1	2	3	4



39.	Gets others to do more than they expected to do	0	1	2	3	4
40.	Is effective in representing others to higher authority	0	1	2	3	4
41.	Works with others in a satisfactory way	0	1	2	3	4
42.	Heightens others' desire to succeed	0	1	2	3	4
43.	Is effective in meeting organizational requirements	0	1	2	3	4
44.	Increases others' willingness to try harder	0	1	2	3	4
45.	Leads a group that is effective	0	1	2	3	4

*Appendix B*

## Regis University Institutional Review Board Approval

12/12/2015

Review of resubmitted proposal...

**Review of resubmitted proposal...**

Institutional Review Board

Sent: Tuesday, September 10, 2013 8:43 AM

To: Gilliam, Dierdre A; Jackson, Alma M

Cc: Institutional Review Board

Importance: High

Dear Ms. Gilliam...

The Institutional Review Board has completed a re-evaluation of your submitted proposal, *Evaluation of Leadership Changes in Adult Primary Care*. I am pleased to inform you that the proposal has been fully approved as an Exempt study per Category #2. You may begin study implementation and data collection upon receipt of this email. An official letter of approval for your study files will be forthcoming. As an aside, please note that this approval does last a full twelve months and we have taken the liberty of extending your project time line to reflect this to allow for adequate data collection, analysis, and interpretation. We wish you success with your project.

Patsy McGuire Cullen, PhD, PNP-BC

Chair, Institutional Review Board

(303) 964-5132

[irb@regis.edu](mailto:irb@regis.edu)

*Appendix C*



THIS IS YOUR OFFICIAL COMMUNICATION FROM THE KPNC IRB  
REGARDING YOUR RECENT SUBMISSION.

May 6, 2013

Dierdre Gilliam  
Principal Investigator  
Sacramento

Re: Evaluation of Leadership Changes in Adult Primary Care

Dear Ms. Gilliam:

A reviewer designated by the Institutional Review Board (IRB) chair has reviewed your application and has found it to meet Kaiser Permanente Northern California (KPNC) policy and federal regulatory criteria (category 2: tests, surveys, interviews, or observations) exempting it from IRB review.

If you change your project, please submit a modification request form for IRB review and approval **before** you implement the change.

Please contact me directly at 510-625-3241 or by email if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'James G. Doyle', is positioned above the typed name.

James G. Doyle, MS, CIP  
KPNC IRB Manager  
James.G.Doyle@kp.org

## Appendix D

### COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM) COURSEWORK REQUIREMENTS REPORT\*

\* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Dierdre Gilliam (ID: 3104995)
- **Email:** dgilliam@regis.edu
- **Institution Affiliation:** Regis University (ID: 745)
- **Institution Unit:** Loretto Highs College of Nursing
- **Curriculum Group:** Human Research
- **Course Learner Group:** Biomedical Research Investigators and Key Personnel
- **Stage:** Stage 1 - Basic Course
- **Report ID:** 8823115
- **Completion Date:** 09/29/2012
- **Expiration Date:** 09/29/2015
- **Minimum Passing:** 80
- **Reported Score\*:** 98

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	09/23/12
Introduction (ID: 757)	09/23/12
History and Ethics of Human Subjects Research (ID: 498)	09/29/12
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	09/29/12
Informed Consent (ID: 3)	09/29/12
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	09/29/12
Records-Based Research (ID: 5)	09/29/12
Genetic Research in Human Populations (ID: 6)	09/29/12
Research With Protected Populations - Vulnerable Subjects: An Overview (ID: 7)	09/29/12
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	09/29/12
Vulnerable Subjects - Research Involving Children (ID: 9)	09/29/12
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	09/29/12
International Studies (ID: 971)	09/29/12
FDA-Regulated Research (ID: 12)	09/29/12

Research and HIPAA Privacy Protections (ID: 14)	09/29/12
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	09/29/12
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	09/29/12
Regis University (ID: 1164)	09/29/12

**For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.**

## Appendix E

Thank you for your consideration in participating in my doctoral research project. This is the final project in my Doctor of Nursing Practice degree program. Your willingness to participate by completing an anonymous online survey will allow me to investigate the differences in how staff members view the leadership traits of Charge Nurses and non-clinical Unit Managers. The results of the survey may be published to add to the evidence base of leadership characteristics needed in adult primary care clinics. There are very few studies that have been conducted and published in nursing journals for the area in which we all work.

A second benefit of this study, and perhaps the most important, is that it will provide much needed information for the type of leadership skills the staff of North Valley Adult Primary Care need to create a positive, productive environment where staff feel supported and new leaders are recognized and developed.

The Multifactor Leadership Questionnaire (MLQ) is a 45-question survey which, "identifies the characteristics of a transformational leader and helps individuals discover how they measure up in their own eyes and in the eyes of those with whom they work" (Mind Garden.com, 2013). More information about transformational leadership can be found on page 2.

There are two groups participating in this research: one in a facility that has been had a Unit Manager for the past year, and one that has not had any changes to its leadership structure, where the Charge Nurse position is still in place. To ensure anonymity I am providing a no-sign in link to the MLQ. The link for your facility is:

<http://transform.mindgarden.com/survey/13204>

[This link will be open until December 13, 2013.](#)

Thank you, again, for participating in this important study.

Dee Dee Gilliam, DNP(c), RN

## References

Mind Garden.com (2013). Multifactor Leadership Questionnaire: The benchmark measure of transformational leadership. Retrieved from <http://www.mindgarden.com/products/mlq.htm>



## What is Transformational Leadership?

Transformational leaders are those who transform their followers into becoming leaders themselves. From Wikipedia, "Transformational leadership is a leadership approach that is defined as leadership that creates valuable and positive change in the followers. A transformational leader focuses on "transforming" others to help each other, to look out for each other, to be encouraging and harmonious, and to look out for the organization as a whole. In this leadership, the leader enhances the motivation, morale and performance of his follower group."

There are four components of Transformational Leadership (Bass, Bernard M. 1998 **Transformational Leadership**. New York: Lawrence Erlbaum Assoc, Inc.):

- ***Idealized Influence*** (also known as Charismatic Leadership) - Transformational leaders act in ways that make them role models. They are respected, admired and trusted. Followers identify with them and describe them in terms that imply extraordinary capabilities, persistence and determination. These leaders are willing to take risks. They can consistently be relied upon to do the right thing, displaying high moral and ethical standards.
- ***Inspirational Motivation*** - These leaders embody the term "team spirit". They show enthusiasm and optimism, providing both meaning and challenge to the work at hand. They create an atmosphere of commitment to goals and a shared vision.
- ***Intellectual Stimulation*** - a Transformational Leader encourages creativity and fosters an atmosphere in which followers feel compelled to think about old problems in a new way. Public criticism is avoided.
- ***Individualized Consideration*** - Transformational leaders act as mentors and coaches. Individual desires and needs are respected. Differences are accepted and two-way communication is common. These leaders are considered to be good listeners, and along with this comes personalized interaction. Followers of these leaders move continually toward development of higher levels of potential.